AMERICAN HEALTH CONSULTANTS®

HOSPITAL CASE MANAGEMENT™

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

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Case Management Certification

Navigating the maze: How to choose and get the CM credential you need

Evaluate your skill set, choose what fits your goals

With the recent explosion in the number of credentials available to case managers, it's become more likely than ever that you'll find at least one that fits your needs, abilities, and aspirations. But deciding which one to pursue — or even whether the pursuit is worth your valuable time and effort — can be a confusing, even frustrating, undertaking.

What's certain is that the field is moving resolutely toward a greater emphasis on credentialing, spurred on in part by emerging trends in case management and by government regulations.

Besides those trends, case management certification provides a real leadership opportunity and increases customer confidence, says **Diane Huber**, PhD, RN, FAAN, CNAA, associate professor at the University of Iowa College of Nursing in Iowa City. "Certification validates that certified practitioners are well-prepared for their jobs and promotes excellence in practice. This competency assessment provides the consumer with a basis for trust and confidence in a quality service," she says.

Trust is one of the most important aspects of the role of the case manager as a patient care planner. "Case managers . . . interact among providers on behalf of clients," at a time when any effort at health care cost containment is seen as suspect by most consumers, Huber says. "Without case management,

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Discharge Planning Advisor

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COMING IN FUTURE ISSUES

■ **Need a job?** Focus your career plans through the Internet looking glass
■ **Budgeting:** What does a community case management program cost?
■ Reports from the CMSA's recent Hospital Case Management Summit in San Diego
■ **Never fear:** Social work's role is vital to hospital's case management department
■ *Hospital Case Management*'s 2001 directory of CM credentials

Case Management Certification

clients face a costly, disconnected, and confusing health care delivery system."

In addition, she says, case management certification increases the practitioner's opportunity to advance his or her career. "It supports the practitioner with a competitive advantage in the job marketplace." Huber should know: She is one of the recently elected members of the Commission for Case Manager Certification (CCMC) and a leader in the case management field.

The CCMC in Rolling Meadows, IL, offers three reasons case managers should consider getting a certification:

• An increasing number of employers are requesting certified case managers.

• Case manager certification is regularly specified in career advertisements.

• States are beginning to require certification for case managers — a trend that will continue.

Unlike other specialties — nurse midwifery, nurse anesthetist, or advanced practice nurse, for example — certification in case management is not mandatory in the United States. However, the CCMC estimates that more than 22,000 case managers have been awarded its certified case manager (CCM) credential in the past seven years, and many others hold other case management or quality-related credentials. Huber predicts that the number of voluntarily certified professionals will continue to grow, considering their need to distinguish themselves in the multidisciplinary field.

"Complexity and variability are part of the case management picture. Case management is multidisciplinary, and the CCMC was built on that very multidisciplinary foundation." In turn, the CCM credential was developed with a very broad focus, she says. Certification examinations that are specific to the various disciplines involved also have been developed in recent years. Most experts agree that if you choose to be certified, you should pick the credential that best fits your current job or your career aspirations.

The Healthcare Quality Certification Board, which administers the certified professional in healthcare quality (CPHQ) exam, has released a position statement on the issue of relevance to the employment setting. It states, "When considering how applicable a particular certification is to an individual employment position, we find some credentials are more specific to the individual components of quality, case / care / disease, utilization, or risk management, all of which are included in the

CPHQ exam. Individuals who are currently satisfied with their employment performing in one of these specific areas may find other credentials with less content breadth more applicable to their needs."

Anne Llewellyn, RNC, BPSHSA, CCM, CRRN, CEAC, says health care professionals should look for an appropriate certification. "The important thing to remember is that the certification measures expertise," whatever that certification may be. "There is case manager certification from the American Nurses Association (ANA)," she says. "If a nurse is in the hospital and plans to stay there, she may want to take [that] exam . . . since its focus is more clinical [than other exams]. I tell people looking for certification to see where they want to go and to look for the certification that will aid them in their career," she says.

Ask yourself these questions

Whatever your specialty, there are steps you should take in choosing the credential that will best serve you as a professional. **Hussein Tahan**, MS, DNSc(C), RN, CNA, director of nursing in cardiac specialties at Columbia Presbyterian Medical Center in New York City, says the one you pick is certainly dependent on your area of practice and the requirements of the certifying body. To make the best choice, he says, case managers should answer the following questions before choosing a particular type of case management certification:

1. What is the benefit of the certification for your career advancement and professional development? Will you be awarded a better salary, or will you be eligible for your dream job if you get the certification? Could you be promoted within your organization or reach some level of leadership?

2. Is the certification a prerequisite for your current or potential job / position options?

3. Is the certification a mandatory expectation for credentialing your organization? To date, the major accrediting organizations — The Joint Commission for Accreditation of Healthcare Organizations, The American Accreditation Healthcare Commission, and the National Committee for Quality Assurance — do not require mandatory case management certification of individuals when they survey organizations as a whole, Tahan stresses.

"However, they look into evidence of qualified professionals taking care of patients. That means that [professionals] have the appropriate training, education, and competencies, and certification is a measure of those competencies. It could help show the accrediting body. 'We have this percentage of certified case managers,' which, yes, will help [the organization] meet the competency criteria," he says.

4. Which care setting do you practice in (acute vs. insurance / managed care or community care), and what are the specific standards of care, practice, and performance present in your practice environment? "For example," Tahan says, "are they managed care-related, rehabilitation- and disability-related, health care quality- and outcomes-related, or occupational health-related?" That can have specific impact on which certification you choose to pursue.

5. What are the eligibility criteria of each of the available case management certifying exams, and for which are you able to meet the criteria? Sometimes the case manager's job description does not necessarily describe the duties of case management required by a certifying organization's criteria. **(See related story, p. 6.)** It is important that your day-to-day activities are considered in line with the national practice for the exam you want.

6. What is the cost of each of the exams, and who will pay for your certification — you or your organization? "Many employers are requiring the CCM or another certification, [such as] the ANA's certification. When they require it, they might pay for it also," says Llewellyn. She encourages case managers to approach their employers about paying for the exam. "Let them know that this is a way to improve the department's clinical competency. Certified individuals have to stay abreast of information since they are required to have a certain number of [continuing education units]. This keeps them on top of things. Also, it gives the case manager credibility," so it might be a valid expense for the organization.

7. How long is the certification valid? Recertification may require taking another exam, paying an annual fee, completing a certain number of continuing education credits, or a combination of any of those requirements.

8. How much information / what kind of information is available from the certifying bodies? Some organizations offer sample questions for test preparation; others might offer a full seminar or course. With either of those options, it is important

CCM Directory Entry

CERTIFIED CASE MANAGER (CCM)
Commission For Case Management Certification, 1835 Rohlwing Road, Suite D, Rolling Meadows, IL 60008. Telephone: (847) 818-0292. Fax: (847) 394-2108. E-mail: info@ccmcertification.org. Web site: www.cccertification.org.

Eligibility requirements

- **Candidates must:**
  - hold current RN licensure or acceptable licensure/certification in a field that promotes the physical, psychosocial, or vocational well-being of the people being served;
  - have 12 to 24 months of acceptable full-time case management employment.
- **Registration fee:** $290. Testing dates: Twice annually in June and December.
- **Testing sites:** Fully accessible, smoke-free test sites are arranged on the basis of the geographic distribution of candidates sitting for the examination. In order to minimize travel expenses, one examination site per state will be established where possible.
- **Recertification:** Certification must be renewed every five years. The recertification fee is $150. Candidates must accumulate 80 hours of acceptable continuing education or retake the CCM examination to become recertified. They also must hold the underlying license or national certification that was the basis of their initial CCM certification eligibility. Candidates who choose to retake the CCM examination must pay an additional fee of $160.
- **Exam content outline:** The one-day exam contains 300 multiple-choice questions. It covers processes and relationships, health care management, community resources and support, service delivery, psychosocial intervention, and rehabilitation case management.

Sample question:

1. The effectiveness of case management services is evaluated most completely:

A. after the extent of the benefits coverage is determined
B. after the case is closed
C. by measuring the costs incurred by the insurer
D. by input from the client

(Editor's note: In next month's issue, Hospital Case Management *will include a complete directory of all 12 major case management credentials.)*

to remember that case management is a practice-based specialty. No matter how much you study, the best way to be prepared for the certification exam is to be engaged in the practice of case management in some form. "Practice provides an opportunity to experience situations that tend to be unusual. You wouldn't read about them in books because books and texts tend to be theoretical," Tahan says.

"Also, books tend not to be current; sometimes it takes a year before they make it to print. As quickly as the nuances and new changes happen, the text may not catch them, while the practice setting has to implement those changes right away. And that better prepares you to answer questions on the test," he explains.

It's important to realize that the information available about the test could be an indicator of its agency's credibility. The more influential the agency is, the more information it will probably share about its exam, Tahan says.

"You can compare the available information with your practice, knowledge, and skills and ask, 'Does this exam fit my career options right now? I don't want to sit for an exam that's heavily insurance when my practice is acute care.'" The bottom line: The exam you choose should match your career advancement potential, he adds.

"The health care environment continues to experience rapid and tumultuous changes," he continues. "These changes make verification of the competence of case managers an increasingly important issue."

While certification certainly does not guarantee that a case manager is competent, it demonstrates that a minimum national standard has been met and the case manager intends to show his or her competence by maintaining those standards in practice, Tahan points out.

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Understanding the terms: A credentialing glossary

Certification, credentialing, accreditation, licensure — the number of pertinent case management evaluation terms can be overwhelming. Plus, the various words often are confused, according to the industry's certification leaders. In fact, the recent Hospital Case Management Summit, a one-day conference offered by the Case Management Society of America that was held in San Diego, included a special panel discussion with the goal of clarifying some of the frequently used terms in this important vocabulary.

❒ **Licensure.** This is the process used by a government agency to grant permission to an individual to engage in a given occupation, upon finding that the applicant has attained the minimum degree of competency required to assure that the public health, safety, and welfare will be reasonably well-protected.[1]

Licensure is the most restrictive form of regulation, says **Carrie Engen**, RN, BSN, CCM, president of Advocare Inc. in Naperville, IL, and chair of the Commission for Case Manager Certification. It is a form of occupational regulation; the government can withhold a license and deny an individual the right to work or the right to call himself or herself a certain type of professional and earn money. She adds that it is illegal for any unlicensed person to engage in the activities defined by the scope of practice or to use the title normally conferred on licensed professionals. Licensure is usually predicated on education and/or work experience.

❒ **Certification.** This is a process by which a governmental or nongovernmental agency grants recognition to an individual who has met certain predetermined qualifications set by a credentialing agency.

Sometimes, the process is called "title control," although there are no laws requiring certification to use the title "case manager," Engen says. It's normally a voluntary process, initiated by members of the occupation or professional group, and administered by an agency created to set standards and award recognition to those that qualify. "The No. 1 reason for certification is protection of the consumer. We want to identify practitioners who have met national standards," she explains, but the specific agency can determine its own particular set of standards. Certification generally relies on a testing instrument and is renewable after a certain period of time through continuing education or re-testing. Eligibility often depends on experience and education. Different agencies set eligibility requirements differently.

❒ **Certificate.** It can be awarded at the successful completion of an education program, usually through an institution such as a university nursing setting or a private company that, in a proprietary way, has decided to offer an educational program. It's important to know the difference between a certification and a certificate, Engen says. "Many groups out there would have you believe they are certifying organizations," when in fact, they award to the candidate a certificate of completion for an educational program that may or may not be predicated on completion of an exam.

❒ **Credential.** This is the end product of certification. It refers to whatever is conferred on the individual, or organization, who has met eligibility requirements and successfully completed the examination process. The term can apply to either the accreditation or the certification process. The credentialing body is the organization that oversees the process of certification or accreditation, usually made up of voluntary professionals from the field.

❒ **Accreditation.** This is a process for applying standards across an industry, which grants recognition to programs or organizations, rather than to individuals. In this process, there is an association or agency that has been created to set the standards based on the services offered. Reviews take place periodically with evaluation, not an examination, as the determining factor for recognition.

❒ **Registration.** It is a listing of people or organizations who have met specific requirements that may or may not have anything to do with quality in the field. Registration is on the state level in some industries. There is typically no testing instrument, and sometimes a fee is required. The common goal of all health care regulatory and evaluation processes is to protect the consumer from substandard case management services.

[For more information, contact:

Carrie Engen, RN, BSN, CCM, Owner and President, Advocare, Naperville, IL; Chair, Commission for Case Manager Certification, Rolling Meadows, IL. Telephone: (630) 355-0001. E-mail: carriee@advocare inc.com.]

Reference

1. U.S. Department of Health, Education, and Welfare, Washington, DC. ■

Is your job description a certification obstacle?

Successful application for case management certification can mean the difference between earning a valuable credential and throwing away a few hundred dollars. It's essential to understand the application process and to understand your job description as part of that process.

For **Kathryn Bennett**, RN, BS, case management coordinator at Bloomington (IN) Hospital and Healthcare System, the road to certification was harder to navigate than she expected. Bennett chose to apply for the Certified Case Manager (CCM) credential from the Commission for Case Manager Certification (CCMC). "That's the one to get." But the requirements for eligibility to sit for the exam are very stringent, she says.

Bennett says she found out, as other applicants have, that her job description did not quite meet the commission's "continuum of care" requirement. "I work in a hospital setting and do refer across the continuum, but one of the requirements is that the continuum must address the ongoing needs of the individual rather than being restricted to services related to a single episode of care or treatment. At one time, our department was basically utilization review," and although the department's case managers now provide care across the continuum, their job descriptions didn't reflect that.

"If you're in the hospital setting, you're not going into the patient's home and [you may not] see the patient's whole life. However, we are . . . doing a lot of the things that case managers do," she adds.

Anne Llewellyn, RNC, BPSHSA, CCM, CRRN, CEAC, owner of Professional Resources in Management Education, a Miramar, FL-based consulting firm, says the solution to that obstacle is as easy as writing a letter. "It's how you word everything," she says. "The application process is used to ensure that those who qualify for the exam have a good understanding of the process of case management. For some, navigating the application process can be as difficult as taking the exam.

"If your job description is vague, then you can write 'a day in the life' and have your supervisor sign it," she advises.

In fact, the CCMC addresses the question of job descriptions on its newly revised Web site in a "frequently asked questions" section. It states, "If for some reason your job description inadequately describes your case management activities, you may write a letter describing what your job duties are in relation to the eligibility criteria. The letter must be on your employer's company letterhead, signed by your supervisor, and notarized."[1]

Carrie Engen, RN, BSN, CCM, president of Advocare Inc. in Naperville, IL, and chair of the CCMC, says understanding the eligibility requirements is essential for anyone planning to sit for the exam. The option to write a letter has existed for several years, she says, "because sometimes job descriptions do not adequately describe the job duties, especially in the case of an employee of a corporation which, as experience has shown us, may have very global job descriptions."

What is more important than the corporate aspect is the CCMC's mission to uphold certain standards. In the past, Engen says, many people who were in positions within health care wanted to call themselves case managers, "which . . . led to some problems with credibility for the entire industry and was one of the reasons that certification was put together in the first place. In [many] cases, hospital-based individuals were doing discharge planning, and once the patient goes home, there is no follow up at all. This is leaving out a very important part of the process — monitoring — integral to case management," she explains.

"Now if a hospital-based case manager is in actuality following up with the patient, monitoring that patient, reevaluating the plan of care, troubleshooting, etc., but it is not reflected in the job description, then within the certification guidebook, there is a remedy," Engen says. "We do not deny individuals applying from the hospital-based case management sector as a matter of course; however, just like everyone else, their job descriptions and / or supporting documentation have to reflect appropriate case management

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CRITICAL PATH NETWORK™

Periop pathway cuts costs, improves efficiency

Fewer preference cards contribute to savings

How would you like to cut your supply costs per case by almost 33%?

The day-surgery program at Vanderbilt University Medical Center in Nashville, TN, achieved this result by implementing a perioperative pathway for endoscopic sinus surgery that helped surgeons and staff focus on what is actually needed for sinus patients. **(See endoscopic sinus surgery perioperative pathway, p. 8.)**

The pathway was implemented in 1996 after almost three months of development that included data review, writing, and evaluation by nursing staff and physicians. Supply cost per case in 1996 was $967.13, and in 1999, the cost per case dropped to $650.23, a decrease of 32.8%.

Implementing perioperative pathways within day surgery began six years ago and was not a difficult task, says **Nancye R. Feistritzer**, RN, MSN, assistant hospital director and administrative director of perioperative services.

"We were a very case management-oriented facility, and our inpatient units were very big into pathway utilization, so introduction of pathways into our [ambulatory surgery center] went smoothly," she says.

Combining preference cards cuts costs

After taking a look at data collected on the different types of surgery performed on an outpatient basis, Feistritzer and her staff identified sinus surgery as one area that pathways could have an immediate effect on cost savings and efficiency.

"We have one surgeon who performs the majority of our sinus surgeries, so we worked primarily with him to look at changes," she says.

One of the first steps in developing the pathways was to combine similar surgeries onto one pathway, explains Feistritzer. Not only did this step cut down on the number of pathways with which staff have to work, it enabled the surgery program to cut the number of preference cards for sinus surgery from 10 individual preference cards for different surgeons to one basic card for all sinus surgeries.

> *"The surgeon who does most of our sinus surgery was meeting with his patients the day of surgery to conduct his pre-op assessment. We showed him that he could easily schedule more surgeries if he conducted the meeting in his office prior to the day of surgery and eliminate these 30-minute meetings on the day of surgery."*

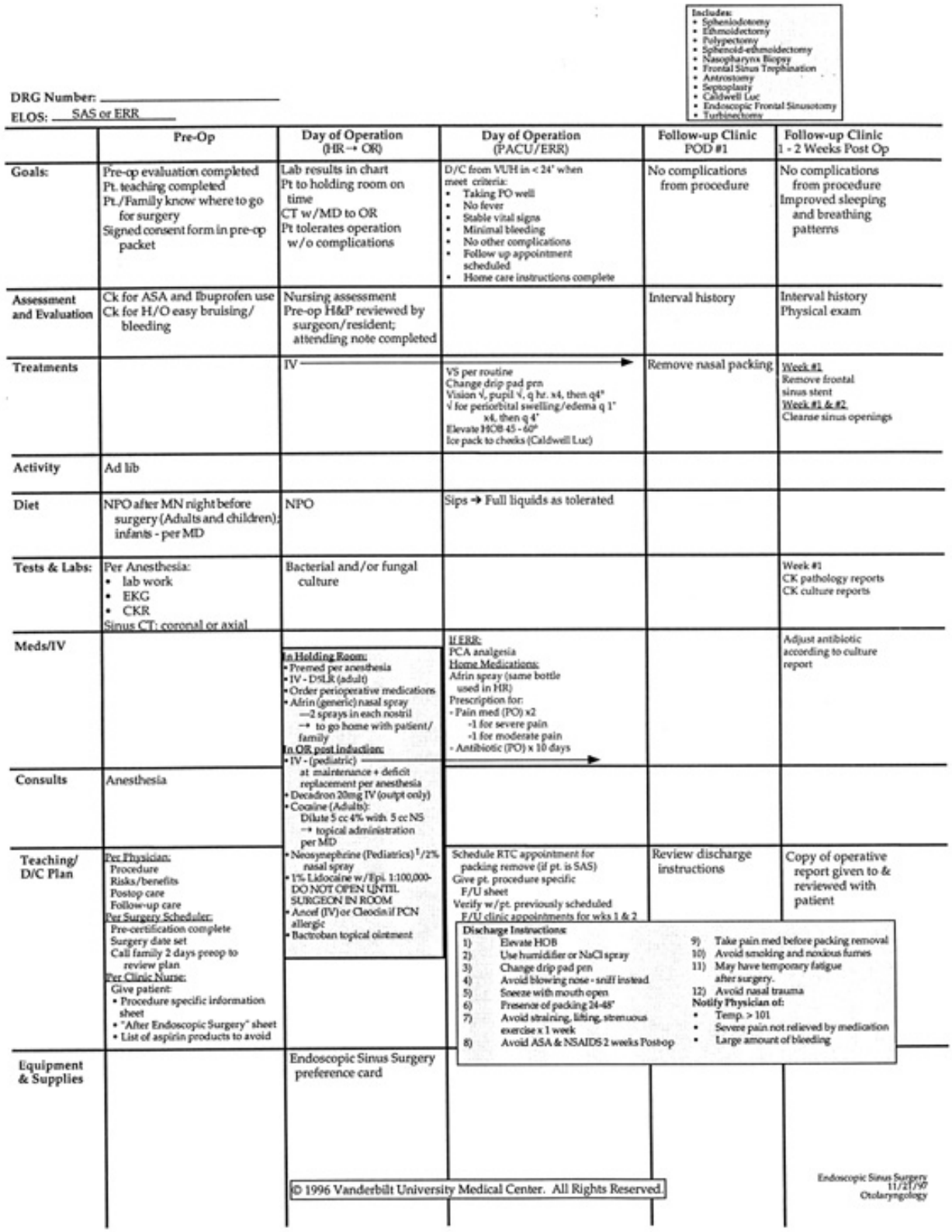
By working with the surgeons, Feistritzer's staff were able to get them to look at the supplies used and agree to standard supplies that each of them are comfortable using.

The review and elimination of the different preference cards has reduced the cost per case because everything on the case cart is used, says **Ken Peercy**, director of the ambulatory surgery center.

The biggest effect of the pathway is the staff's

(Continued on page 9)

Endoscopic Sinus Surgery: Pediatric and Adult



Includes:
- Sphenoidotomy
- Ethmoidectomy
- Polypectomy
- Sphenoid-ethmoidectomy
- Nasopharynx Biopsy
- Frontal Sinus Trephination
- Antrostomy
- Septoplasty
- Caldwell Luc
- Endoscopic Frontal Sinusotomy
- Turbinectomy

DRG Number: _____
ELOS: SAS or ERR

	Pre-Op	Day of Operation (HR → OR)	Day of Operation (PACU/ERR)	Follow-up Clinic POD #1	Follow-up Clinic 1 - 2 Weeks Post Op
Goals:	Pre-op evaluation completed Pt. teaching completed Pt./Family know where to go for surgery Signed consent form in pre-op packet	Lab results in chart Pt to holding room on time CT w/MD to OR Pt tolerates operation w/o complications	D/C from VUH in < 24° when meet criteria: • Taking PO well • No fever • Stable vital signs • Minimal bleeding • No other complications • Follow up appointment scheduled • Home care instructions complete	No complications from procedure	No complications from procedure Improved sleeping and breathing patterns
Assessment and Evaluation	Ck for ASA and Ibuprofen use Ck for H/O easy bruising/ bleeding	Nursing assessment Pre-op H&P reviewed by surgeon/resident; attending note completed		Interval history	Interval history Physical exam
Treatments		IV →	VS per routine Change drip pad prn Vision √, pupil √, q hr. x4, then q4° √ for periorbital swelling/edema q 1° x4, then q 4° Elevate HOB 45 - 60° Ice pack to cheeks (Caldwell Luc)	Remove nasal packing	Week #1 Remove frontal sinus stent Week #1 & #2 Cleanse sinus openings
Activity	Ad lib				
Diet	NPO after MN night before surgery (Adults and children); infants - per MD	NPO	Sips → Full liquids as tolerated		
Tests & Labs:	Per Anesthesia: • lab work • EKG • CKR Sinus CT: coronal or axial	Bacterial and/or fungal culture			Week #1 CK pathology reports CK culture reports
Meds/IV		In Holding Room: • Premed per anesthesia • IV - D5LR (adult) • Order perioperative medications • Afrin (generic) nasal spray —2 sprays in each nostril → to go home with patient/ family In OR post induction: • IV - (pediatric) → at maintenance + deficit replacement per anesthesia • Decadron 20mg IV (outpt only) • Cocaine (Adults): Dilute 5 cc 4% with 5 cc NS → topical administration per MD • Neosynephrine (Pediatrics) 1/2% nasal spray • 1% Lidocaine w/Epi. 1:100,000- DO NOT OPEN UNTIL SURGEON IN ROOM • Ancef (IV) or Cleocin if PCN allergic • Bactroban topical ointment	If ERR: PCA analgesia Home Medications: Afrin spray (same bottle used in HR) Prescription for: - Pain med (PO) x2 -1 for severe pain -1 for moderate pain - Antibiotic (PO) x 10 days →		Adjust antibiotic according to culture report
Consults	Anesthesia				
Teaching/ D/C Plan	Per Physician: Procedure Risks/benefits Postop care Follow-up care Per Surgery Scheduler: Pre-certification complete Surgery date set Call family 2 days preop to review plan Per Clinic Nurse: Give patient: • Procedure specific information sheet • "After Endoscopic Surgery" sheet • List of aspirin products to avoid		Schedule RTC appointment for packing remove (if pt. is SAS) Give pt. procedure specific F/U sheet Verify w/pt. previously scheduled F/U clinic appointments for wks 1 & 2 **Discharge Instructions:** 1) Elevate HOB 2) Use humidifier or NaCl spray 3) Change drip pad pen 4) Avoid blowing nose - sniff instead 5) Sneeze with mouth open 6) Presence of packing 24-48° 7) Avoid straining, lifting, strenuous exercise x 1 week 8) Avoid ASA & NSAIDS 2 weeks Post-op 9) Take pain med before packing removal 10) Avoid smoking and noxious fumes 11) May have temporary fatigue after surgery. 12) Avoid nasal trauma **Notify Physician of:** • Temp. > 101 • Severe pain not relieved by medication • Large amount of bleeding	Review discharge instructions	Copy of operative report given to & reviewed with patient
Equipment & Supplies		Endoscopic Sinus Surgery preference card			

Endoscopic Sinus Surgery
11/21/97
Otolaryngology

Source: Vanderbilt University Medical Center, Nashville, TN.

efficiency, says Peercy. Most of the ear, nose, and throat surgeons were ordering the same items each time, "but we still had to wait for the order to prepare for the case. Now, we are more able to anticipate what is needed and prepare ahead of time."

The nurses knew what was needed so well that they primarily wrote the sinus surgery pathway, explains Peercy. "From experience, they knew what items were routinely used or thrown out. They were able to put together a pathway that met with the surgeons' approval because it reflected their practice anyway."

After evaluating the data, the staff saw one immediate way to become more efficient. "The surgeon who does most of our sinus surgery was meeting with his patients the day of surgery to conduct his pre-op assessment," Feistritzer says. "We showed him that he could easily schedule more surgeries if he conducted the meeting in his office prior to the day of surgery and eliminate these 30-minute meetings on the day of surgery."

> *"Make sure your program has forms to track the basic items, such as cost, times, and reasons for delays. You can't base your decisions on anecdotal information because things are not always what they seem."*

The surgeon had previously scheduled no more than four surgeries per day, and now he averages five procedures per day, says Peercy.

Although Vanderbilt's same-day surgery program has an on-line charting system that captures the patients' history and physical, lab results, nursing pre-op assessment, and discharge planning, there were some items identified during development of the pathway as responsible for holding up surgery, says Feistritzer.

"One of our surgeons frequently orders CT scans for his patients, but the documents weren't placed in the patients' charts prior to the day of surgery. So we delayed surgery as we looked for the information," she explains.

A simple fix was put into place when the staff realized that the charts of this surgeon's patients were not flagged as surgery patients. "Now we make sure the charts are flagged so that the scans are read and the documents prepared in time for surgery," she adds.

"We also reviewed pre-op standards and eliminated some tests that were unnecessary for most patients," says Feistritzer. "Chest X-rays, urinalysis, and EKGs are not ordered unless there is a special need." A pre-op protocol was also established, and pre-op assessments are performed by nurse practitioner, she adds.

Anesthesiologists were included in the pathway development to help identify anesthetics that would work well for sinus patients but enable them to wake quickly and reduce the amount of time in recovery.

Good data essentially

The best way to develop pathways is to focus on your top procedures, says Peercy. "Get detailed data concerning costs and time per procedure, and present it to the physicians."

Because physicians are scientists, they like objective information such as numbers; however, don't expect them to suggest the changes from data only, he says.

"Offer alternatives and suggestions on how the preference card might be changed or how he might alter his practice," Peercy says. The pathway has to reflect what the surgeon wants, or it won't be used, he adds.

Feistritzer admits that the data are crucial, but she says she wasn't prepared for the difficult task of collecting them.

"Make sure your program has forms to track the basic items such as costs, times, and reasons for delays," she says. "You can't base your decisions on anecdotal information because things are not always what they seem."

Evaluating the costs

For example, staff members said a particular surgeon was the most expensive because of the supplies and equipment he used. "But once we evaluated the data, we discovered that he was one of the less costly surgeons for that procedure," Feistritzer says.

[For more information about perioperative pathways, contact:

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LOS remains short in nation's psych facilities

NAPHS' annual survey results released

Most of the nation's psychiatric hospitals are maintaining stable, and brief, length of stay (LOS), according to survey data released recently by The National Association of Psychiatric Health Systems (NAPHS) in Washington, DC.

However, the association's 2000 annual survey report, *Trends in Behavioral Healthcare Systems: A Benchmarking Report*, shows that based on responses to the spring 2000 questionnaire, it's hard to predict if short LOS will remain the status quo.

> *"Outpatient care has not grown to the degree necessary to adequately provide the care required for the most severely ill patients. The challenge for the future will be to ensure that all levels of care receive adequate support and funding . . ."*

Limited monetary resources, limited access to aftercare services, and lack of funding and support for the most severely mentally ill patients are concerns that **Mark Covall**, executive director of NAPHS, expressed with the release of the report. "Resources remain exceedingly tight for behavioral health care," he says, "and behavioral health caregivers are working harder with limited resources. Community access to aftercare services [such as outpatient care and partial hospitalization] is becoming an increasing concern," he explained.

Key findings are favorable

The report was compiled from survey responses of NAPHS members, including 300 specialty hospitals, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, partial hospital services, behavioral group practices, and other providers of behavioral health care.

Within the hospital setting, LOS remain short, according to the results of the survey. Average hospital LOS for all age groups was 10.2 days in 1999, the same as in 1997. Over the same period, median LOS continued to decline, from 9.4 days in 1997 to 9.2 days in 1999.

The continuing downward pressure on LOS is part of a dramatic shift in the role of hospitals toward a stabilization model. Over the past decade (from 1990-1999), hospital LOS plummeted 60.1%, going from 25.6 days in 1990 to the current 10.2 days.

At the same time, respondents to the survey report that they're treating significant numbers of patients. A typical hospital in 1999 saw an average of 1,831 inpatients, an increase of 4.9% since 1997. And hospital occupancy rates have grown, as well, from 54.5% in 1997 to 62.3% in 1999. *(Editor's note: no survey was conducted in 1998; therefore, comparisons track trends from 1995, 1996, 1997, and 1999.)*

NAPHS members are providing significant care for the Medicare and Medicaid populations. Together, those government programs accounted for 40.9% of all inpatient admissions in 1999, according to the survey data.

"With continued reductions in [LOS], hospitals now focus on stabilizing patients and discharging them to outpatient care as soon as possible," Covall stated.

"However, outpatient care has not grown to the degree necessary to adequately provide the care required for the most severely ill patients. The challenge for the future will be to ensure that all levels of care receive adequate support and funding so that individuals with the most severe mental illnesses will receive effective care," he added. ■

Share your hospital's 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. Fax: (404) 262-5447. ■

Discharge Planning Advisor®

– the update for improving continuity of care

- Accelerated discharge
- Staff cooperation
- Placement strategies
- Reimbursement
- Legal issues
- Case management

Patients placed quickly with software combo

Coding, documentation happen concurrently

Case managers at Arnot Ogden Medical Center in Elmira, NY, use a combination of high-powered software systems to ensure the proper placement and care of patients — and documentation of their decisions occurs in the computer, says **Tina Davis**, RN, MS, CNS, senior director of continuum of care.

The software is an interface between Health Data Management (HDM), a 3M software that examines coding, and InterQual software, a systematic approach to determining who should be an inpatient, she notes.

"As the case managers review a case, they use HDM to code the patient to come up with a concurrent working DRG [diagnosis-related group]," Davis explains. "After the patient is coded, the case managers access the InterQual program to identify if the patient meets the criteria for admission."

The beauty of combining the two programs, Davis says, is that the case manager reviews the chart and documents the results of that chart review in the computer.

"The system is an actual database that we can run reports from," she adds. "We run reports to identify how many patients meet the admission criteria, and we can compare the results [according to] physician and payer. This information is shared with the hospital's utilization review committee to act upon."

Since many insurers use InterQual criteria to determine whether, for example, a patient should be an inpatient or an observation patient, she adds, the process allows hospital to make the same determinations, and to have documentation should it have to fight a denial of reimbursement.

Arnot Ogden's case managers use a Patient Review Instrument (PRI), a tool that is unique to the state of New York, to identify what level of nursing home placement is appropriate for the patient, Davis says. (**See chart, p. 12.)**

Soon after Medicare began using resource utilization groups (RUGs) in 1986 to determine reimbursement for nursing home placement, the PRI was developed by the Professional Standards Review Council of America (PSRCA) to facilitate that process, she explains.

Nursing homes use the PRI for reimbursement purposes, Davis adds, while hospitals and community agencies use it to identify the level of care the patient will need.

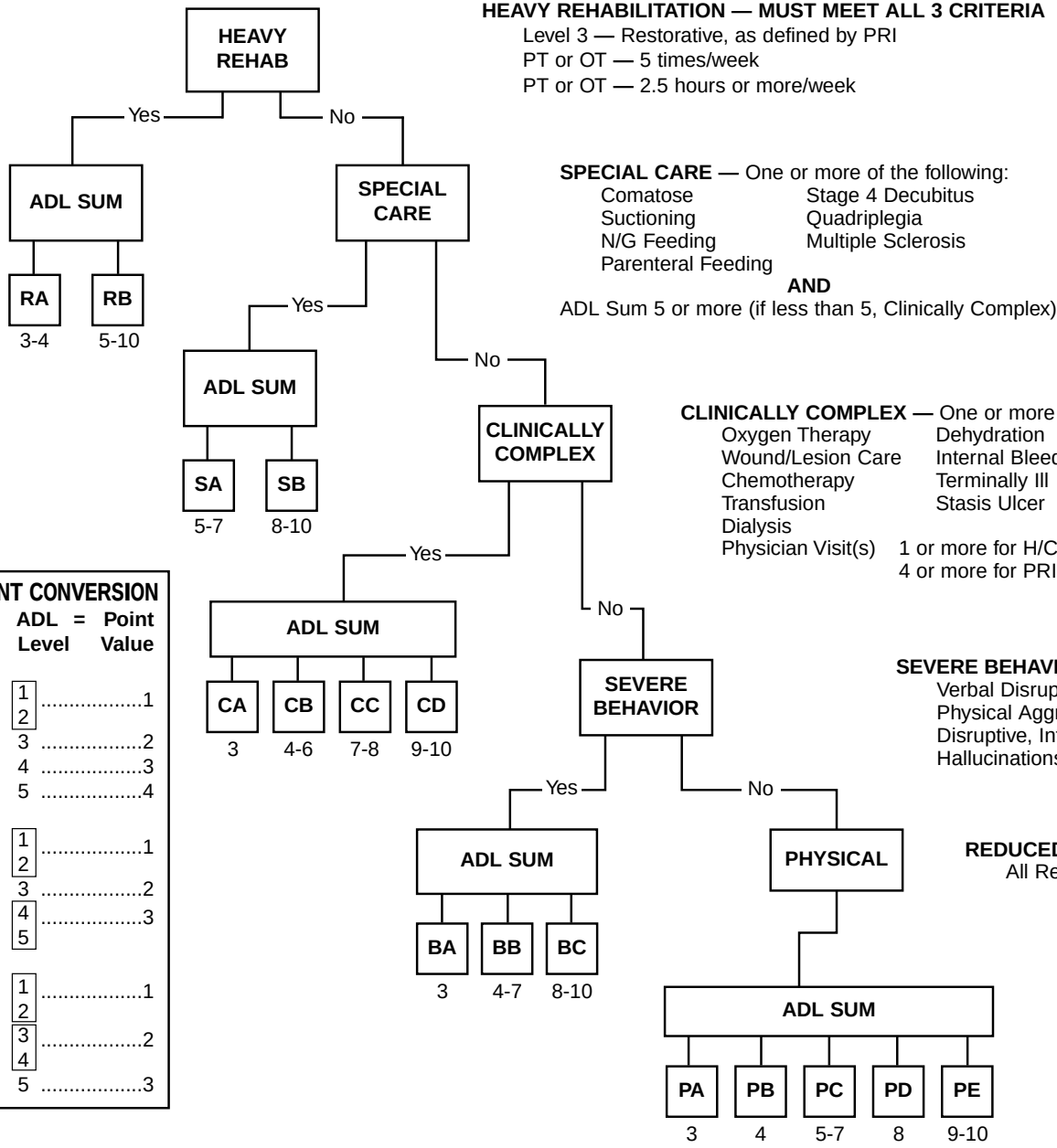
"When the case manager, the social worker, the physician, and the family all identify that the patient can be moved to an alternate level of care, the case manager fills out a PRI form for the patient and comes up with a RUGs classification score," she says. "Depending on the score, we know whether the patient is a nursing home patient or an adult home care patient."

In screening for admission to their facility, nursing home officials look at the PRI score to see what level of care the patient will need, Davis points out. "It's a neat classification system, which helps us understand exactly what the patients' needs are — if they're clinically complex, need rehab, and so forth."

The state requires an eight-hour training class — which all of Arnot Ogden's case managers have attended — for those who complete the PRI, she says. Those who are certified receive a card with an identification number, and that number must be written on each PRI, which is then signed by the person completing it, Davis adds.

(Continued on page 13)

RUGS-II Classification



HEAVY REHABILITATION — MUST MEET ALL 3 CRITERIA
Level 3 — Restorative, as defined by PRI
PT or OT — 5 times/week
PT or OT — 2.5 hours or more/week

SPECIAL CARE — One or more of the following:

Comatose	Stage 4 Decubitus
Suctioning	Quadriplegia
N/G Feeding	Multiple Sclerosis
Parenteral Feeding	

AND
ADL Sum 5 or more (if less than 5, Clinically Complex)

CLINICALLY COMPLEX — One or more of the following:

Oxygen Therapy	Dehydration	Cerebral Palsy
Wound/Lesion Care	Internal Bleeding	UTI
Chemotherapy	Terminally Ill	Hemiplegia/Hemiparesis
Transfusion	Stasis Ulcer	
Dialysis		**OR**
Physician Visit(s)	1 or more for H/C-PRI 4 or more for PRI (NF)	Meets Special Care Criteria but ADL sum is less than 5

SEVERE BEHAVIORAL PROBLEMS — One or more of the following:
Verbal Disruption, Level 4
Physical Aggression, Level 4
Disruptive, Infantile/Inappropriate, Level 4
Hallucinations, Level 1

REDUCED PHYSICAL FUNCTIONING
All Remaining Patients

ADL POINT CONVERSION

	ADL Level	= Point Value
Eating	1 2	1
	3	2
	4	3
	5	4
Transfer	1 2	1
	3	2
	4 5	3
Toileting	1 2	1
	3 4	2
	5	3

Source: Professional Standards Review Council of America, New York City.

[InterQual Products Group, Marlborough, MA, is a subsidiary of McKesson-HBOC. For more information on the system, call (800) 582-1738 or visit the Web at www.InterQual.com.] ■

Daily care rounds put all staff in the know

One of the most effective innovations at Arnot Ogden Medical Center in Elmira, NY, has been the institution of "daily care rounds" for every patient in the hospital, says **Tina Davis**, RN, MS, CNS, senior director of continuum of care.

"This is a multidisciplinary forum where we identify an interdisciplinary plan of care for the patient." There are representatives from case management, social work, nursing, respiratory therapy, pharmacy, physical therapy, occupational therapy and the dietary department, she notes. "We're all sitting at the table, discussing the patient, and this includes every patient in every nursing unit."

For eight units, the process happens every day; for the long-term care unit, it occurs once a week, Davis says. "We spend 20 to 30 minutes for each unit, depending on the unit."

The goal, she explains, is to move the patient through the system in such a way that all disciplines know what's going on and exactly what they are to do for each patient. "Nursing knows what physical therapy is doing, and dietary [staff] know what they're supposed to do. It's wonderful because a lot of the assessment piece happens here and it is concurrent. We know now what has to happen with the patient, not tomorrow after reading the chart."

Although daily care rounds have been in place for three years, in the past year the process has been taken to a new level, Davis notes. In conjunction with the implementation of new computer systems at Arnot Ogden, she sat down with an analyst from Atlanta-based Per Se Technologies and developed a documentation tool for the process.

"Every day, for each patient, we document that this is happening," she says. "We used to just write things down on a sheet of paper and archive those pieces of paper separately from the medical record, but now the information is in the patient's chart. Anybody who wants to see what's going on with the patient from daily rounds can see this. It's a very integral piece of communication that benefits the patients."

The case manager who is present does the documentation and is responsible for entering it into the computerized medical record, she notes. "From the daily rounds format, case management can move forward into doing a more in-depth assessment if needed."

That might include, for example, determining if the patient should go to a nursing home, Davis says. "Once we identify that the patient could benefit from nursing home placement and the patient agrees, the social work department facilitates this process, because of all the emotional issues involved. It may be difficult for the patient's family to get used to the idea of moving [the family member] into a nursing home."

This part of the process is where social work "really excels," she points out. "They identify all the emotional baggage, all the support the family and patient need, and then bring that information to daily rounds, when we decide the patient is going to be placed." ■

On CM frontier, defining care model is crucial

Case managers who are in one of the newest frontiers of the profession, the physician practice, may find themselves in an isolated environment with no clear blueprint as to the skill set and resources they'll need, says **Sandra Lowery**, RN, BSN, CRRN, CCM, president of the Case Management Society of America (CMSA) in Little Rock, AR.

Many of the professionals in this position, notes Lowery, who also is president of CCMI Associates, a consulting firm in Francestown, NH, come from a hospital or physician-hospital organization background, and may not have the experience that will prepare them for the unique demands of the physician practice.

Capitation typically is the reason case managers find themselves in this setting, she notes. "It's wherever there is a transfer of financial risk." In some cases, Lowery explains, a health plan allows a provider to manage utilization — this is called "delegation" — while the health plan gives oversight and holds the provider accountable through "report cards" and evaluation.

Such case managers are often in the position of trying to avoid the need for hospitalization and of making sure an individual's health needs are met,

she says. This can be difficult, Lowery adds, if the case manager doesn't have a knowledge base of community resources, assessments, and community needs.

Additionally, in some cases, she suggests, neither the case manager nor the physician truly knows how to make the best use of the case management function in this setting.

"Most case managers are there because the physician [or physician group] has taken on capitation of some sort, whether just for primary care or more globally," Lowery says. "The physician often thinks the case manager's primary role is just to manage the utilization of the patients in a hospital setting, which really isn't going to be the best bang for your buck."

Depending on his or her exposure to and understanding of case management, she adds, "the physician may not know that the 'gatekeeper model' — managing utilization of resources through managing access, which isn't really case management — won't result in the ultimate desired outcome.

"What we're seeing in terms of the best outcome is a community-based model, where financial risk is assessed in the community — whether in the physician's office or in the patient's home — by using certain triggers," she explains. Those triggers, she says, may be that someone is taking five or more medications, has an inadequate support system, or has had two or more hospitalizations in the past six months.

With this approach, Lowery adds, "the case manager can be much more proactive in achieving a better outcome before the individual reaches a higher intensity and need. This is the ideal model."

What's also unique is that while both may be employed in a physician practice setting, there are typically far more nurses than social workers performing the case management function, she points out. "Whoever does it should have a solid knowledge base of psychosocial needs and resources, as well as medical needs and resources. A high-risk individual needs both."

That usually means the case manager needs more training in one area or the other, she adds. "Physicians may not realize they need these resources. They assume 'a nurse is a nurse' and a natural case manager."

For outside support and resources, Lowery says, case managers in physician practices should take advantage of whatever professional associations are available to them.

"I certainly recommend they become part of a professional society, and of course, I recommend CMSA. If there's a local chapter, they should join that, and minimally they should get connected to a national society." At the least, Lowery notes, these groups can provide standards of practice and information about certification.

Although the CMSA doesn't have a special interest group as yet for case managers in physician practices, she adds, "I wouldn't be surprised if that is coming. When individuals join or renew, we get information about where they practice, and we do member surveys."

[Editor's note: Discharge Planning Advisor *would like to hear from case managers working in physician practices. Please share your concerns and experiences by contacting editor Lila Moore at (520) 299-8730 or lilamoore@mindspring.com.]* ■

Certifying group updates Web site

To help case managers become certified quickly, the Chicago-based Commission for Case Manager Certification (CCMC) has revised and updated its Web site: www.ccmcertification.org. The site features a brief tour designed to facilitate the certification process. The application form, as well as the recently published newsletter, can be downloaded from the site.

"The new Web site responds to the health care industry's need for certified case managers," **Susan L. Gilpin**, CEO, announced. "An increasing percentage of employers are requesting certified case managers; certification is regularly specified in career advertisements; states are beginning to require certification; and we are responding to those needs."

CCMC recently was granted accreditation by the National Commission for Certifying Agencies (NCCA), the only national accreditation body for private certification organizations in all disciplines. An NCCA panel of experts reviewed all aspects of the Commission for Case Management certification process, including validation of the methodology used in the certification examination.

The NCCA helps to ensure the health, welfare, and safety of the public through the accreditation of certification programs that assess professional competency. ■

(Continued from page 6)

duties as stipulated in the guidebook as well as appropriate licensure and/or certification."

Llewellyn stresses that follow-up with discharged patients is something that hospital case managers must actively pursue, not just to meet certification or accreditation rules, but because it is good care. "I am hopeful that discharge planners do follow-up in some way on the plans that they set up, even if it is not mandatory. This is a professional responsibility. The goal is that the case manager is working with the patient to see that things go well, and if not, they have someone to follow up with so [the patient doesn't] fall through the cracks."

Bennett agrees. "Some [hospital facilities] say they do case management discharge planning but actually just inform the insurance company that the patient needs home care, and that's it." On the other hand, she contends that many hospitals do perform continuum care after discharge but aren't recognized for it. "I think there's a big group that really do a good job of discharge planning and getting involved with the family, and they're being missed in this whole [certification] picture."

Bloomington Hospital's administration is now reviewing the case management department's revised job description, which reflects some of the changes in their job philosophy. "We have started doing follow-up phone calls and working with outside agencies on making continuum pathways," she explains.

Once the new job description is approved, Bennett plans to go ahead with her application for the CCM examination. "I'm going to try. I still think it's very difficult for hospital case managers to prove they go across the continuum, but I think good case management needs to be recognized within the hospital setting."

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Reference

1. Commission for Case Manager Certification (CCMC) official Web site: http://www.ccmcertification.org/pages/12frame_set.html. ■

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Editorial Questions

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

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What do employers look for in case managers?

As valuable as certifications and credentials have become in case management circles, most employers look beyond the initials near your name to determine if you're a good fit for their organization. There are minimum requirements, in most cases, and the certifications are not always included in those lists.

"My two most important requirements [for potential case managers] are people who are clinically competent and have excellent communication skills," says **Kerry Eaton**, RN, MS. Eaton is the director of physician services / case management at St. Vincent's Medical Center in Bridgeport, CT. "I mean, 99.9% of the job is communicating with other people, so if you don't have that, you're in trouble." "Unfortunately, certification doesn't tell you anything about somebody's communication skills."

Eaton says that her minimum requirements are that applicants must be an RN, and they have to be either bachelors'-prepared or actively enrolled in a bachelor's program. "I use it as a kind of screen." While [a bachelor's degree] doesn't necessarily mean better preparation for the job, applicants with that level of education "usually demonstrate excellent assessment and critical-thinking skills, and I want people with initiative who aren't satisfied with the status quo," she says.

Her facility, a 396-bed teaching hospital, is experiencing the effects of the nursing shortage and aging RN work force, like many hospitals across the nation. "In our area, there are far fewer graduates of nursing [programs] than there are vacancies for them," she admits. With regard to certification, she explains, "the shortage may delay how quickly it becomes absolutely essential to become certified to get a job, especially at a staff level or case manager level."

On the other hand, Eaton says, certification is a valuable option as more people come into the field.

"I think [certification is] kind of a double-edged sword because, while it's gotten to be more widely available and more people are sitting for the exams, it won't necessarily make me hire them," sh adds. "However, if I got a resume of someone who's certified, I would know that [he or she] actually had an active interest in it and [would] be a good candidate to interview. What would make me hire [him or her] are the two things I mentioned earlier: communication skills and clinical competence." ■

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. ■

PATIENT SAFETY ALERT™

A quarterly supplement on best practices in safe patient care

Has the nursing shortage decreased health care quality?

Physicans say time constraints, managed care share in the blame

In what some in the industry are calling a "landmark" study, more than half the U.S. physicians surveyed said their ability to provide quality health care to patients has deteriorated over the past five years, and fewer than one in six said that ability had improved over the same period.

"These findings are alarming," notes **Robert Blendon**, ScD, survey author and professor of health policy and management at Harvard. "What's worse is that many doctors fear this decline in quality will continue."

The study, conducted jointly by the Harvard University School of Public Health in Boston and The Commonwealth Fund in New York City, surveyed 528 practicing generalists and specialists (cardiologists, gastroenterologists, and oncologists) in the United States and approximately 2,000 physicians in Australia, Canada, New Zealand, and the United Kingdom.

Survey respondents cited several key factors in the decline of quality:

- Nursing staff levels are inadequate.
- Primary physicians don't have enough time to spend with patients.
- Hospitals do a poor job finding and addressing errors.
- Doctors are not encouraged to report medical errors.
- Physicians are concerned about their ability to keep abreast of new medical developments.

American physicians said their greatest concern about hospital resources was inadequate nursing staff levels. **Steve Eilen**, MD, a physician with Atlanta Cardiology Group, couldn't agree more. "Hospitals can't hire enough nurses to fill their staffs," he says. "What happens is they hire agency nurses who don't know where anything is, how to do anything, or who to call to get anything done. Ironically, on a per-hour basis they're much more expensive than permanent nurses, so hospitals are forced to spend more money for inferior care."

"There clearly is a shortage," offers **Richard A. Lewis**, MD, FACC, a partner in Cardiology Associates of Fredericksburg (VA), although he says he does not have a problem with the quality of the nurses with whom he works. "The nurses we have are very qualified and dedicated, but they are being stretched thin. Supply has been decreased because there are so many other career opportunities today, hospital administrations are stretched thin; their reimbursements keep coming down; and the biggest expense is salary."

"In some institutions they have really reduced staff below what I call a safe level," asserts **Dave Spencer**, CEO of Tampa, FL-based Safety-Centered Solutions Inc., a vendor of medical error reporting systems. "We have seen clearly that as staff reductions are made, the incidence of medical errors goes up."

These staff reductions have a real, and sometimes critical, impact on the ability to deliver quality care. "I had an indigent patient with an aortic dissection and tried to get him moved to a tertiary care center for specialized surgery," recalls Eilen. "The hospital wouldn't take him, citing a lack of beds. I talked to a thoracic surgeon, who told me the administrators no longer wanted to

As patient safety issues gain importance, American Health Consultants has created this supplement as a service to our readers, to provide up-to-date information on patient safety issues and trends, together with expert advice on how to meet the coming imperative for better quality and safety in patient care. Special thanks to Safety-Centered Solutions Inc. for help in preparing this issue.

accept indigent patients. They were in such dire straits that they could no longer do surgery after hours. There are only so many nurses to go around, and the hospital did not want them to work after hours because they'd have to pay overtime."

"The busier each nurse is, the more errors they can make," adds Lewis. "They're under stress; there's not as much time for review; and there's not as much time for teaching. Nurses have more bedside time than doctors, and they can help reassure and educate patients if they have the time to do it."

Patients do notice the difference, says Eilen. "I've had patients in telemetry beds who vehemently refused to stay at a specific hospital because the nursing care was so bad. With fewer nurses per patient, the patients become frustrated because they don't get bathed; beds don't get changed; they don't get to the procedures they're supposed to go to; doctors' written orders are not followed; or their medicines are late."

Compounding the problem is that at the same time the quality of care is dropping, the patients' level of sickness has increased, Spencer adds. "We're compressing the length of stay. People are being discharged earlier, so while they are in the hospital, they are sicker on the average. Also, people don't get admitted for less acute conditions. So we are faced with these two converging forces."

Eilen concurs with the survey respondents who noted that physicians don't have enough time to spend with patients. He places the blame squarely on managed care. "Here's what happens: A patient walks into the office, and he has a [copayment] of $10. You make $40 from that patient. That hardly pays for you to walk in the door, not to mention your overhead," he says. "So you need to see more patients or reduce your overhead in order to try to compensate for that. You can use [physician's assistants], which a lot of people do, but many patients are not happy about it; they want to see the physician. And my personal opinion is that the quality of care is not as good."

Lewis says he also feels frustrated by managed care. "It has definitely driven quality down from many aspects. There are increased demands for record keeping, which detract from the amount of time you can spend with each patient. With decreased reimbursement, you need to see more patients, so you have less time with each individual patient."

Lewis says the "gatekeeper" structure actually restricts access to specialty care. "The primary physician may not be qualified to determine if there is a need for specialty care. Sometimes, the patients know best, and some-times just the reassurance a specialist can provide is therapeutic."

He adds that nonphysician reviews of charts and cases that "second guess" a physician's diagnosis and treatment plan can put pressure on physicians. That could cause them to "discharge a patient before [they] think [that patient] is ready and to restrict access to testing [the reviewers] feel is inappropriate but that the practitioner feels is medically necessary. They're not doctors; they don't have the experience with patient contact that we do. They go by written guidelines, but every patient is different, and every case is different. Unfortunately, managed care discourages individualism and creativity and doesn't reward experience."

The good news from the survey is that not all respondents said a continued decline in quality is inevitable. They said that technology, especially electronic record keeping, can serve to curtail a significant number of errors.

"I would think that's true," says Lewis. "We spend a lot of time documenting, and technology would help. It also may cut down on errors; for example, a lot of programs identify potential drug interactions."

"It's a very legitimate claim," adds Spencer. "A tremendous number of things can be done to increase the accuracy of reporting and to give caregivers more access to data. Most of the errors can be eliminated if we will use the information and technology intelligently."

Eilen says he has mixed feelings. "I've looked into electronic prescription, and in its current state, it's more labor-intensive, at least in the beginning. For me, it's not a great timesaver. Electronic record keeping will be good for a lot of reasons, but only if records are centralized."

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Study targets errors in ambulatory setting

Seeking to close a cavernous information gap, The Robert Graham Center for Policy Studies in Family Practice and Primary Care in Washington, DC, has launched a nationwide study of family physicians to identify medical errors in an ambulatory setting. According to the organization, most medical-error research to date has focused on inpatient information.

"I arrived in the U.S. [from New Zealand] in 1999, at about the same time as the Institute of Medicine's *To Err is Human*[1] study came out, and I was assigned to the topic of medical errors," recalls **Susan Dovey**, MPH, a Graham Center analyst and head investigator for the study. "I quickly became aware that virtually all discussion of medical errors is focused on hospital care. But our organization's focus is primary care."

In fact, Dovey's initial efforts involved a major study of exactly where people encounter the health care system in the United States, which was when she discovered that 25 times as many people in this country have experiences with office-based providers than with hospital-based providers. "This sort of crossed over into the current study," Dovey explains. "Everyone talks about medical errors in terms of problems such as wrong-sided surgery, but relatively very few people have those sorts of problems."

Dovey is clear that one of her goals is to fill an information gap in the medical literature.

Linda C. Stone, MD, president of the Ohio Academy of Family Physicians and a member of the faculty at The Ohio State University in Columbus, says Dovey's on the right track.

"There's currently a big push in family medicine," she says. "But if we're really going to advocate for our patients, we need to have practice-based research. Most of our patients don't go to the hospital. We should be looking at our outcomes. Are we proving over time that the things we're doing continue to work? At Ohio State, our big push is practice-based research, to in turn make sure our ongoing family practices are evidenced-based."

In all, 42 family physicians filled in Dovey's data form between May and August 2000. She is adamant about the fact that the focus of her study is errors.

"People often confuse terms," she explains. "For example, there are adverse events, which may or may not be due to a mistake. A certain number of people will always have an adverse reaction to the 'right' medication.

"Then there are critical incidents, or near-misses, which are sometimes adverse events but not always. Then you must distinguish between mistakes and medical errors; there can be times when the wrong thing clearly happened, but it may or may not result in an adverse outcome. We were very focused on medical errors," Stone says.

She also makes it clear that all errors merit attention. "Little errors sometimes progress and kill people," she notes. "Hospital protocols can help prevent that kind of progression, but there are no equivalents for primary care or for laboratory tests. That's why we needed to collect these data." **(The progression of a little error can result in what Dovey calls a "Toxic Cascade." See related story, p. 4.)**

Whatever the survey turns up, Stone says all errors will be divisible into what she calls "two piles:" low-tech and high-tech errors. "To me, the most important is low-tech. As family physicians, the most important thing we establish with a patient is a relationship. If we communicate really well back and forth, that will be the first big step to eliminating errors. If you go where the patients are, you will serve them better."

For example, she says, when you tell patients the tests show they have cancer, you must be aware they will hear nothing else you say, which makes it that much more critical to write down your discussion. "The patient will get home and not remember what to tell family members."

As for the high-tech role in eliminating errors, Stone encourages her patients to explore the Internet. "They will feel empowered to communicate with you. Otherwise, they may miss pieces of information and be sent down the wrong path."

Dovey says her hopes for future studies reflect a similar respect for the collaborative role between patient and physician.

"Our current study is only from the doctor's world view," she admits. "Studies also need to be done from the patient's world view and from the clinician's world view."

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Reference

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Survey leads to new model for illustrating errors

A funny thing happened to **Susan Dovey**, MPH, as she was conducting a study for The Robert Graham Center for Policy Studies in Family Practice and Primary Care in Washington, DC. She developed a new model for illustrating and analyzing medical errors.

Dovey, an analyst with the center, was lead investigator in a study examining medical errors in an ambulatory setting. As the study progressed, she created a model for illustrating what she calls "Toxic Cascades" and "The Patient Safety Grid." **(See box, below.)**

"As the data started coming in, we became immersed in them," she says. "It soon became clear that current models . . . were not appropriate for us."

The Toxic Cascade refers to four separate categories of errors, each progressively serious:

1. trickles, e.g., misfiled records;
2. creeks, e.g., prescribing contraindicated medications;
3. rivers, e.g., undiagnosed fractures;
4. torrents, e.g., amputating the wrong leg.

Errors in the less-serious categories progress into the more serious categories in some cases, while in others they do not. The Patient Safety Grid, in turn, incorporates the Toxic Cascade model into four different settings:

1. self-care;
2. clinicians' offices;
3. institutional-based ambulatory care;
4. hospitals.

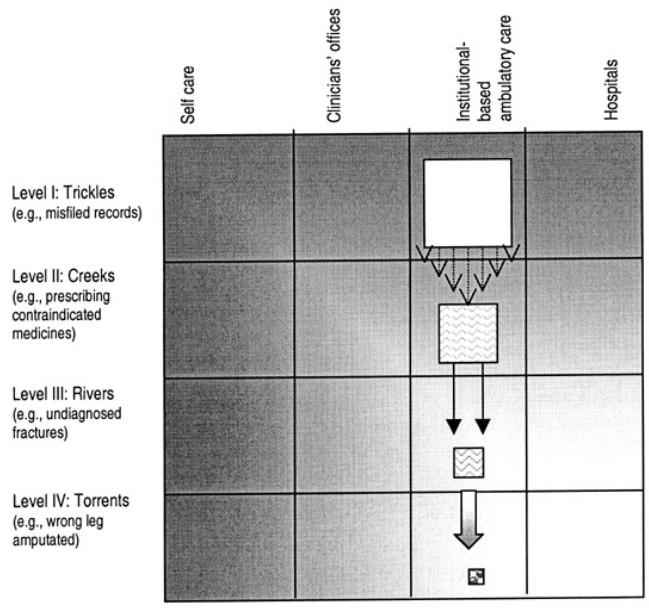
The purpose of the model is to help identify problem areas and areas where appropriate intervention can make a difference, Dovey explains. "Perhaps these minor things in primary care can build up to a torrent. We often lose opportunities to stop those from moving much further up the system. Take antihypertensive medications. Most of the patients taking them would not have a heart attack anyway, but some of them would have and didn't because they were on the appropriate medication."

A "trickle," such as a filing error, is quite common, but if that trickle involves a lab result showing a breast lump to be malignant, inaction could be fatal, she says.

"Having a misfile of an important result that should have been acted upon becomes a creek. If [it is] left without being acted upon until it's too late, it becomes a river, and if the patient dies, it's a torrent," Dovey explains.

The Patient Safety Grid was designed to researchers to "take a real 'macro' look at the whole scope of medical errors," she says. "What we currently know most about is patient deaths. If a patient dies, we say we can't let that happen again; we explore the reasons and increase our knowledge. But if they were just harmed, we don't know as much. In addition, what we currently know most about is what happens in health centers because that's where most of the research has been done." ■

Patient Safety Grid: Toxic Cascade



Source: The Robert Graham Center, Washington, DC.