AMERICAN HEALTH CONSULTANTS®

HOSPITAL CASE MANAGEMENT

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

Inserted in this issue:
2000 Caseload Survey for Case Managers

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Expect a community care focus in case management's future

Technology, data sharing also will play likely roles

Hospital case management can expect significant changes to its landscape in the near future. The incorporation of new technologies into health care and a growing focus on community case management are two trends that hospitals can't afford to ignore as health care prepares to greet the new millennium.

"It is an exciting time to be a case manager. The field is growing and developing," says **Diane L. Huber**, PhD, RN, FAAN, CNAA, associate professor at the University of Iowa College of Nursing in Iowa City. According to Huber and other industry leaders, several trends have begun to emerge that soon may be standard practice in hospital case management:

1. The inclusion of community care management.

"Case managers provide a critical client-oriented coordination of care that benefits both the . . . individual client's needs and the need to control high costs," Huber says.

As a newly elected member of the Commission for Case Manager Certification (CCMC) in Rolling Meadows, IL, she says case management will help improve health care in the United States by "going beyond an episode of care. [Case managers] work across service environments; they interact among providers on behalf of clients . . . and they address multifaceted needs for care in a system marked by fragmentation."

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Next month:
Credentials — A case manager's advantage

How important are those initials after your name? According to **Diane Huber**, PhD, RN, FAAN, CNAA, a newly elected member of the Commission for Case Management Certification in Rolling Meadows, IL, they are essential. "Certification validates that . . . practitioners are well-prepared for their jobs and promotes excellence in practice," she says. "This competency assessment provides the consumer with a basis for trust and confidence in a quality service." There are several credentialing boards throughout the United States, and it's important to get the certification that best fits your career goals. Look for the complete directory of certification options, as well as more detailed reports about credentialing in the January *Hospital Case Management.*

COMING IN FUTURE ISSUES

- **Special Report on Credentialing:** Choosing the credential that best fits your career goals
- The return of *Hospital Case Management*'s directory of case management credentials
- **Need a job?** Focus your career through the Internet looking glass
- **Budgeting:** What does a community case management program cost?
- Reimbursement rules and how they affect the entire care continuum

Some case managers already are addressing that fragmentation, says **John Borg**, RN, MS, senior vice president at Clinical and Community Services of the Valley Health System in Winchester, VA. "I think case management is moving to the continuum, and though it [has been] very acute-care oriented, length of stay and cost savings for the inpatient acute are pretty much maxed out. The only [way] we have to cut costs now is to translate [case management] and put it on the continuum. . . . Case management is going into the community," he asserts.

Linking acute-care patients to external services such as skilled nursing facilities, nursing homes, and home health agencies may be something that's more typically associated with payer-based case managers, but experts point out that hospitals need to consider the positive effect that community-based care can have on their outcomes, as well.

"From a cost-benefit standpoint, it's clearly more effective than readmission," says **Judy Homa-Lowry**, RN, MS, CPHQ, president of Homa-Lowry Healthcare Consulting in Canton, MI. More importantly, there's an increased emphasis on care. The bottom line, she insists, must be making the patient safe, healthy, and independent.

Taking it to the streets

Community case management provides a bridge from the hospital stay or emergency room visit to the patient's daily life. In some cases, patients may have a skilled nursing need; in others, simple instructions for good self-care are the only real prescription.

Homa-Lowry has seen that develop in hospital maternity wards. Case managers will initiate care education during a new mom's hospital stay, teaching her about infant care as well as her own physical and emotional needs after the birth, then the case manager will go into the home to follow up that care education. "We need more of that in diabetes management, asthma, and other disease management."

Possible obstacles to community care

Hospital acute care case management extends into the community when hospitals assume financial risk for a selected population or have a business imperative for managing patients across the continuum. In that case, hospitals will definitely

Case management caseloads: How much is too much?

American Health Consultants, publisher of *Hospital Case Management*, and the Case Management Society of America in Little Rock, AR, are collaborating on a unique caseload survey that will, for the first time, shed light on national practices for setting and coordinating case management caseloads. Case managers in both the payer and provider settings will be surveyed as we compile a national database, which explores pressing issues in managing case management caseloads across the care continuum, such as:

- methods used to assign a new case to case managers within organizations;
- average case management caseload within organizations based on practice setting;
- criteria for measuring case manager productivity within organizations.

Please take a moment to complete and fax back the caseload survey inserted in this issue, or complete the survey on-line at www.ahcpub.com/cmcaseload.html. In return for your participation, you will receive a free copy of an executive summary of the results of this national survey when it is released next spring. ■

want to measure the effectiveness of community case management, says **Larry Strassner**, MS, RN, consultant with CapGemini Ernst & Young in Philadelphia.

But as in the maternity example, case managers have found that their personalized community care is proving effective, "in terms of return visits to the hospital, the pediatrician, or the OB/GYN," Homa-Lowry explains.

Reimbursement a possible obstacle

Experts warn of another issue that might work against the push to integrate acute and community care: reimbursement. Hospital case management may be moving into the community, but limits on Medicare reimbursement to skilled nursing facilities, nursing homes, and home health agencies could cause problems, Strassner says.

"We are seeing a trend in Medicare HMO plans discontinuing services and home health agencies closing due to budget constraints as a result of Medicare reimbursement. . . . That is creating placement and post-acute care coordination issues. Case management is experiencing a level of 'pushback' from the community and the need to keep the patient in the acute care setting," he says. "Within the next three years, we're not going to be able to move patients out of the hospital as quickly as we have before."

"The only place we can continue to cut costs now is to transition [to] community case management and integrate it with the home care program so it functions on the health continuum," Borg says. "Case management needs to be outside the acute care walls to continue its effectiveness." **(For more on community case management, see *Hospital Case Management*, July 2000, pp. 107-109.)**

2. **The integration of acute care with other services through technology.**

"Case management needs to be enhanced by additional clinical documentation systems that tie together acute care, outpatient, physician, and clinic visit information," Borg says.

The ability to transfer and store information for multiple users will get easier as Internet and intranet systems continue to take hold, he explains. While this is a very expensive venture right now, "the Web is going to make it more accessible." Independent physicians' offices and home health agencies will start using the affordable technology available, and case managers can benefit from all of that knowledge.

Without the technology, Borg says, "We spend an average of an hour to two hours on every discharged managed patient, calling two or three physicians to make sure they know what medications [the patient] is on." Sharing information on the Internet could change that.

The technology also could help tackle another severe problem in the scope of the nation's health care: medication mismanagement, especially of the growing elderly population. "Case management is the key to medication compliance and [avoiding] medication errors," Borg says. "Many of our [elderly patients] are on nine to 15 drugs a day and need constant, correct supervision. Physicians generally don't develop relationships like that."

Of course, regulatory factors will be important, especially in light of the Health Insurance Portability and Accountability Act rules. Those rules include case management under covered "atypical" services, making it subject to the privacy standards set forth by the federal government. In practice, that means case managers will have to be diligent in following their facilities' guidelines

regarding the privacy of patient information transmitted electronically. But the benefits of technical integration far outweigh the risks.

3. **Case management as the facilitator of better communication among disciplines within a facility.**

Homa-Lowry laments the lack of communication in many care facilities today. She says you sometimes can tell by "looking at the medical record that the patient's care hasn't been integrated very well." Case managers should be the ones who maintain good relationships among the different departments "because they have a better opportunity and ability to step back and look at the big picture." Instead of one person worried about risk, one about reimbursement, one about supplies, and one about discharge, "there must be consistency and communication," she says.

Corporate compliance, for example, is a big issue. Are case managers getting the back-end data [about the analysis between medications, supplies, and billing]?" she asks. "They clearly should be," so that they can measure against it.

Huber agrees. "With case management, value is placed on finding needed resources . . . and using professional expertise to communicate and problem solve. In this way, the management of complex conditions is enhanced and accelerated." Both the individual and the health care system at large benefit from good communication, with shorter stays and better-focused care plans.

Other issues loom in case management's future as well. Credentialing will become even more needed and respected, says Strassner. More importantly, case managers will need to continue to demonstrate that they have the clinical depth and experience that make them valued health care professionals.

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Nursing shortage takes toll on CM departments

What can we do to combat the nursing problem?

By now, news of the country's shrinking nurse work force probably has reached all points on the health care map. An extensive review of population data, published in the *Journal of the American Medical Association*, confirmed that within 10 years, the average age of registered nurses will rise to 45.4 — with 40% of the work force older than 50.[1] *Hospital Case Management*'s annual salary survey shows that among hospital-based case managers, age is shifting the same way. **(For the complete report, please see *HCM*'s salary survey report, inserted in this issue.)**

But how does that affect hospital case management departments, and what is being done to solve the problem? **Judy Homa-Lowry**, RN, MS, CPHQ, president of Homa-Lowry Healthcare Consulting in Canton, MI, says that in some organizations, RN case managers are shared with other departments.

They perform both case management and on-the-floor patient care. Sometimes that causes higher stress levels and increased burnout rates, with case managers performing double-duty and doing extra paperwork. Whereas the traditional case management role was largely "Monday through Friday," it now includes evenings, weekends, and holidays, she adds.

"If you're in an area with a lot of shortage," Homa-Lowry says, "your professionals are going to be doing a lot of things, and that will affect what you're doing in the case management department."

State of transition

The shortage of personnel "makes the role of the case manager even more important," she says, but it also "puts the hospital case management department in a state of transition." Your success depends on your organization's philosophy of case management, she says. The department, and the role of each person within it, should be clearly defined in order to bridge the current trends.

"Roles are evolving because of the nursing shortage. We need a value-added analysis [of the case manager's role] to determine what

functions they should retain and what should be eliminated."

Homa-Lowry says one hospital tried to deal with the problem by investing a lot of money in case management. It hired a lot of high-level individuals and absorbed the hospital's utilization review staff as well. "Still, it is not able to execute." For that hospital, case management looks great on paper, but striking the right balance between patient care roles and management roles has been difficult.

During this time of nursing shortages, organizations need better definitions of case manager responsibilities, continuing staff education, good monitoring, and staff compliance with their defined roles, in order to achieve success, she explains.

What's being done about it?

Enrollment trends at U.S. nursing colleges haven't helped the current situation. "Nursing schools across the nation purposefully have downsized their programs and reduced the number of students they admit, in part, because there aren't enough nurse faculty members to go around," and also because of a lack of interest from young people, says **Lucy Leusch**, director of graduate admissions at Emory University's Nell Hodgson Woodruff School of Nursing in Atlanta. Admissions professionals are doing what they can to reverse the shortage for future generations.

"We're doing some innovative things in partnering with hospitals, both to recruit students and to help them employ nurses," Leusch says.

One such program is NEAT, or Nursing Employment and Tuition — a partnership with the university's health system, Emory Healthcare. The system pays 50% of tuition for 20 incoming students (BSN) per six-month semester, and in return, those students agree to work within the system after graduation for an equal six-month period.

Renewable each semester, NEAT can lead to up to two years of nursing employment for the hospital system. Other colleges have similar programs with their neighboring health systems.

Nursing faculty members also are interested in visiting secondary schools, and even elementary schools, to educate young people about the positive aspects of health care careers. And the American Association of Colleges of Nursing in Washington, DC, has assembled a new national task force to advise its members about recruiting more nurses and keeping them in the profession.

"What case management does for nursing is to create a career adjunct, similar to advanced practice fields, that provides nurses with another career option, explains **Diane Huber**, PhD, RN, FAAN, CNAA, associate professor at the College of Nursing at the University of Iowa.

"Seen as an attractive advancement, case management is a positive recruitment mechanism for potential new nurses. It is a way to showcase skills in expert clinical judgment, critical thinking, problem solving in complex situations, and advocacy across the health care continuum," she says.

Lack of communication is the real issue affecting the work of case management, Homa-Lowry continues. "It's not necessarily the number of bodies; it's that various disciplines [within the care continuum] aren't complementing each other and sharing data. When you're planning care, the unit manager or head nurse and the case manager need to be on the same page," so that effective care can be administered, Huber says.

Often, the lack of sharing is not by design, but the case management department needs to make a conscious effort to meet with other departments, in terms of similar information needs and outcomes, she says.

In addition, people need to know about the good things case management is doing in patient care, Homa-Lowry asserts. "It would be nice to measure good patient care outcomes, not only pathway adherence or payment measurement. That will take some work on the part of case management."

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1. Buerhaus PI, Staiger DO, Auerbac DI. Implications of an aging registered nurse workforce. *JAMA* 2000; 283:2,948-2,954. ■

GUEST COLUMN

Evaluate the contribution of social services

Use survey tool for CM improvement

By **Patrice Spath**, RHIT
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Social work services provide an important link between the ambulatory and inpatient providers and health care clients. Social workers assist patients in finding available and appropriate resources, help with financial issues, arrange transportation for patients, and conduct many more enabling tasks. Social workers assist in the assessment of patient needs and ensure that appropriate post-hospital services are provided.

For the ambulatory care client, whether hospitalization has occurred or not, social workers can provide a link from one service to another. In addition to coordinating support services, social workers assist patients and their families in resolving personal or emotional problems that affect the patient's participation in clinical care.

Equally important, they provide patients and their families with a shoulder to lean on and encouragement to continue the care process until the treatment is concluded or the problem is resolved as effectively as possible.

Measures of the social worker's contribution to the case management process are linked to the job responsibilities. Listed below are common job tasks performed by social workers involved in hospital-based case management:

❒ Conduct patient/family assessments to identify barriers that may impede recovery and/or the patient's return to the community.

❒ Help patients identify their concerns about their illness and recovery, consider solutions, and find necessary resources.

❒ Investigate patient or family allegations of abuse and neglect and intervene if necessary.

❒ Plan for appropriate post-discharge supportive services and follow through to assure that services were actually provided and met patients' needs.

It is important that social workers collect and analyze data about the effectiveness of case management interventions so that opportunities for improvement can be identified.

Performance measures

Performance measures generally are easiest to determine for social work activities that have established and quantified goals. When no goals exist for an activity, the case management team should revisit the fundamental question: What are social workers expected to achieve? Several examples of common goals for social work interventions are listed below:

❒ Patient/family are satisfied with social work services.

❒ Provider/community services' are satisfied with social work services.

❒ Social workers respond to referrals in a timely manner.

❒ There is complete documentation of service plan and interventions.

❒ Case management goals, as established in patient-specific case management plans, are achieved.

❒ Unnecessary overutilization of acute care services is minimized.

Patient and family satisfaction with social work services can be measured with a survey instrument. The survey can be mailed to patients after they leave the hospital or given to them on discharge. **(For a sample of a questionnaire that is used to gather information about people's satisfaction with social work services, see box, p. 189.)**

By periodically collecting data about patient and family perceptions of staff performance, the social work department can make constant improvements in its quality.

In the survey, include questions that assess the social worker's capacity to express sincere sympathy and empathy, the timeliness of the services, the clarity with which the social worker communicates the service plan of care, and how well the plan meets the needs and wishes of the patient and the family. Similar types of survey instruments can be used to gather satisfaction information from physicians, post-hospital treatment providers, and community service agencies.

With today's short hospital lengths of stay, social workers must quickly evaluate patients' needs and make necessary post-hospital arrangements. Thus,

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CRITICAL PATH NETWORK™

Revising outcome measures for an established pathway

By **Marilyn Hanchett**, RN, MA, CPHQ
Clinical Pathway Coordinator
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In 1996, the orthopedic multidisciplinary team of Columbia Regional Hospital developed and implemented a clinical pathway for total knee replacement (TKR). Columbia Regional Hospital is a 100-bed community hospital, which became part of University of Missouri Health Care in 1999. Orthopedics and rehabilitation have traditionally been and remain the highest volume lines of service.

Patient case management is performed by registered nurses using a modified, intensive model that includes social-work support. The case management function emphasizes utilization management, facilitation of the multidisciplinary team approach, and discharge planning. Case managers also serve as primary agents in organizing, revising, and maintaining the institution's clinical pathways.

Focus on length of stay

The primary outcome measured during the first phase of this project focused on length of stay (LOS). Following implementation of the new pathway, hospital average length of stay for patients undergoing TKR (DRG 209) has progressively decreased to the current 4.5 days for acute care patients.

There has been no increase in infections, hospital readmissions, or changes in the level of patient satisfaction. Not only has the volume of cases remained high, the hospital has simultaneously achieved a five-star (best) rating by HealthGrades.com in its 2001 analysis of TKR first surgeries.

The new challenge to case managers has been not only to maintain the established pathway so that it accurately reflects the most current practices but explore alternative outcome measures once LOS had been stabilized within the targeted range. However, case managers quickly realized that differing levels of outcome expectancy among the principal stakeholders in the TKR pathway required a new approach to consensus building in order to sustain the momentum of the project.

The need for a new methodology was recognized when updating potential outcome measures associated with the pathway. Opinions varied widely among the members of the multidisciplinary team, generally reflecting the measurement priorities most closely associated with each role.

In order to focus on broad-based outcome measures and encourage team members to consider data collection beyond their immediate service needs, the literature base on TKR surgery published within the past six years was reviewed. The most frequently cited outcome measures in the published studies were then extracted and compiled for analysis by the team. **(See chart, p. 184.)**

The process was led by the case manager, who initially helped the team establish core criteria for outcomes measure selection. It was important that the new criteria support the hospital's transition from short-term, process-oriented measures,

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Common Outcome Measures for Total Knee Replacement

This table describes the outcome measures most frequently used in clinical studies specific to total knee replacement. This is not a comprehensive list of all outcome measures reported in the literature.

Outcome Measure	Definition	Standard Pre/Post Eval Required	Comments
Average-Actual LOS	Compares the LOS of each case to the average of all cases in same category	No	Statistics may be adjusted for comorbidities, severity, and other factors
Average-Actual Charges (or Costs)	Compares charges for each case to the average of all cases in same category	No	Organizations are generally more willing to share charge, rather than actual cost, data
ER Visits and/or Readmission within Six Months of Surgery Measure	Frequency of emergency and/or hospital care for TKR patients in first six months of DC	No	ER/readmissions for other, non-TKR surgery problems are not included
Frequency of Pathway Use by Organization	Rate of pathway implementation by clinical team; often compared to frequency of variances from the pathway	No	Very basic, although common first measure by organization, most shift quickly to trend analysis of pathway variances
Pre- & Post-Op Knee Scores	Detailed assessment scores for joint function are compared before and after surgery	Yes	Short LOS may make any differences reported in these scores statistically (although not clinically) insignificant
Functional Status	Patient's ability to perform ADLs; some tools may include IADLs	Yes	Wide variety of pre/post assessment instruments available
Perceived Health Status	Patient's personal rating of how well he/she is feeling, responding to treatment, etc.	Yes	Wide variety of pre/post assessment instruments available
Patient Satisfaction	Patient's personal rating of how he/she perceives the overall experience of receiving health care and/or services; often completed by proxy if patient is ill or unable to complete the tool	No	Standardized, validated tool required for benchmarking; often criticized as too "soft" a measure to be meaningful, but considered by customer service experts as essential
Health-Related Quality of Life	Patient's personal rating of how he/she feels about the impact of health or health problems on his or her life quality	Yes	Generic and specific tools available; specific tools tend to yield more "sensitive" results; longitudinal analysis is needed to capture most changes in scores
Incidence of Surgical Site Infection	Frequency of wound infection at the surgical site	No	Benchmarking and comparative data currently available
Incidence of Other Post-Op Complications	Frequency of any other post-op complication	No	Comparative data available from a variety of published sources
Effect of Preadmission Screening and/or Teaching	The impact of comprehensive screening and/or patient education on outcome (usually LOS) of case	No	Usually done to cost justify program revisions and/or in conjunction with a special study
Effect of Post-DC Destination (e.g., skilled unit, rehab)	The degree to which DC to another, less-acute setting impacts the outcome (usually LOS) of the case	No	Used most frequently in international studies with U.S. national data used as the benchmark

Progression of Key Outcome Measures Total Knee Replacement Pathway

Examples of outcome measure progression as a pathway moves from the initial phase of implementation and into the maintenance phase of an established clinical tool.

TKR Outcome Measure: Initial, Appropriate for New Pathway	TKR Outcome Measure: Revised, Appropriate for Established Pathway
Short term: Measurable within 30 days	Long(er) term: Trended over 3+ months
Process-oriented with emphasis on compliance with pathway guidelines and specific tasks	Patient-oriented with emphasis on the results or impact of care provided
Reduction in DRG-associated LOS	Correlation of targeted LOS to quality of care indicators (e.g., incidence of surgical site infections and/or other complications)
Earlier ambulation, increased activity levels; earlier transfer to rehab (as appropriate)	Improvements in disease- and/or joint-specific functional ability
Patient satisfaction (using hospital-specific tool with limited or no opportunities for benchmarking)	Patient satisfaction (using validated, national tool suitable for benchmarking and specific to hospital unit and/or DRG)
Provision of daily teaching and reinforcement of anticoagulation therapy	Incidence of adverse events, including complications, related to anticoagulation therapy

often associated with pathway compliance, to more patient-oriented measures. By first developing a simple yet practical set of selection criteria, the team was able to meet this goal. It was also able to create a conceptual foundation for identification of its key issues as well as team measurement priorities.

The following core criteria were approved by the team:

- The outcome measure must support the hospital's continuing efforts to maximize operational, financial, and clinical process efficiencies.
- The outcome measure must be based on data which are accurate, available, and accessible.
- The outcome measure must be appropriate for comparative analysis and/or external benchmarking.
- The outcomes measure must be associated with analysis of high-volume, high-risk and/or high-cost care and/or services.

After applying the criteria to the list of potential new outcome measures gleaned from the literature, the case manager then used a multivoting technique popular in quality improvement activities to encourage active participation by all team members.

The results revealed a clear, very strong preference by the team for four specific outcome measures. Analysis of hospital LOS associated with the TKR pathway remained within the top four selected. Added to the list were incidence of surgical site infection, incidence of other postoperative complications, and changes in functional status.

A need for results-based measurement

It is significant that the measures chosen via the new methodology did not vary substantially from many of the topics studied in the early phases of pathway implementation.

However, unlike the earlier indicators, the criteria-based measures reflected a growing understanding of the need for results-based measurement and deepening appreciation of the need to gather data using reliable and valid tools. **(See box, above.)** It was clear from the process that as

the team's knowledge and experience relative to the pathway use increased, so had its understanding of pathway measurement.

The proposed revisions were presented to the hospital's utilization review committee, which recommended inclusion of patient satisfaction data. Orthopedic surgeons performing TKRs also reviewed the new outcome measures. The groups served as content experts and provided diversity and objectivity to the final, revised list. This collaboration strengthened the growing consensus regarding outcome measure selection and prioritization for the TKR pathway in 2001. It also dramatically reinforced the need for and effectiveness of consensus building among everyone associated with the pathway.

The project supports the growing base of research, which suggests that as clinical pathways succeed in compressing LOS to the lowest level without jeopardizing quality of care standards, the outcome measures associated with the pathway must expand beyond hospital days/LOS statistics.[1]

While there is no defined methodology for achieving that, the integrated approach facilitated by the case management team at Columbia Regional Hospital appears to have practical value. Review of current literature, combined with application of case management principles, multidisciplinary teamwork, use of hospital-specific criteria, and collaboration with content experts and physician stakeholders are keys to the success of revising, updating, and expanding the scope of clinical pathways and their associated outcome measures.

Reference

1. Stern SH, Singer LB, Weissman SE. Analysis of hospital cost in total knee arthroplasty. Does length of stay matter? *Clinical Orthopedics* 1995; December(312):36-44. ■

Rules have 'off-campus' EMTALA application

Hidden in the hundreds of pages of regulations for the outpatient prospective payment system (OPPS) are important definition and language changes that create new hospital EMTALA obligations, says **Stephen A. Frew**, a Rockford, IL, health care lawyer who advises hospitals on the 1986 law.

Those obligations are based on off-campus, satellite, and remote site operations, he says. "HCFA [Health Care Financing Administration] has been warning hospitals about EMTALA applying to urgent care and other services located apart from the main hospital, but for the first time, these regulations create specific guidelines and require specific actions," he notes.

Under the new regulations, a hospital's campus is defined as the main hospital building, a zone of 250 yards around the hospital (including parking lots, driveways, and hospital buildings), and HCFA-approved "provider-based services" (off-site locations, satellites, and remote hospital sites) that participate in the new OPPS, Frew adds.

Included, he says, are these EMTALA rules:

1. Covered sites must have policies and procedures for medical screening exams, including stabilization and either a response from the main hospital or a transfer to the main hospital, as appropriate.

2. Covered sites that do not have physicians must go through a formal process to designate a qualified medical person at the site.

3. Hospital policies must include response plans to areas within the 250-yard zone of the hospital.

4. Remote sites that might transport to a closer facility than the home hospital must have transfer agreements in place covering these circumstances.

"While not all hospitals have remote or satellite facilities to worry about, all hospitals do have to be concerned with the 250-yard exterior zone and formulate policies to deal with it," Frew says.

Additional information on the requirements and a link to the full text of the HCFA publication area available at Frew's Web site at www.medlaw.com. ■

Share your pathway successes

Hospital Case Management welcomes guest columns about clinical path development and use. Articles should include any results (length of stay, cost, or process improvements) that use of your pathway has helped achieve and should be from 800 to 1,200 words long. Send article submissions to: Lee Reinauer, editor, *Hospital Case Management*, P.O. Box 740056, Atlanta, GA 30374. Telephone: (404) 262-5460. ■

AMBULATORY CARE
QUARTERLY

Hospitals offer rehab within wellness centers

Hospital systems increasingly are opening medical-model wellness centers, creating opportunities to expand outpatient rehabilitation programs. Two new wellness centers offer a variety of rehab services for patients with chronic illnesses. Between them, the centers provide services to patients with musculoskeletal problems, diabetes, cardiac disease, and pulmonary disease.

At the same time, wellness centers provide the community with a fully equipped fitness facility staffed by health care and fitness professionals. The centers are an important addition to a hospital's continuum of care, transitioning some sick patients to the community and providing the community with disease-prevention opportunities.

Regional Rehabilitation Center of Pitt County Memorial Hospital, part of the University Health Systems of Eastern Carolina in Greenville, NC, planned its 52,000-square-foot wellness center, named ViQuest, for several years before its summer 2000 opening. "We look at this center as a part of the continuum of health care," says **Wanda Bennett**, MS, OTR/L, administrator of outpatient rehabilitation services for the hospital. "We've been able to set up a program to transition patients to a wellness environment," she says.

Wellness centers can be tailor-made to suit a particular hospital's and community's needs. "There really was a huge need for a wellness center," Bennett says. "We have fitness clubs in the area, but many times those clubs aren't meeting the needs of our patients, who are less than fit."

While musculoskeletal problems were a big concern for Pitt County Memorial Hospital, other hospitals have different priorities. For example, Cape Fear Valley Health System in Fayetteville, NC, has opened a wellness center, HealthPlex, which features special programs on diabetes management, cardiac rehab, and pulmonary rehab.

Hospital officials wanted to move those types of services to a wellness center to give patients a sense they are away from the clinical, sterile hospital environment, says **Marcie Justice**, MS, executive director. The 65,000-square-foot facility also devotes clinical space to physical therapy, sports medicine, and occupational therapy. Staff include physical therapists, occupational therapists, a vascular health exercise physiologist, a risk-reduction exercise physiologist, a psychologist, a diabetes nurse, a cardiac nurse and physiologist, and a pulmonary nurse and physiologist. There also are two contract dietitians and a fitness staff of 35.

Here are a few of the wellness centers' features:

- **Orthopedic therapy:** ViQuest treats patients with musculoskeletal injuries, including hand and back injuries, whether they resulted from work, sports, car accidents, or other causes. "[Patients] include athletes who are injured and need to compete," Bennett says. "Or it could be a weekend warrior who overdid it a little bit and may need some therapy services."
- **Cardiac rehab:** Cape Fear's HealthPlex has designed a rehab program for people with heart disease, including those who have had a heart attack, bypass surgery, or angioplasty. Physicians refer patients to the program for three months of treatment using a multidisciplinary approach. The cardiac team includes a nurse, psychologist, exercise physiologist, and dietitian.
- **Return-to-work:** The Pitt County rehab center's WorkReady program includes training on how to prevent injuries, as well as job-safety visits to local companies. Since part of the hospital's outpatient rehab facility has moved to ViQuest, the wellness center has become part of the continuum of care for WorkReady clients.
- **Diabetes:** Cape Fear's diabetes program has moved to the wellness center, where clients are taught how to manage their disease in two or three sessions, lasting about four hours in all. The program, recently affected by Medicare cuts, originally offered eight hours of education in two half-day sessions, Justice says.

• **Pulmonary rehab:** The HealthPlex program is similar to its cardiac therapy program. "Basically, it's set up like cardiac but is designed for people who have pulmonary disease, whether it's chronic lung disease or emphysema," Justice explains. "Patients are referred by a physician; they come to the hospital for a couple of weeks and then they come out to the HealthPlex to be integrated into the wellness-center environment." ■

Patients can help with documentation

Save time with this medical record form

Would you like patients to help your staff document information on the medical record form? At South Jersey Health System in Bridgeton, NJ, a unique emergency department (ED) medical record form allows patients to start their records as part of the sign-in process, just as they would provide information in a physician's office.

The form was developed by a multidisciplinary group whose goals included:

• having patients fill out sign-in information directly on the triage sheet;

• streamlining patient and paper flow from entry point to discharge;

• increasing patient participation in the care continuum and reducing redundant interview and history procedures;

• avoiding duplicate documentation;

• allowing documentation to flow according to the sequence of events in the patient's visit.

At triage, the sign-in sheet instructs patients to fill out the top part of the form, which is placed nearby on the counter. That form becomes part of the medical record, says **Michelle Regan Donovan**, RN, BSN, president of Millennium Strategies, a health care consulting firm in Charlottesville, VA. Donovan helped develop the form.

The chart is placed in a designated space intended to notify the triage nurse who might be seeing another patient, she says. "Even if she has received four or five of these sheets, the triage nurse now has sufficient basic information for a 'primary' triage. That eliminates the verbal questioning of several patients who may have signed in on a sign-in sheet since her last check."

The triage nurse has the patient's name with its proper spelling, the chief complaint in the patient's own words, a phone number, and a family physician's name, says Donovan. "The hospital now has the recorded time of entry and a home phone number for risk management should the patient leave the hospital prior to being seen," she adds.

The form also offers documentation prompts for items required for safe and lawful billing, claim assignments, and claim processing, she says. For example, the form includes prompts for physicians' histories, physicals, and plan of care. "This reduces discrepancies in levels of examination and level-of-service fees billed out, which is a policy variant often cited in fraud and abuse investigation and prosecution," Donovan says.

Because full assessments are not completed in the triage area, the time a patient spends in triage is decreased, explains **Sandra Dietrich**, RN, MSN, director of nursing for emergency services at South Jersey Health System Hospital. On average, the chart saves 10 to 15 minutes per patient, which improves overall patient flow, she says. "The physicians and nurses aren't hunting all over the place for the patient's chart and aren't waiting for each other to complete their documentation." Previously, patients had to be asked for all information verbally, including their names and times of arrival, she says. "As long as it's legible, we can go right past that, so it saves time."

Form reduces liability

Patients used to sign a sheet when they arrived, but they only included their names and the arrival times because the chief complaint could be determined during the exam, says Donovan. "This created an inefficient process since the triage nurse still needs a chief complaint if she is to sort more than a single patient."

The form allows the triage nurse to get more information instead of just a name and time recorded on a publicly accessed sign-in sheet. "Joint Commission [on Accreditation of Healthcare Organizations] standards on patient confidentiality disallow the documentation of chief complaint on the sign-in sheet since other patients have access to same," she says.

The form also reduces the liability and workload of the triage nurse when several patients appear at one time for triage with unknown reasons for visiting, Donovan says. "When the triage nurse has access to multiple charts initiated by the patient, she is able to review them for determining the order of triage processing," she explains. ■

(Continued from page 182)

identification of patients who may require social worker interventions should be done as soon as possible. A screening tool can be useful for identifying patients who need a referral. When a preadmission screening process is in place, social workers can measure how quickly patients are seen after admission. Ideally, high-risk patients are seen the same day they are admitted or within 12 hours of referral.

The patient's medical record is a vital communication tool, and that's why it is essential that social workers adequately document patient assessments, service plans, and interventions. It is important that psychosocial

Social Work Services Satisfaction Survey

Let us know how you feel about the assistance you received from social workers at the hospital. We appreciate you taking the time to complete this questionnaire. Your answers will help us identify problem areas, as well as what we're doing right. Any comments you make, positive or negative, will remain strictly confidential. Your signature is optional, not required. Just complete this form and mail it back to us in the envelope provided.

Please mark the appropriate response: A. always; B. usually; C. rarely; D. never.

1. You were treated courteously by the social worker.	A. ☐	B. ☐	C. ☐	D. ☐
2. You received pleasant and helpful assistance in filling out paperwork.	A. ☐	B. ☐	C. ☐	D. ☐
3. The social worker listened to your concerns.	A. ☐	B. ☐	C. ☐	D. ☐
4. The social worker spent enough time with you and/or your family.	A. ☐	B. ☐	C. ☐	D. ☐
5. The social worker was available to you and/or your family.	A. ☐	B. ☐	C. ☐	D. ☐
6. You were confident in the social worker's ability to assist you in getting the post-hospital services you needed.	A. ☐	B. ☐	C. ☐	D. ☐
7. You understood the information given to you by the social worker.	A. ☐	B. ☐	C. ☐	D. ☐
8. The social worker involved you in the decisions about your care.	A. ☐	B. ☐	C. ☐	D. ☐
9. You were satisfied with the post-hospital arrangements made for you by the social worker.	A. ☐	B. ☐	C. ☐	D. ☐
10. You would use social work services again at this hospital.	A. ☐	B. ☐	C. ☐	D. ☐

About You

Age: _____

Sex: Female ☐ Male ☐

Is this your first visit to this hospital? Yes ☐ No ☐

Have you seen a social worker during other stays at this hospital? Yes ☐ No ☐

Present services you now receive: (check all that apply)

- ☐ Home health agency
- ☐ Support group
- ☐ Meals on Wheels
- ☐ Senior service center
- ☐ Aging services
- ☐ Other; explain: _____

Thank you for choosing our hospital for your health care needs. By working together and listening to each other, we can help to assure your continued well-being.

Signature: _____
(optional)

issues are well-documented so that the caregivers understand the environmental influences the patient is coping with while undergoing medical care.

The thoroughness and conciseness of the social workers' documentation in the patient record is all-important, and no performance measurement system is complete without an analysis of documentation. However, the measure of quality should focus on aspects of patient care, not just the fact that charting did or did not occur. For example, the performance measure, "percent of medical records that contain an appropriate psychosocial assessment" places emphasis on documentation, not the patient. By changing the measure to "percent of patients receiving appropriate psychosocial assessment," the emphasis is on the importance of proper patient care rather than on documentation.

Call-backs verify care

Patient-specific case management plans should contain goals, and achievement of the goals is a common measure of performance. However, evaluating this aspect of social work services can be difficult when goal attainment is not expected to occur until after the patient leaves the facility. For example, it may be a week or more before the social worker can verify that a discharged patient is actually receiving the community services that have been arranged.

The fact that the social worker made the appropriate referral is important; however, the goal of obtaining community service support for a patient is not actually achieved until the services are delivered as promised. Gathering goal attainment information post-discharge will require some type of call-back system to verify that patients are receiving necessary services.

Social workers can help to reduce overutilization of acute care services. When a social work assessment is completed on time and a referral is initiated early in a patient's hospitalization, discharge is more likely to occur as soon as the patient is medically stable. Measures of resource utilization problems that may be attributable to problems with social work services include:

❒ number of patients with recognized psychosocial problems that were not resolved during the hospital stay and for whom no post-hospital support was arranged (patients who are at high-risk for readmission);

❒ number of patients readmitted to the hospital within 30 days with suspected abuse/neglect symptoms who were not seen by a social worker during the first hospital stay;

❒ number of patients with a history of suicide or drug abuse not seen by a social worker and/or not offered a referral to follow-up counseling clinic;

❒ number of discharge delays due to late referrals/arrangements by social service staff.

The National Association of Social Work (NASW) has developed professional standards and clinical indicators for many aspects of social work and psychosocial services, including case management activities in acute care and psychiatric hospitals. The resources can be found on the NASW Web site: http://www.naswdc.org/practice/standards/standards.htm.

The NASW supports the establishment of systems and processes that enable social workers to evaluate the quality of case management services to patients, families, and other customers. Ideally, performance improvement of social work services is part of a coordinated effort of all disciplines within the case management department. ■

Industry growth prompts launch of new association

A resource for CMs' professional development

With the August launch of the first issue of its journal, *CareManagement: Official Journal of the Academy of Certified Case Managers*, the Academy of Certified Case Managers (ACCM) in Fairfield, CT, announced its entry as a new organization to support the education needs of certified case managers. Its leaders hope to provide additional support for this specific group of health professionals.

"We saw a gap or a need in the case management industry," notes **Gary S. Wolfe**, RN, CCM, CNA, a consultant from San Francisco, past president of the Case Management Society of America (CMSA), and executive vice president of the ACCM. Wolfe says the ACCM "is a specialty case management organization for certified case managers only. We want to be a vehicle to promote communication among the many case management certifications and help case managers understand the various certification programs

available, how the qualifications of certified individuals vary, and how they are similar." **(The January 2001 issue of *Hospital Case Management* will take a closer look at credentials, their value in your career development, and which ones best fit your personal goals.)**

Case managers new to the field may not be aware of the June 1996 merger of CMSA and the former Individual Case Management Association (ICMA). At that time, many industry leaders argued that consolidating the two organizations was a necessary step that would allow case managers to speak with one voice when trying to influence health care legislation.

However, the field of case management has experienced tremendous growth since early 1996, and some experts feel there is a place now for more than one professional association. "I anticipate that the academy will offer one more option for those who choose to take advantage of it," explains **Mindy Owen**, RN, CRRN, CCM, corporate director of complex care management with Coordinated Care Solutions in Coral Springs, FL. Owen is a member of ACCM's leadership council and past president of the CMSA.

An addition, not a replacement

"Let me be very clear. [The ACCM] should be viewed as an addition to the practice and the field, not instead of or taking the place of any other organization. CMSA is now and should always be considered the professional organization representing the overall practice of case management," Owen says.

Sandra L. Lowery, BSN, CRRN, CCM, who is president of Consultants in Case Management Intervention in Francestown, NH, and current national president of CMSA, says, "While the *CareManagement* publication is a wonderful educational resource for case managers, it should be clear that the ACCM is a new membership organization. It is most unfortunate that just when case managers, through grass-roots efforts, have finally begun to become recognized and sought-after at the national and international levels, they are facing fragmentation that could decrease the value of their future efforts in support of their practice."

Industry leaders say case managers should ask themselves several questions as they consider membership in a professional organization. These questions include:

- What is the association's mission and vision?
- Is it a for-profit corporation or a nonprofit professional association?
- How will this association help me achieve even greater success in my career?
- What do I get for my membership dollars?
- Are the leaders responsive to my questions and concerns?
- Are the association's leaders elected by the membership or appointed?
- What are the academic and clinical

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Editorial Questions

For questions or comments, call **Russ Underwood** at (404) 262-5521.

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backgrounds of the organization's officers and committee members?

Although the new academy's name may imply it is open only to case managers who hold the CCM (certified case manager) credential from the Commission for Case Management Certification (CMCC) in Rolling Meadows, IL, **Deborah Smith**, MN, RN, Cm, CNAA, a consultant with American Medical Systems in Los Angeles and chair of the leadership council of ACCM, says ACCM membership is open to case managers who hold a variety of certifications. "At this point, the academy recognizes the CCM, RN-NCM, CRRN, GCM, CMAC, CRC, COHN, CDMS, CIRS, and A-CCC. One of those certifications is all you need to qualify for membership in the academy," she says.

In fact, the ACCM has no affiliation with CCMC or any other credentialing board, note Wolfe and Smith. "We are totally separate and independent of any other organization," says Wolfe. "However, on our leadership council, we have industry leaders who represent a range of other organizations."

The sole focus of the ACCM is the education of case managers through publications and conferences. In addition to *CareManagement*, the academy plans to launch a pharmaceutical update and a literature review. Its first conference will be held in March 2001 in conjunction with the 13th Annual National Managed Health Care Congress at the Georgia World Congress Center in Atlanta.

"I believe the ACCM has a significant place in the practice of case management," Owen says. "The mission is to promote educational opportunities for the certified case manager that should raise the level of knowledge in the practice. These are individuals who have taken the initiative to gain knowledge in the field in which they practice, and I think anything that we can do to continue to support and raise the bar is important."

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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. ■

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2000 SALARY SURVEY RESULTS

HOSPITAL CASE MANAGEMENT™

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

How does your salary stack up against your peers'?

Know all you can about your profession - here are the numbers

Making the most of a case management career — indeed, any career — means knowing everything available about the industry, including the average salaries and demographics of others in similar positions.

With useful information, employees can judge how their facilities work in comparison to their peers' and if they are being compensated fairly for the work they do. *Hospital Case Management*'s annual salary survey results have been compiled to assist readers in that endeavor.

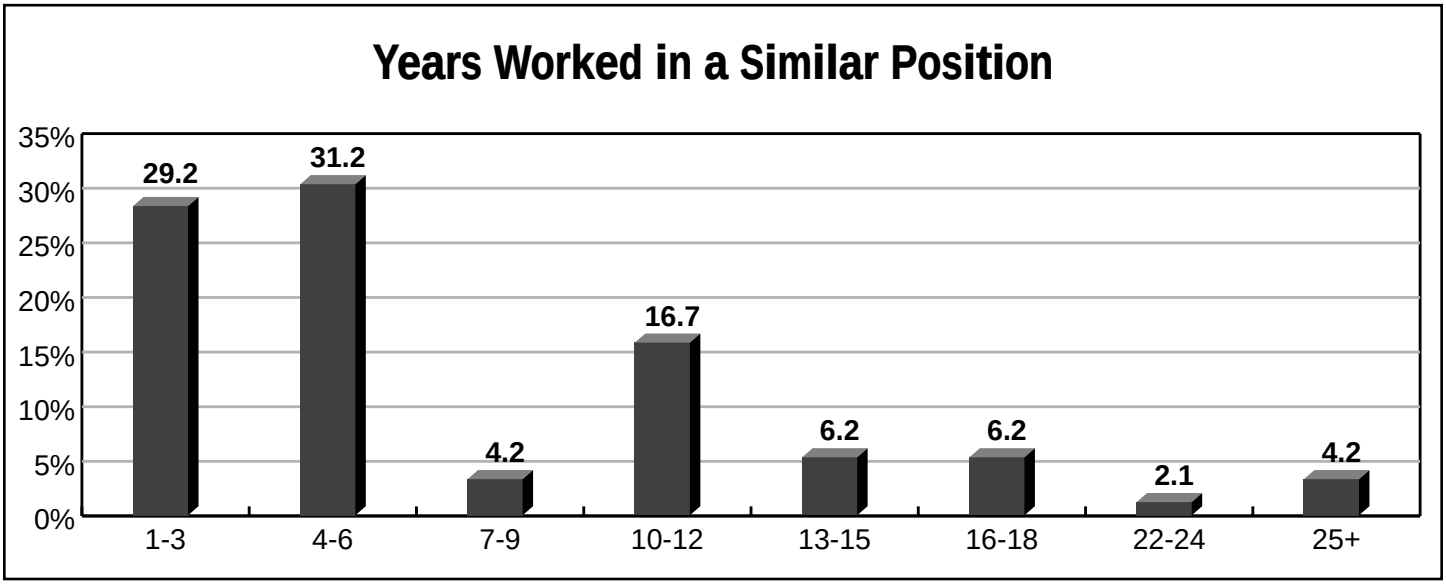
The questionnaire was mailed to readers with the July issue. Confidential responses were compiled and analyzed at the Atlanta offices of *HCM*'s publisher, American Health Consultants.

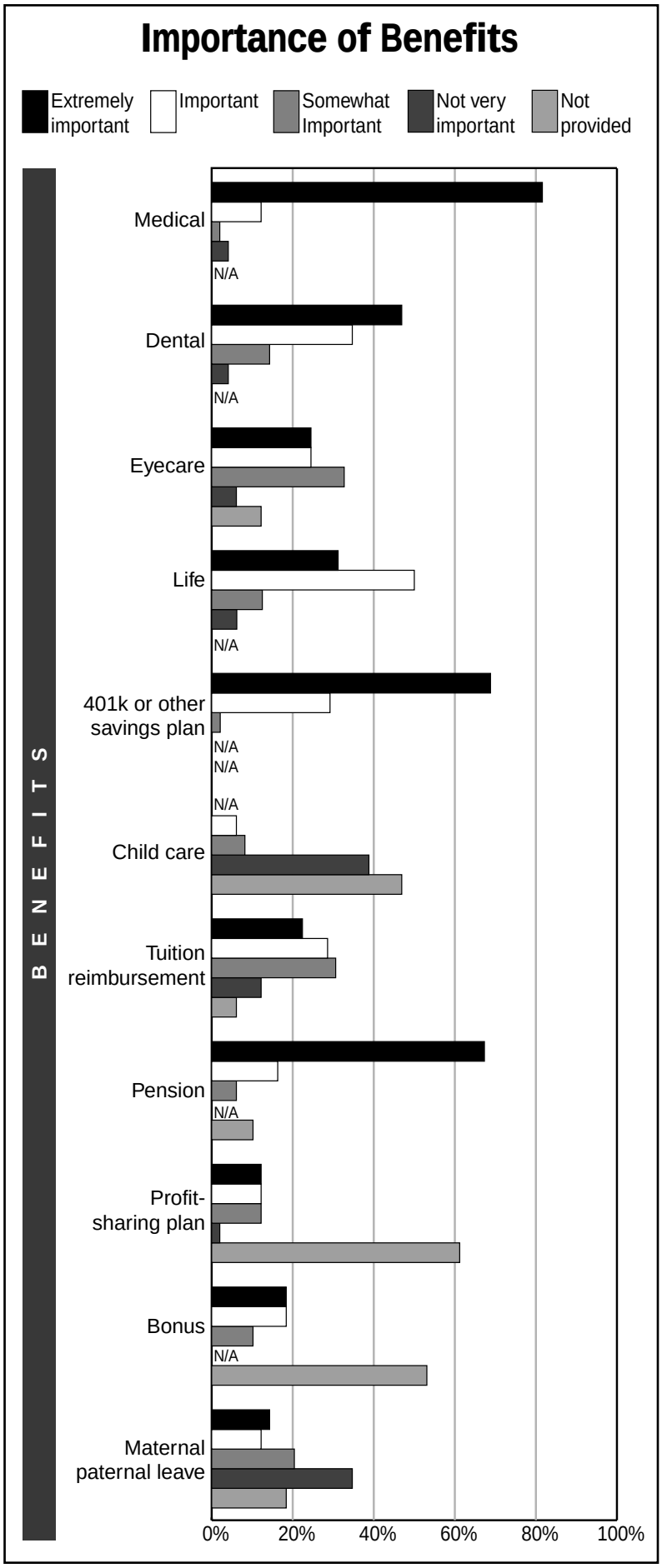
This report presents the results we deem most important or interesting to *HCM* readers.

Most readers who responded indicate that they earn healthy midlevel salaries. Of those participating, 34.5% report annual earnings between $60,000 and $69,999. Another 12.7% report income levels of $50,000 to $54,999. Only 1.8% take home more than $135,000. On the opposite end of the scale, only 3.6% make less than $30,000.

Titles vary

Titles and job descriptions vary and include case managers, directors of case management, clinical nurse specialists, clinical pathway coordinators,





quality improvement coordinators, directors of outcomes management, coordinators of clinical care management, directors of utilization management, and social workers. A sizeable majority of respondents (93.8%) are female.

Long hours

Hospital case managers are working hard for their money. Work schedules for 36.7% of survey participants include between 41 and 45 hours per week. Another 34.7% work 46 to 50 hours per week, and 12.2% report working an impressive 56- to 60-hour week.

When it comes to years of experience in health care, the largest percentage of those responding, almost 35%, say they've been in the field more than 25 years.

Only 4% report working in health care fewer than 10 years. Directly related to experience are the ages of respondents: 31.2% are between 46 and 50.

Education levels for most participants include master's degrees — MSN, MS, or a master's in another field. Another 37.5% have attained a BSN. In addition, most case managers are certified in some capacity.

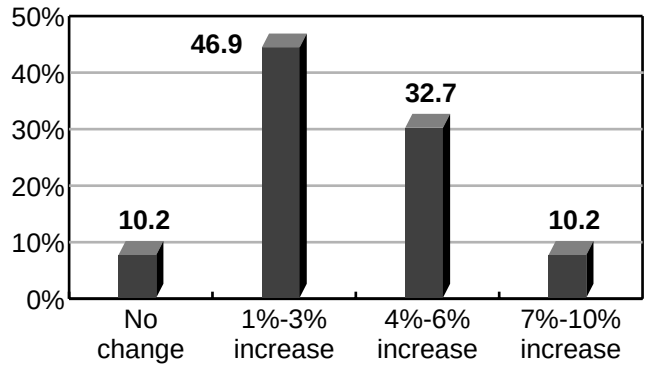
Credentials

The certified case manager (CCM) credential was most frequently reported, and several respondents hold the CMC, CMAC, CPHQ, or other certifications.

Almost half of our respondents indicate a 1% to 3% increase in salary within the past year; another 32.7% received pay raises of 4% to 6%. However, about a fifth of the respondents say their case management department's size (number of employees) has decreased in the past year. Another 43% say employment levels have remained constant.

Employee benefits remain an important issue in every sector, including health care. Responses indicate that most readers regard medical coverage (94%) and dental coverage (82%) as important or extremely important. Over the past 12 months, 63% say their contribution to the cost of medical coverage has increased, not including deductibles or copayments.

Salary Increased or Decreased in the Past 12 Months?



Life insurance is regarded as important or extremely important by 81%, and a 401k or savings plan is important or extremely important to almost all respondents (98%).

Several other benefits reportedly are not offered to hospital employees taking our survey: 47% say they do not have a child care benefit; 61% do not have a profit-sharing plan; 53% do not receive an annual or semiannual bonus; and almost three-quarters, or 73.5%, report that they do not have an elder care benefit included in the terms of their employment.

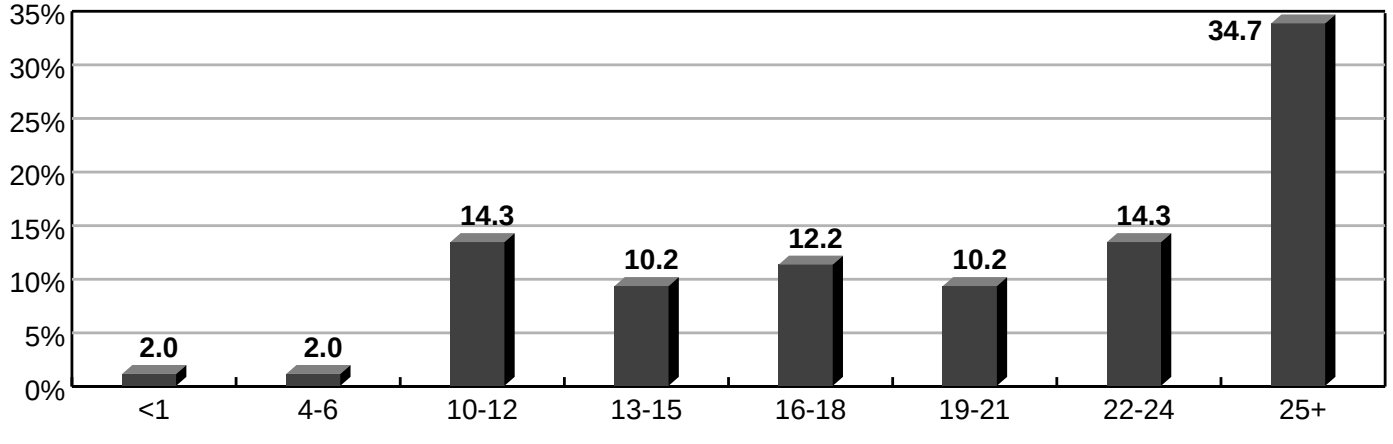
Slightly more than one-third of those participating work in the Southeastern section of the country or in Texas. Another 22% come from the North Central part of the country (Ohio and Michigan on the Eastern border to the Dakotas, Nebraska, and Colorado on the West); 18% hail from the Northeast. About 37% report that their facilities are located in urban areas.

Annual Gross Income

Less than $20,000	1.8%
$20,000 to $24,999	1.8%
$35,000 to $39,999	1.8%
$40,000 to $44,999	7.3%
$45,000 to $49,999	11%
$50,000 to $54,999	12.7%
$55,000 to $59,999	11%
$60,000 to $64,999	14.5%
$65,000 to $69,999	20%
$70,000 to $74,999	5.4%
$85,000 to $85,999	3.6%
$105,000 to $109,999	3.6%
$120,000 to $124,000	1.8%
$130,000 to $134,000	1.8%
$135,000 to $139,999	1.8%

Of those responding, 45% work in facilities with fewer than 200 beds. Only a fraction (4%) report having 800 or more beds. A majority of those hospitals (78%) are nonprofit, with 12% for-profits and 10% owned by government agencies (Veterans Affairs or state, county, or city entities). ■

How Many Years Have You Worked in Health Care?



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