AMERICAN HEALTH CONSULTANTS

HOSPITAL CASE MANAGEMENT™

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

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Conflict to cooperation: Integrating social work into your CM model

Team approach to case management uses all talents

Three months ago, when **Ann Marie Distasio**, RN, BSN, MSA, began working at Memorial-Hermann Memorial City Hospital in Houston, she could sense real fear among the social workers in her case management department. They were worried about job security and what their roles were within the department.

"I think that as the clinical models for case management have evolved and become more common

HCM's annual directory of case management credentials

In the practice of case management, certification is becoming an increasingly important standard, in both the hospital and the payer-based settings. What certification you choose depends on your career goals and your expertise. Enclosed in this issue, you will find a comprehensive directory of the most commonly sought-after case management credentials. Each entry lists eligibility, registration, and application information, as well as sample questions where available, summarized directly from the candidate handbooks supplied by credentialing organizations. **(For more on case manager certification, see *Hospital Case Management*, January 2001, pp. 1-12.)**

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COMING IN FUTURE ISSUES

- Prospective payment for rehab facilities takes effect April 1, 2001: Are they ready?
- A look at home care's prospective payment system and its effect on hospital case management
- Case management goes on-line: How CMs are making use of the Internet
- Budgeting: What does a community case management program cost?
- *Critical Path Network* reports on patient pathway involvement and open-heart recovery in home care

in hospitals, the older, more traditional social work role was being threatened, in the view of the social workers," says Distasio, director of case management services at Memorial-Hermann.

But in fact, she says emphatically, case management clearly positions social workers as vital members of the care team. The Memorial-Hermann case management model, "gives the most support ever seen in hospitals to the very absolute nature of social work — that is, working with people to help them adjust to changes that will occur due to their medical or surgical condition," she explains.

Progressive case management

Memorial-Hermann recently has implemented a new case management model that its parent organization is launching across all of its 12 hospitals in Southeast Texas.

"It's a very progressive case management model," says Distasio. "It includes all the departments that have an effect on outcomes. Our department includes infection control and performance improvement, and there are very strong liaisons with risk management and quality, and of course, nursing and social services. We even include pastoral services as part of the multidisciplinary team."

Sharing case management duties works, says **Toni Cesta**, PhD, RN, director of case management at Saint Vincents Hospital in New York City. For the past two years, her facility has been using a dyad model of case management services, in which nurses and social workers perform definitive functions within the department and work together to manage patients.

"It's been working quite well. It really uses the professionals where their expertise lies, and to me, that just makes good sense," Cesta says.

Using the dyad model, Cesta's case managers are RNs who work with social workers to help patients who meet certain high-risk criteria that the department has identified.

"The functions are split up for different clinical areas: medical-surgical, maternal-child, HIV practice, the emergency department, etc." she says. "By having the prospective referral criteria, we're able to deploy the social worker more quickly and to the right patients."

The objective is that with improved clinical pathways and reduced length of stay, not every patient will require social services or extended clinical care, Cesta explains. **(For an example of**

referral guidelines, see box, below.)

Distasio's facility uses a similar model that includes a series of collaborative meetings about each patient.

"Once a week, there is a critical care team conference," that includes the nutritionist, the pharmacist, the chaplain, a respiratory therapist, and a physical therapist, she says. During the 45-minute conference, problematic patients are identified — those the team anticipates are headed for longer-than-normal stays. Distasio says this meeting alone is very useful. "I was overwhelmed when I started working here at how efficient this approach is."

In addition to meetings, the case management department at Memorial-Hermann completes a daily review. The RN case manager begins by addressing every new admission in critical care. If the diagnosis hits the established risk screen, the case management team is called in, beginning with the APACHE system coordinator, who gathers the data. "We want all the clinical data, as objectively as possible, to be recorded right from the start," Distasio explains.

"The next person we pull in is the social worker, to do a complete psychosocial assessment within 48 hours. At the least, contact within the first 24 hours is an absolute," even if a complete social services assessment can't be completed due to other circumstances.

"My picture is that, in order to go somewhere [within the health system], there is a driver. The

CM Model Makes Good Use of Team Members' Talents

The following is an inpatient case management model for AIDS patients, broken down by role, that has been used effectively at Saint Vincents Hospital and Medical Center in New York City:

RN CASE MANAGER

- ✔ Performs admissions and concurrent utilization management, including insurance calls.
- ✔ Tracks data, e.g., variances in patient care and systems standards.
- ✔ Facilitates daily rounds and team meetings.
- ✔ Makes referrals to certified home health agencies, department of AIDS services for home care services.
- ✔ Orders transportation, equipment, and supplies.
- ✔ Alternate level of care notification.
- ✔ Issues hospital-issued notice of noncoverage letters.

SOCIAL WORKER

- ✔ Completes screens.
- ✔ Participates in daily rounds and team meetings.
- ✔ Collaborates with community agencies.
- ✔ Initiates referrals to community agencies as needed.
- ✔ Provides crisis intervention, advocacy, counseling around impact of illness on the patients / significant other, bereavement, domestic violence, sexual assault, child protection, substance abuse, and patient education.
- ✔ Facilitates discussion around health care proxies, guardianship, and do-not-resuscitate orders.
- ✔ Provides financial assessments and referrals to entitlement programs.
- ✔ Maintains contact with patients through their first follow-up medical provider appointment, post-discharge.
- ✔ Refers patients to long-term and subacute placement.

SHARED RESPONSIBILITIES

- ✔ Assess each patient.
- ✔ Identify and communicate with prior and future providers of medical and psychosocial services.
- ✔ Assist physicians in completing discharge planning forms.

person sitting in that seat is the nurse case manager, and riding shotgun is the social worker. Without those two people, we cannot move forward," she says.

That daily team approach to managing patients also is in use at Vanderbilt University Medical Center's case management department, which is led by **Evelyn Koenig**, MSW, director of the Nashville, TN, facility's case management office.

"Our philosophy is that every patient needs to be managed, but not every patient needs case management." To determine which ones do, Vanderbilt has a triad team: nurse case manager, social worker, and utilization manager (UM). If a case is psychosocially complex, the social worker picks it up and "drives" the management. "But they all discuss the patients every day, so even if the social worker is managing, the nurse and the UM still have input," she adds.

> *"When you think of the issues confronting the population in our country, who could best serve that but a social worker? RNs are not trained in how to deal with dysfunctional families; that is not our expertise.*

Koenig says one of the obvious deterrents to implementing case management models of this nature is the apparent cost. She notes that, because two disciplines are involved, it appears costly, but in fact, the cost savings that can be achieved more than offset the salary costs. "My bias is that any administration that . . . feels that one discipline or another is unnecessary is shortsighted. An optimal case management model makes use of various skills. Collaborative practice is what's truly going to make a difference in health care," she emphasizes.

In fact, at Memorial-Hermann, the administration is watching to make sure the new case management model does not in any way stifle the social workers, Distasio says. "They've come right out and said that," she adds.

As for the social workers who are at Memorial-Hermann, Distasio says their fears have subsided somewhat under this case management model. She predicts that as case management moves more into the community — into ambulatory care facilities, long-term care, and other subacute areas — social workers will experience a kind of renewal within case management. Social services skills are specialized.

"When you think of the issues confronting the population in our country, who could best serve that but a social worker? RNs are not trained in how to deal with dysfunctional families; that is not our expertise. The sensitivity for the expertise in social workers needs to be developed among nurses," she adds.

"We understand their fear," Distasio says, but there's really no need for it. "Will the fears ever be eliminated? Maybe not.

"But as the case management model in this company grows and expands into community care, I have a sneaking suspicion that our social workers will have no fear. They will see a rise in their esteem in the medical community. The bottom line is, case management cannot be done without them."

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Reclaim your denials to help save bottom line

Strategies to maximize your reimbursement

In the current era of managed care, hospitals are experiencing a dramatic change in reimbursement structures.

Some hospitals are losing up to $1.5 million per month because of claims denials, according to industry experts. One hospital alone faced a loss of $6 million. Is your facility trying to bridge this perilous gap?

If so, there's something case managers can do to help fix the bottom line: As demonstrated in a presentation at the Case Management Society of America's (CMSA) recent Hospital

Case Management Summit, a one-day conference held in November, 2000, in San Diego, a structured denial management program can help improve your overall reimbursement numbers.

Jon Mayer, RN, FNP, MBA, a management consultant with Chicago-based Milliman and Robertson Inc., emphasizes that case managers can play a vital role in helping recoup those staggering reimbursement losses.

"Denial management programs are in place in several organizations as they interface with managed care organizations (MCOs)," Mayer says, but not in all organizations. "It varies by size and type of facility, and by the amount of managed care in the particular area," he says.

Effectively addressing denials

Since there doesn't seem to be a standard definition of denial management, many different individuals within the hospital might be addressing denials. But, Mayer asks, "Are they effective? Does what they're doing prevent denials?"

In some cases, recouping the funds from denied claims can take more than a little change — it can require a major overhaul. That's what **Dan Wassailchalk**, MHA, RHIA, director of performance improvement / utilization management for The Johns Hopkins Hospital in Baltimore, found out.

For fiscal year 2000, his facility began a multiphase program it called the "Revenue Recovery Initiative," which examined not only claims denials but also ineffective relationships with payers, lingering appeals, inaccuracies at registration, coding and case mix intensity, bills processing, and poor clinical documentation. The result: Johns Hopkins recovered more than $8 million — $2.6 million of which came from a reduction in payment denials.

"We knew there was $20 million on the table and we were going to get something," Wassailchalk says.

In fact, Hopkins' denial rate had been climbing since 1998. Every 0.1% in the denial rate was equivalent to about $340,000, he explains. "We realized that to drop it 0.3% was worth $1 million."

Wassailchalk's plan included many different components, but one of the most important ones was integrating what he calls a "triad case management team," made up of a nurse case manager, a social worker, and a performance improvement / utilization management member, who would be able to follow a patient from admission to discharge.

"That would provide continuity within the case management program," he says, and create better communication among everyone.

Going a step beyond

Mayer says case managers have specific responsibilities when it comes to denials, because of their function as communicators. Typically, denials management is assigned to the business office of a hospital, the people who negotiate contracts with MCOs, or utilization management, he explains. If it's a large system of several health care facilities, denials may be handled centrally, even in another city.

"But there are specific functions that are localized, or decentralized, and those are the ones the case manager handles," and should handle, he argues, because they're on-site, talking to physicians, and interfacing with the patient.

Ultimately, Mayer stresses, case managers should get involved at the base level: contract negotiation.

"Let's go a step beyond," he says. Rather than the finance department identifying a fee or rate for managed care, case management should be involved at the earliest stage. The best way for it to work, he suggests, is for there to be a meeting at the time of contracting between the hospital staff — including case management — and the payer.

Understanding payers' criteria

Depending on the size of the organization, the head of the case management department or individual staff members might attend that meeting. This is the optimal way for the case manager to understand the payer's criteria, and in order for denials management to work, case managers must understand the criteria as well as, if not better than, the payer, Mayer says.

At Johns Hopkins, the contract implementation team is responsible for the planning, coordination, review, and ultimate approval of a contract. Again, the idea is that different people bring different perspectives to that process.

Wassailchalk's other initiatives included:

1. **Improving accuracy at registration.** They made sure registrars were trained to ask

the right questions so that more days were certified up front and fewer denied on the back end.

2. **Becoming clinically efficient.**
"We needed to reduce delays in service, improve documentation, move patients more efficiently through the system, and keep the payer as informed as possible."

3. **Better communication with payers.**
One of the strategies Johns Hopkins employed was to bring more payer reviewers on site. "We set them up with the tools they need and the access to staff," so they could meet weekly with clinicians, reduce phone calls back and forth, and make decisions in a timely manner.

4. **Increasing appeals.**
"We realized you can't win if you don't play," Wassailchalk says. Because Johns Hopkins had improved its clinical documentation early in the performance improvement process, it also had more to work with and more reasons to initiate appeals.

5. **Picking up strays.**
In addition, the team needed to address reimbursements that remained in limbo in the system. Some appeals that Johns Hopkins had initiated had never been addressed by the payers, so there was money — $1.9 million, to be exact — that had never been recovered. The hospital hired someone to focus solely on these cases and recovered $900,000 of the deficit.

6. **Watching for problem cases.**
"Finally, we focused on problem-prone cases, assigned by DRG, and then channeled our frequency of phone calls to payers based on those cases," Wassailchalk says.

"Almost immediately we saw a 24% increase in calls to insurance companies, and that led to a 35% increase in days that were certified up front," he adds.

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Cultural competence is a must for all hospitals

America isn't a melting pot; it's a 'mixed salad'

Fact: Most of the major accrediting agencies, including the Joint Commission on Accreditation of Healthcare Organizations, the National Commission on Quality Assurance, URAC, and even Medicare and Medicaid, now require hospitals to incorporate into their practice a certain degree of cultural or linguistic competency.

The national standards are generally established, and requirements fall into four categories: linguistic services, translated signs and materials, obligations to provide specific languages, and some kind of office of diversity.

There are more requirements to come. In spring 2001, a surgeon general's report is expected to address mental health, race, ethnicity, and culture. Though it is not yet finalized, this report will provide direction and possibly requirements or guidelines for the future.

More important than the fact that requirements exist, however, is that hospitals, patients, and payers all benefit from a culturally appropriate care model. For one thing, there can be a great reduction in the cost of services.

"Clinically appropriate services are always the most cost-effective," stresses **Beth Remus**, RN, BGS, MS, MSS, president of Remus and Associates in Chicago, who is an independent consultant and leader in the field of cultural competency in health care.

Cultural competency cuts costs

In her presentation at the recent Hospital Case Management Summit in San Diego, Remus said that in the area of medication alone, studies in ethnopsychopharmacology have found that different responses to medications are linked with different cultures. To use the correct ones means reduced costs to the patient and the facility, and better care.

For example, in mental health, the therapeutic range of lithium differs among ethnic groups: Asians have a lower therapeutic range (0.4 - 0.8 mEq/L) than Americans (0.6 - 1.2 mEq/L). Also, side effects vary across ethnic groups.

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CRITICAL PATH NETWORK™

Pathway achieves first steps toward improvement

Clinical development team happy with results

Two years ago, Pomona Valley Hospital Medical Center's case management team, along with the decision support department and the administrators, realized that community-acquired pneumonia (CAP) was a diagnosis-related group that needed to be revisited in their organization.

"We weren't competitive with any of our local facilities," says **Maria Robles**, RN, respiratory case manager for the Claremont, CA, hospital. "We also knew from our experience that there was so much variation in practice that the patients weren't getting any standard of care." Physicians and nurses were treating patients with different antibiotics, with and without preventive care, and so forth.

After a chart review of 1999's January to December patients, a new pathway for CAP was developed, which reduced length of stay (LOS) by an overall 1.1 days, saving somewhere around $1,000 per case. **(See pathway, pp. 24-25.)**

"We implemented the risk-class system that was designed by the Infectious Society of America and the American Thoracic Society (ATS). It's a scoring system based on severity of illness for CAP," Robles says.

Patients' ambulatory status important

Their guidelines categorize risk Class 5 patients as those with the highest mortality rate, and Class 1 or Class 2 as patients not necessarily needing hospitalization.

The bulk of cases studied fell in the Class 3 and Class 4 range, and average LOS for those patients improved even more: seven days for nonpathway Class 4 patients, vs. 4.6 days for pathway Class 4 patients.

"One of the interventions [of the pathway] was that patients get out of bed within 48 hours," Robles notes. Comparatively, patients on the pathway achieved that goal 91% of the time, while nonpathway patients only achieved 77%.

"Getting out of bed prevents embolisms, which can go to the head and produce a stroke, as well as preventing other complications including bedsores," she says.

Getting more patients off IVs

Additionally, the pathway team knew that addressing patients' conversion from intravenous (IV) antibiotics to oral antibiotics was important in reducing overall LOS.

Conversion can reduce the risk of the complications from invasive IV medication — phlebitis, systemic infection, and other problems, Robles adds. Pathway patients converted on day three twice as much as nonpathway patients (18% vs. 9%).

"One thing we did really badly on was collecting sputum before the antibiotic is administered," Robles says. (On the pathway, 27% of CAP patients had sputum tests done before antibiotic administration.) Testing sputum is necessary to identify the organisms causing the illness. However, there's some controversy between the Infectious Society of America and the ATS about how mandatory this action should be.

"It's very hard to get a good sample. You need

(Continued on page 26)

This pathway is a general guideline and does not represent a professional care standard governing provider's obligations to patients. Care is revised to meet the individual patient's needs.

	Discharge Outcomes	Date: Time Frame: First 24 hours of admission	Date: Time Frame: Day 2	Date: Time Frame: Day 3	Date: Time Frame: Day 4	Date: Time Frame: Day 5
Hospital area						
REFERRALS		*Initial those ordered*	*Initial those ordered*	*Initial those ordered*	*Initial those ordered*	*Initial those ordered*
	Patient receives needed therapy and post-discharge resources. *Initial those ordered.* Infectious/Pulmonary M.D. Respiratory therapy Physical therapy Dietary Social Services Speech therapy Stead Heart Smoking Cessation Respiratory Case Manager PICC Case Manager Home Health Referral Other	R.T. PRN Social Services PRN	R.T. PRN Social Services PRN P.T. PRN Dietary, PRN Anti-smoking consult PRN-Stead Heart	R.T. PRN P.T. PRN Dietary, PRN	PICC for home IV antibiotics PRN Anti-smoking consult PRN-Stead Heart	
ASSESSMENT		*Each discipline initial pertinent area*	*Each discipline initial pertinent area*	*Each discipline initial pertinent area*	*Each discipline initial pertinent area*	*Each discipline initial pertinent area*
Physical	Discharge criteria will be met: Vital signs stable, HR<100, T. <100.0 RR<24. Breath sounds clearing, able to cough secretions	Assessment per standard of care **Pneumonia Class Risk #** **Antibiotic taken prior to admission?** **Name NA** **For how long?** **Last Pneumovac date** **Last Flu Vaccine date**	Assessment per standard of care	Assessment per standard of care **Discharge criteria met? Y N**	Assessment per standard of care **Discharge criteria met? Y N**	Assessment per standard of care **Discharge criteria met? Y N**
Psycho-Social	Patient & family will be provided with emotional support	Assess patient & family needs	Assess needs and implement interventions	Assess needs and implement interventions	Assess needs and implement interventions	Assess needs and implement interventions
Socio-Economic	Patient & family are aware of and have access to community resources	**Advanced Directive review Y N** Discharge planning assessment	**Advanced Directive review Y N** Discharge planning assessment	Evaluate need for ECF or home health	Evaluate need for ECF or home health	Evaluate need for ECF or home health
ACTIONS						
Tests/Labs	Sputum & Blood cultures to be done prior to administration of antibiotics within 2 hours of admission	CBC with differential Chem 7 **Blood cultures time:_____** **Sputum cultures time:_____** Chest X-Ray ABG to room air SpO2 (oxygen saturation) EKG PRN		CBC with differential		

ADDRESSOGRAPH

Demographics and Clinical Information

Additional Diagnosis: _____
Significant Other _____ **Allergies:** _____
Route of admission: _____ **Time:** _____

Pomona Valley Hospital Medical Center

Clinical Pathway

Community Acquired Pneumonia

(Continued from page 22)

phlegm from deep in the lungs, and it's just hard to get. Some people are too weak to cough that deeply; sometimes it's just too deep in the lower lobes. The pathway didn't produce any better results in getting those sputums out, and we had some fighting among our physicians about whether or not we needed to get it," Robles says.

> *"We felt that in order to change the culture of our facility, we needed to do it in steps. It's a best practice, but it's not yet the ideal practice. So with revision, it will get even closer to the ideal."*

"In the ideal world," she points out, "we need to absolutely know [the organism], but the other important goal is to give the antibiotics within two hours of presentation, because that decreases mortality very significantly."

Pomona did very well improving its antibiotic administration. On the pathway, the benchmark was two hours, and in 2000, the pathway patients received it, on average, within 2.59 hours. Non-pathway patients in 1999 had an average of 6.1 hours delivery time.

One final improvement was in preventive treatment for CAP patients. The pathway research included a significant change: In 2000, 100% of pathway patients who needed flu and pneumococcal vaccinations were given them upon discharge, whereas in 1999, that percentage had been only 4.5%.

CAP goals include revision

Since Pomona developed its CAP pathway in 1999, revised guidelines about new antibiotic treatment have been released by the Infectious Society and ATS. Robles says the department plans to revise its pathway in accordance with the new data.

"These data are from recommendations for 1998, and there have been new ones now. We need to revise all the orders for what antibiotics come next, according to the new guidelines from the two groups." But revision has been part of the plan since its inception.

"We worked very hard on a system that would function effortlessly; the pathway wouldn't require someone to constantly follow it, so that any nurse or physician from any specialty could use it. If we continue to pursue it this year, and we will, we could probably cut another day," Robles says.

In addition, Pomona didn't want to make the initial pathway a sudden, 180-degree change. "We felt that in order to change the culture of our facility, we needed to do it in steps. It's a best practice, but it's not yet the ideal practice. So, with revision, it will get even closer to the ideal," she explains.

Several specialties were involved with the development of the pathway — pulmonologists, infectious disease specialists, family practitioners, rehab specialists, administration, nursing, physical therapy, and the dietician — so we have a lot of buy-in, and that empowers the staff, she adds.

"It's important to work as a team and have a lot of physician involvement, because they are the ones who have to feel that the data are worth it. We had some very reputable pulmonologists and infection doctors who were the lead physicians on the project," says Robles.

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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. ■

PATIENT EDUCATION
QUARTERLY

Higher risk of re-admits when patient can't read

Use materials, techniques to boost comprehension

Warning: Health literacy can have a serious impact on your hospital's bottom line by affecting more than the patient education department. Patient educators say that patients who do not understand or can't read instructions for prescriptions, informed consent forms, educational materials, and appointment slips have more hospital visits and longer hospital stays than those with higher health literacy skills.

"If patient education managers don't pay attention to health literacy, they won't have good health outcomes. The ultimate goal of doing patient education is to have healthier people," says **Audrey Riffenburgh**, MA, president of Riffenburgh & Associates, an Albuquerque, NM-based business specializing in health literacy and plain-language communication.

Health literacy is a difficult issue because people who read poorly have different levels of reading skills. If two low-literacy patients are handed the same pamphlet, their level of understanding would differ because they both understand words from the material differently. "One of the frustrating things about people who do not read well is that they do not all read poorly in the same way," explains **Deborah Yoho**, CEO of the Greater Columbia (SC) Literacy Council. Even good readers have difficulty understanding materials at such times when they are in pain, under stress, or unfamiliar with a medical condition.

While it is important to note a patient's ability to read and understand complex information, many other factors influence comprehension. The patient's motivation, interest, and investment in the situation impact health literacy, as well as their culture, primary language, age, and disabilities, says **Helen Osborne**, MEd, OTR/L, president of Health Literacy Consulting in Natick, MA.

The following is a list of components that should be included in a patient education program to ensure all patients understand, regardless of their health literacy level.

- **A variety of teaching materials.** People do not all learn in the same way. Some learn best by reading the information, while others are visual or audio learners. Therefore, a variety of teaching materials should be kept on hand, including visual charts, posters, models, videos, and audiocassette tapes.

"For basic diabetes education, a health educator might sit down and tape the instructions on how to take medication so patients have a cassette tape they can listen to in the car or with other family members," says Riffenburgh.

To determine how patients learn best, ask them, she says. If they don't know, suggest they think of a time when they learned something new. Ask them if they watched someone else do it, if they listened to a lecture, read about it, or just tried it on their own, she suggests.

- **A good assessment of the patient group.** Know who uses your clinics and hospital, advises **Linda McIntosh**, EdM, RN, CS, coordinator of patient education at Cambridge (MA) Health Alliance. Her health care facility serves a large number of people who speak Haitian Creole, which only recently evolved into a written language. Therefore, those who are educated read French, while the others may not read at all or have limited literacy.

Because people don't read, the families who have immigrated to the United States exchange information with their friends and relatives in Haiti using audiotapes. Therefore, the health care facility picked audiotapes as a teaching tool, as well as print materials with pictures and one-word descriptions.

To determine how best to teach Haitian patients with diabetes, McIntosh formed a focus group and found that the Haitians liked to sit around and talk gathering information from each other.

As a result, support groups for Haitians with diabetes were organized.

Computers can help by making collecting demographic information easy. To determine such factors as age, ethnic background, and whether English is the patient's first language, ask them those questions when they come to the clinic and track the information on a computer, says Yoho. She recommends these teaching techniques:

• **A program to educate health care providers.** Health care workers who understand the issues of health literacy and how to overcome barriers to learning will do a better job of teaching patients. Therefore, those who educate patients must be taught how to effectively teach people who might have difficulty understanding the information. They also must learn to create a safe, nonjudgmental environment for learning, says Riffenburgh.

• **Policies for proper evaluation of learning.** Good patient education techniques include the assessment of the patient before teaching to uncover learning barriers, as well as an assessment of their understanding following the teaching. To determine if a patient comprehends the teaching, Riffenburgh suggests the following techniques:

— Ask patients to tell you how they will explain what they've learned to their family. Help them rehearse in their own words.

— Have them demonstrate what they learned, for example, changing a dressing or measuring a dose of medication for their child.

— Encourage patients to identify one action they will take in the next week. Have them describe the action in detail so you know whether they have understood the instructions.

In a busy clinic, it is almost impossible to determine if a patient can read. Therefore, time would be better spent determining comprehension by asking the patient questions about their treatment or having them demonstrate a skill, says **Kristina Anderson**, literacy coordinator at Harborview Medical Center in Seattle. "We need to determine patient understanding rather than do a literacy assessment, and we need to make sure there is a variety of tools available to teach," she says.

• **Easy-to-read written materials.** Whenever possible, have easy-to-read materials on a topic that provide the basic information and additional print materials written at a higher level with more information. In this way, patients can be given a choice, says Riffenburgh. Also, if you suspect the patient has difficulty reading, review the material with him or her. "Provide people with review markers when working with print materials. Circle, underline, highlight, or put arrows to the points you want the patient to remember and go back to review," she explains.

Print materials always should be used to reinforce teaching, and not used in place of verbal instruction. "Sometimes, when health educators are busy, they just hand patients material; the interactive piece is what makes it valuable. It isn't so much whether patients know the information off the top of their heads, but if they can find the information. Show them how to use the material," advises McIntosh.

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Find Out More About Literacy

Need help with health literacy issues? **Helen Osborne**, MEd, OTR/L, president of Health Literacy Consulting offers TeleClasses, which are interactive training sessions conducted over the phone. For a list of classes, visit her Web site at www.healthliteracy.com.

Audrey Riffenburgh, MA, president of Riffenburgh & Associates, offers workshops on evaluating written materials with computer software readability formulas. They can be conducted via conference calls with up to five people. Information on health literacy also can be found by visiting Health Literacy Toolbox 2000 at www.prenataled.com/healthlit/. ■

(Continued from page 22)

"Basically, the idea that a drug will act identically in two different people is being re-thought." Remus says. It's a fairly new concept, she adds. "I have looked around and not found anyone studying from this direction but . . . there is more and more literature relating to misdiagnosis and therefore mismedication and treatment, which is very costly."

In hospitals, the move toward complete cultural competency is just beginning. "Diversity training" has been a buzzword for several years, in business, health care, and virtually every other industry. But it's only a stepping stone, Remus says.

Francie Handler, RN, BSN, CMC, team supervisor in case management at St. Vincent's Hospital in Santa Fe, NM, says that in her facility, "We're are doing diversity training on a departmental level at this point; hopefully soon it will be hospitalwide," she says.

Even though the area's population includes both Hispanic and Native American cultural groups, and competency is essential in the hospital staff, she says, "We probably need more formal training. No matter how much you know, you still need to hear it again and again."

Bridging the gap between resources

So, how do hospitals go about becoming competent? Case management can be a conduit, Remus says. "Case management is an excellent place to begin the process. The case managers and their support staff are the link; they play a multifunctional role in bridging the gap between mainstream organizations (i.e., the hospital) and the ethnic minority communities and their provider networks."

For example, if Hospital A is not particularly culturally competent, but its case management department is, it can immediately shift gears and make sure that the patient's cultural needs are met, she adds.

Handler agrees. "I think case management is in a critical spot because we're often the first people who go in and . . . do our assessments. We're often the first people who, for example, bring in an interpreter, and [language is] so critical to developing a trusting relationship and getting the information you need."

Several of St. Vincent's discharge planners are Hispanic and fluent in Spanish, so there are also important links to the community resources within the case management department, she adds.

As an individual case manager, or as a department, there are several steps you can take to get on the road toward cultural competency. Remus suggests the following:

• **Seek out training within the population.**

"There's a lot out there," she says, and especially in the urban areas, it's easy to find courses and instructors. You'll want someone, preferably, who is of the culture you're studying.

Handler says that her facility often requests guidance on cultural issues from Santa Fe's Public Health Services Hospital, which treats the area's Native American population and has recently asked some people from Public Health Services to present an educational program to the St. Vincent's case management staff on subjects they feel are important to the Native American population.

• **Read about the culture you're serving.**

"If you read a couple of references, and a couple of articles, I'm not saying you'll know it all," says Remus, but you'll start to hear the same information over and over, and start to understand about the people in a particular group — their customs and norms and typical behaviors.

• **Start a "cultural catalog" about the population group.**

"Include in it things like nonverbal communication issues you observe: spatial things, touching things," Remus says.

It also helps to list specific dietary restrictions, healing rituals and folk medicines, medical risks and socioeconomic factors, and community resource information, such as "Which doctors in the community speak this language? Which social workers do?" It becomes a resource book that even can be used during the orientation and training of your case management department's new hires, she suggests.

• **Learn some of the everyday phrases and their uses in the language of that population.**

You can't be culturally competent if you don't know the basics of their language, and it really says something about your interest in and your openness toward the population.

Evidence that America's diversity is growing has been available since the most recent U.S. Census data were compiled. Take a look at the patients around you, and you might see a small sampling of what the census found. At least 210 different nations are represented within the borders of the United States; experts predict that by

the middle of the 21st century, the average U.S. citizen will trace his or her ancestry to Asia, Africa, the Pacific islands, or a Hispanic country — not to Europe; and since 1980, the number of people who speak a language other than English at home has increased by 43% to 28.3 million.

We really can't call it a melting pot, according to Remus. "I would suggest that we're a mixed salad. Ethnic groups are no longer that interested in melting into the country; they are interested in maintaining their ethnic backgrounds, their dynamics, and their uniqueness."

For health care facilities, this poses a challenge not only to provide the appropriate required services, but to develop different attitudes and mindsets. However, Remus says, "Eliminating the disparities is going to be very difficult in this country."

Hospital facilities that serve very diverse populations might have a harder time implementing new practices for every ethnic group that they serve. But Remus says it's possible to take baby steps.

"I start from where the priority is and weave one in at a time," she says. "Once you learn the skills set for changing an organization, you can do it again and again." Besides that, on a practical level, the larger, philosophical movement toward becoming culturally competent is still in its infancy.

"There are no real best practices going on out there right now, Remus explains. "This is a real grace period. If organizations go forward and start making [any] movement towards the goal of being culturally competent, they're ahead of everybody."

Increasing cultural understanding

Beyond all the rules and the cost benefits, Remus says, "The thing that touches my heart is that being culturally competent is ethically and socially the right thing to do." Getting to the real implementation of cultural competence might seem an endless journey, but case management departments and hospitals overall can treat it as a performance improvement project, Remus notes.

"Find out who you've got, then complete a mini-assessment of your department, relative to that population," she says. Most importantly, assess and evaluate your progress as you become more culturally competent.

Remember, actions speak louder than words. "A case manager can be the one — the source of information for others in the hospital — just by doing what's right," Remus says. "I can see case managers being highlighted in hospital newsletters, not because they're touting [cultural competency] but just by doing it."

[For more information, contact:

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Francie Handler, RN, BSN, CMC, Team Supervisor, Case Management Services, St. Vincent Hospital, 455 St. Michael's Drive, Santa Fe, NM 87505. Telephone: (505) 820-5823.] ■

Hiring how-to: Use the Internet as supplement

Internet supplies larger pool of candidates

Although the Internet generally is the first place people look for job opportunities these days, one director of case management does not see a real need to go on-line for qualified case manager candidates.

"I personally don't have to bother," says **Elaine Cohen**, EdD, RN, director of case management at the University of Colorado Health Services Center in Denver.

"I've been fortunate to have an extremely good staff, and I like to recruit from within," she says. Typically, Cohen uses her facility's human resources professionals to promote floor nurses and other employees into case management positions.

However, Cohen acknowledges that the Internet is a good tool to contact and interact with potential employees; one of her colleagues has set up an extensive network for that purpose, she says.

Communication exchange is important, and the Internet is a convenient way to connect the department with job applicants, Cohen adds.

In addition, the Internet can provide employers with a significantly larger pool of candidates from all over the nation, and it can help narrow those down to the ones they really want, says **Ted Elliott**, president of JobScience.com, an Oakland,

CA-based health care jobs Web site.

In fact, JobScience.com currently boasts 25,000 active, registered users, and it's only one of the many Web sites of its kind. To provide for all those job-seekers, Elliott is actively campaigning to put more employers on-line.

"Last year, health care activity on-line was a bit on the slow side, but this year, it's picking up. Because there's an increasing shortage of candidates, [employers] are deciding they have to look outside their neck of the woods to attract qualified employees," he explains.

Case management positions are included in JobScience.com's specialized search engine, which once focused solely on careers in California but has recently expanded to include more than 30 state job markets.

"There are plenty of case management positions, and there will be more," Elliott confirms. "Every [human resources] executive I talk to says, 'We've got problems across the board.' They're having tough times filling positions."

Find out where candidates are coming from

One of the top issues managers have is that "they need an idea of where the candidates are coming from. In health care, there's a real need to screen out people who are not qualified," Elliott explains. One of the ways to do that is by specialty focus. Employers can list jobs by department or by advance practice specialty, and job seekers can collect all the jobs under those headings and send their resume out to all of them with the click of a mouse.

Elliott estimates that only 1% of health care human resources departments do not consider turnover a problem. "Retention is the real issue," he says.

Hospitals, in an effort to employ qualified staff, often are spending two to three times their budget when they hire temporary and per diem employees, Elliott adds, so it's even more important for them to find the right employee.

Cohen agrees that retention is key. She says that with the current and predicted work force shortages in health care, it's important to keep her case managers happy. She does that by recognizing their levels of expertise and maturity.

Even though the job is challenging, she says, with practice statistics and payer regulations, it offers employees a leadership opportunity.

"They have chosen the case management route to expand, to develop professionally . . . and I've seen it help me in attracting and recruiting," Cohen adds.

[For more information, contact:

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Ted Elliott, President, JobScience Inc., Oakland, CA. Telephone: (877) 298-6598. Web site: www.jobscience.com.] ■

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Editorial Questions

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NEWS BRIEF

Conference targets quality in case management

Experts will share their proven ideas for successful case management at **The 6th Annual Hospital Case Management Conference: Blueprint for Case Management Success: Information, Accountability and Collaboration**, to be held March 25-27, 2001 in Orlando, FL. The conference is sponsored by American Health Consultants, publisher of *Hospital Case Management*.

The timely topics offer something for every hospital-based case manager or quality professional. A number of speakers will address issues including:

- New avenues for community case management
- Knowledge-driven care coordination
- Creating a heart service line report card
- What you can teach your CEO about managed care
- Values, ethics, and legal parameters in case management
- The ABCs of the Balanced Budget Act
- Reimbursement: An ever-changing process
- Key concepts in case management
- An interdisciplinary practice model for acute-care case management
- Better case management through denial management
- Measuring the impact of case management interventions

Each session sets aside time for you and your peers to ask the experts your most burning questions. Nineteen contact hours of continuing education will be offered.

The conference fee includes a cocktail party to network with speakers and other registrants, continental breakfasts, lunches, a course manual, and a form exchange for attendees.

For more information, contact American Health Consultants, Customer Service, P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291. E-mail: customerservice@ahcpub.com. ■

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. ■

HOSPITAL CASE MANAGEMENT™

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

Special Report: Building a Successful CM Career

Directory of the top 12 CM credentials

When it comes to case management certification, it's not a one-size-fits-all world. You should select the certification program that best fits your personal work experience, education, and professional needs. The information in this special supplement is summarized directly from candidate handbooks supplied by the credentialing boards. For complete eligibility criteria, candidate applications, and candidate handbooks, contact the appropriate credentialing board directly.

1. 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.ccmcertification.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 persons 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: 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

[correct answer is b]

2. Nurse Case Manager (RN-NCM)

American Nurses' Association, American Nurses' Credentialing Center (ANCC), 600 Maryland Ave. S.W., Suite 100 W., Washington, DC 20024. Telephone: (800) 284-2378. Web site: www.ana.org/ancc.

Eligibility requirements: Candidates who currently hold a core nursing specialty certification* must:

— hold an active RN license in the United States or its territories;

— show proof of current, nationally recognized core nursing specialty certification;

— have functioned within the scope of practice for a minimum of 2,000 hours within the last two years prior to application for the exam.

(*In September 1999, the ANCC Commission on Certification confirmed that candidates with a current, nationally recognized core nursing specialty certification do not need to hold a baccalaureate or higher degree in nursing to be eligible to take modular exams. The Nurse Case Manager exam is a modular exam.)

OR

Candidates who do not hold a core nursing specialty certification must:

— hold an active RN license in the United States or its territories;

— hold a baccalaureate or higher degree in nursing (transcript showing conferral of degree must be submitted);

— have functioned as a RN for 4,000 hours (2,000 of those within the scope of practice), within the last two years prior to application for the exam.

Registration fees: Fees range from $130 to $370 depending on ANA membership status, core nursing specialty certification, and type of exam.

Testing dates: (tentative) June 30, 2001, and Oct. 6, 2001. **Testing sites:** More than 80 testing sites throughout the United States and its territories.

Recertification: Certification is valid for five years. Recertification requirements vary slightly depending on an individual's specialty. In most instances, the recertification requirements include both continuing education and retesting. Please note: the Commission on Certification is finalizing changes to the recertification rules in its 2001 handbook.

Exam content outline: The test covers the five components of the nursing case management process: assessment, planning, implementation, evaluation, and interaction.

Sample question: "A patient on crutches is ready for discharge but does not have a ride home. Which of the following modes of transportation would be most appropriate?"

3. Case Manager, Certified (CMC)

American Institute of Outcomes Case Management (AIOCM), 12519 Lambert Road, Whittier, CA 90606. Telephone: (562) 945-9990. Web site: www.aiocm.com.

Eligibility requirements:

To become certified, a candidate must be a member of AIOCM. Applicants are awarded eligibility points for education, professional experience, and education in outcomes case management in the AIOCM's standard certification process. A minimum number of points is required in all three categories for entrance to the examination. When applicants have had significant outcomes case management experience but do not meet the eligibility points under the standard procedure, they may submit a portfolio of their education, experience, and relevant training for review, accompanied by a personal statement and at least one reference from an AIOCM CMC. Upon favorable review of the portfolio, the applicant will be eligible to sit for the examination.

Registration fee: $200 ($50 application fee, $75 AIOCM membership fee, and $75 examination fee).

Testing dates: As arranged. **Testing sites:** Various sites throughout the United States.

Recertification: Certification is valid for two years. Recertification fees are $50. Recertification requirements include:

— membership in good standing with AIOCM;

— seven continuing education points during the two-year recertification interval;

— letter acknowledging the AIOCM code of ethics and agreeing to abide by the AIOCM code of ethics.

Additional information: The AIOCM is not affiliated with the National Academy of Certified Care Managers (NACCM) in Colchester, CT, whose certified professionals also use the abbreviation "CMC."

Exam content outline: The two-hour examination covers knowledge in outcomes case management, business, finance, management, critical thinking capabilities, and other relevant areas of outcomes case management.

4. Certified Professional in Healthcare Quality (CPHQ)

Healthcare Quality Certification Board of the National Association for Healthcare Quality (NAHQ), P.O. Box 1880, San Gabriel, CA 91778. Telephone: (626) 286-8074. Fax: (626) 286-9415. Web site: www.cphq-hqcb.org.

Eligibility requirements: Criteria for eligibility cover both education and experience. Candidates must meet BOTH the minimum education and experience requirements to register for the examination. If one but not both of the requirements below is met, preapplication review of eligibility may be appropriate. If candidates wish to request equivalency review, they should request the candidate hand book for further details as soon as possible. Deadline for submission of equivalency materials is 90 days prior to the exam date.

Education criteria include:

— associate, baccalaureate, final, master's, or doctoral college degree in any field, or RN license or license in practical nursing (LVN or LPN), or accreditation in medical records technology (Registered Health Information Technician [RHIT] or Registered Health Information Administrator [RHIA]).

Experience requirements include:

— minimum of two years full-time experience or its part-time equivalent (4,160 hours) in quality improvement, quality management, case management, care management, disease management, utilization management, and/or risk management activities within the last five years by the date of the examination.

Registration fees: The "early-bird" exam fee is $300 for applications postmarked by June 30, 2001. NAHQ members who meet the "early-bird" deadline may pay the special NAHQ member fee of $235. For applications postmarked after June 30 but not later than the Aug. 31, 2001, deadline, the fee is $350. NAHQ members may take advantage of the $285 special NAHQ member fee. The Healthcare Quality Certification Board also extends the lower NAHQ-member exam fee to candidates who are members of national health care quality societies outside the United States that have formally affiliated with NAHQ.

Testing date: The date of the next exam is Nov 10, 2001. Non-Saturday testing for those with specific religious restrictions is available in some locations. **Testing sites:** Exams are administered at colleges and universities in more than 45 locations nationally and internationally. Specific information about the test site is included on the admission ticket. Candidates living more than 400 miles from a testing site may request a special testing site for an additional nonrefundable fee of $300.

Additional information: The Healthcare Quality Certification Board has issued a position statement that says, "Although the largest percentage of the CPHQ examination assesses knowledge of quality management, it also covers the important elements of case/care/disease, utilization, and risk management as well as data management and general management skills."

Exam content outline: The CPHQ examination is based on an international survey of QM professionals. Each of the following four categories is covered in the exam questions: management and leadership; information management; education, training, and communication; performance measurement and improvement.

Sample question: Which of the following processes is most cost-effective in preventing unnecessary resource consumption in the hospital?

5. Case Management Administrator, Certified (CMAC)

The Center for Case Management, 6 Pleasant St., South Natick, MA 01760. Telephone: (508) 651-2600. Fax: (508) 655-0858.

Eligibility requirements: Candidates must meet one of the following five criteria:

— master's degree and one year experience in case management administration;

— master's degree and three years experience as a case manager;

— bachelor's degree and three years experience in case management administration;

— bachelor's degree and five years experience as a case manager;

— one of the following active case manager certifications accepted as entry into the CMAC exam: A-CCC, CRRN, CCM, CDMS. Evidence of certification must be supplied upon application.

Additional information: According to Robyn Ripley, director of consulting support at the Center for Case Management, certifying at the administrative level is not only unique, but very important because "the skills required at [that] level go across the definitions of case management." She explains, "We had a lot of feedback from people who said, 'I don't have a BA, but I'm certified, and I've been doing case management administration for a number of years.' And so we broadened our eligibility. We looked at several certifications which met our criteria, and we're actively reviewing that every six months and adding certifications that [are appropriate]."

Registration fee: $300.

Testing dates: April 28 and Oct. 20, 2001. Sunday testing for those with specific religious restrictions only is available upon written request. Requests must be received eight weeks before the test date. **Testing sites:** More than 15 states have testing centers. Candidates living more than 500 miles from an established

testing center may request special arrangements for an additional $100 fee.

Recertification: Certification is valid for five years. To recertify, candidates must retake and pass the CMAC exam.

Definition of case management administration practice: Case management administrators supervise employees who perform the following role functions, or, if applying as an experienced case manager, perform at least eight of the following functions on a daily basis:

— case finding;
— comprehensive assessment of client situation;
— evaluation and coordination of plan of care;
— matching client resources to client need;
— monitoring delivery of service;
— critical thinking, appropriate prioritization, and time management;
— measurement and evaluation of financial, clinical, functional, and satisfaction outcomes;
— accountability for financial, clinical, function and satisfaction outcomes;
— effective leadership displayed in performance of current role;
— effective communication;
— evaluation of and response to learning needs of clients, clinicians, and community.

Exam content outline: The exam covers the following seven domains: identification of at-risk populations; assessment of clinical system components; development of strategies to manage at-risk populations; assessment of organizational culture; market assessment and strategic planning; human resource management; and outcomes measurement, monitoring, and management.

Sample question: Case managers provide a source of data on the adequacy of continuum resources for specific patient populations based on which of the following?

6. Continuity of Care Certification, Advanced (A-CCC)

National Board for Certification in Continuing of Care (NBCCC), 241 Dunlap Court, Jacksonville, IL 62650. Telephone: (877) 661-0066. E-mail: hss2@csj.net. Web site: www.nbccc.org. The test is administered for NBCCC by The Professional Testing Corporation (PTC), 638 Broadway, 17th Floor, NY, NY 10018. Telephone: (212) 356-0660. E-mail: ptcny@ptcny.com. Web site: www.ptcny.com. Case managers may request an application and guidebook on-line through the PTC Web site.

Eligibility criteria:

— a baccalaureate degree or higher and two years of full-time experience in continuity of care within the last five years (or equivalent part-time experience within the last five years);
— verification of employment is required.

OR

— candidates without a baccalaureate degree must verify eight years of full-time experience in continuity of care within the last 12 years;
— verification of employment and verification that job responsibilities include continuity of care functions;
— a copy of the candidate's current job description must be submitted with the application.

Registration fee: $300.

Testing dates: May 5 and Nov. 10, 2001. **Testing sites:** Multiple sites available nationwide in 11 states. In addition, special testing centers can be requested for candidates who live more than 500 miles from the nearest testing site. There is a $100 fee for special testing sites.

Recertification: Certification is valid for five years from the date of initial certification. To achieve recertification, a candidate must:

— provide documented evidence of at least 50 contact hours of continuing education related to continuity of care within the five-year certification period;

OR

— retake and successfully pass the certification examination.

Both options require payment of a recertification fee.

Exam content outline: The test covers the continuity of care process, health care delivery systems, professional issues, standards, reimbursement, regulation and legal issues, and clinical issues.

Sample question: Implementation is the phase of continuity of care in which:

a) agreed-upon plans are put into place and managed
b) the patient's needs are assessed

c) the requested services are reviewed
d) the initial plan is evaluated by the physician

[correct answer is a]

7. Certified Disability Management Specialist (CDMS)

Certification of Disability Management Specialists Commission, 1835 Rohlwing Road, Suite E, Rolling Meadows, IL 60008. Telephone: (847) 394-2106. Fax: (847) 394-2171. E-mail: info@cdms.org. Web site: www.cdms.org.

Eligibility criteria:

Candidates must meet one of the following five criteria:

— master's degree in rehabilitation counseling with 600 clock hours of certified supervision by a CDMS or CRC (certified rehabilitation counselor);

— certification as a CRC and 12 months of acceptable supervised experience;

— license as an RN with 24 months of acceptable experience (12 of the 24 months must be under direct supervision);

— bachelor's or master's degree and license with 12 to 24 months of acceptable experience (12 of the 24 months must be under direct supervision);

— bachelor's degree (or higher), acceptable course work, and 36 months of acceptable experience (12 of the 36 months must be under direct supervision).

Registration fee: $290.

Testing dates: Twice annually in April and October. **Testing sites:** Fully accessible, smoke-free test sites are arranged on the basis of the geographic distribution of the 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. Candidates must accumulate 80 hours of acceptable continuing education, four of which must be in the area of ethics, or retake the CDMS examination. The recertification fee is $150. Candidates choosing to retake the exam pay an additional $160.

Exam content outline: The one-day exam contains 300 multiple-choice questions. It covers disability case management, psychosocial intervention, vocational aspects of disability, managed care and disability management concepts, and business knowledge related to disability management.

Sample question: An employee becomes totally incapacitated for work beyond the day on which the injury was sustained but is subsequently able to return to work without permanent impairment. Under the workers' compensation system, this type of disability is classified as:

a) permanent-total disability
b) temporary-total disability
c) temporary-permanent disability
d) permanent-partial disability

[correct answer is b]

8. Certified Rehabilitation Registered Nurse (CRRN)

Rehabilitation Nursing Certification Board, 4700 W. Lake Ave., Glenview, IL 60025-1485. Telephone: (800) 229-7530. Web site: www.rehabnurse.org.

Eligibility criteria:

— a current unrestricted RN license;

— at least two years of practice as a registered professional nurse in rehabilitation nursing.

OR

— at least one year of practice as a registered professional nurse in rehabilitation nursing and one year of advanced study beyond a baccalaureate in nursing;

— all candidates must provide verification of rehabilitation nursing experience by two professional colleagues, one of whom is a CRRN, or the candidates' immediate supervisor;

In addition, as of Dec. 1, 2000, candidates also must have:

— completed by the examination date a formal course in the core content of rehabilitation nursing of at least one semester hour or 1½ quarter hours for a total of 15 classroom hours;

OR

— completed at least 15 contact hours in the core content of rehabilitation nursing as approved by a body accredited to do so by the American Nurses Credentialing Center in Washington, DC.

Registration fees: $195 for Association of Rehabilitation Nurses (ARN) members, $285 for nonmembers.

Testing dates: Twice annually in June and December. **Testing sites:** Multiple testing sites nationwide and at the ARN national conference.

Recertification: Certification must be renewed every five years. The CRRN credential may be renewed by either passing the CRRN examination within one year prior to the certification expiration date or submitting a renewal application to renew by 60 points of credit by the established deadline.

Exam content outline: The exam covers the following four domains: functional health patterns; rehabilitation and rehabilitation nursing models and theories; the rehabilitation team and community re-entry; legislative, economic, ethical, and legal issues in rehabilitation nursing.

Sample question: The most crucial measure for the prevention of pressure ulcers is:

a) ensuring adequate diet
b) using systemic antibiotics
c) routinely relieving pressure
d) preventing bowel and bladder incontinence

[correct answer is c]

9. Certified Social Work Case Manager (CSWCM)

National Association of Social Workers (NASW) Credentialing Center, Attention: Specialty Certifications, 750 First St. N.E., Suite 700, Washington, DC 20002. Telephone: (800) 638-8799, ext. 409. E-mail: credentialing@naswdc.org. Web site: www.naswdc.org.

Eligibility criteria:

— active NASW membership in good standing;

— bachelor's in social work (BSW) degree from a Council on Social Work Education (CSWE) accredited institution;

— one year (1,500 hours) paid, post-BSW, supervised work experience;

— one of the following: NASW ACBSW credential, current state BSW-level licensure, if applicable, or passing score on the AASSWB basic exam;

— 1,500 hours paid, post-BSW, supervised experience as a case manager, case management being the primary job function (hours cannot be accumulated in less than one year or more than five years);

— knowledge of the seven core functions of social work case management (engagement, assessment, planning, implementation/coordination, advocacy, reassessment/evaluation, and disengagement);

— one hour supervision for every 15 hours direct client-level case management tasks;

— supervision must be by a BSW with five years or more experience or an MSW with two years of more experience;

— a reference from a BSW- or MSW-level supervisor;

— a reference from one colleague (preferably a social worker).

Registration fee: $100. (This is an introductory fee and may be raised when the board meets in December.)

Testing dates/testing sites/exam content: Not applicable. There is no examination. Certification is earned by meeting the eligibility requirements and upon review of the candidate's references.

Recertification: Certification must be renewed every two years. Candidates must complete 20 contact hours of approved continuing education. In addition, candidates must state to which of the seven core functions listed above the training applies. Candidates also must agree to adhere to the NASW Code of Ethics and the NASW standards for social work case management and are subject to the NASW adjudication process.

10. Certified Managed Care Nurse (CMCN)

American Board of Managed Care Nursing (ABMCN), 4435 Waterfront Drive, Suite 101, Glen Allen, VA 23060. Telephone: (804) 527-1905. Fax: (804) 747-5316. Web site: www.abmcn.org.

Eligibility criteria:

— RN license or LPN license or a current license to practice nursing in any American state, territory, or protectorate;

— completion of the prescribed curriculum of the ABMCN.

OR

— an affidavit that attests to completion of equivalent course work taken elsewhere.

Registration fee: $225.

Testing dates: As arranged with the candidate's local Sylvan Technology Center. **Testing sites:** Any

Sylvan Technology Center at more than 300 locations throughout North America.

Recertification: Information unavailable.

Exam content outline: The exam includes roughly 150 multiple-choice questions focusing on the vocabulary, concepts, and application of managed care in the health care delivery system. Most candidates complete the exam in three hours.

Sample question: The primary purpose of a workers' compensation program is to:

a) provide sure, prompt, and reasonable income and medical benefits to insured workers, regardless of fault

b) protect the employer against frivolous lawsuits

c) assure the injured worker access to the legal system

d) help establish a network of rehabilitation providers

[correct answer is c]

11. Certified Occupational Health Nurse/Case Manager (COHN/CM)

American Board for Occupational Health Nurses, 201 E. Ogden Ave., Suite 114, Hinsdale, IL 60521-3652. Telephone: (630) 789-5799 Fax: (630) 789-8901. Web site: www.abohn.org.

Eligibility criteria:

— current active status as a COHN;

— current licensure as an RN or its international equivalent;

— 10 documented hours of case management continuing education in the five years prior to application.

Registration fee: $185, application and exam fee.

Testing dates: April 21, 2001, and Oct. 13, 2001. **Testing sites:** More than 35 sites nationwide.

Recertification: Certification must be renewed every five years. There is a $100 recertification fee.

Exam content outline: Many of the multiple-choice questions on the ABOHN case management examination are written in "case sets." Case sets of test questions are groups of items pertaining to a single patient or situation. The case begins with an introductory paragraph, and several questions are usually asked about the initial situation. Then additional information is supplied, as time passes or healing or a complication occurs, and more questions are asked. Case sets lend themselves to clinical situations.

Sample question: Mr. David Johnson, who has diabetes mellitus (type 2), is a housekeeper in a hospital. He reports to the employee health unit complaining of a painful swollen knee that limits his ability to perform his duties. Mr. Johnson states that he fell while on duty about one week ago.

At this time, which of these actions should the nurse case manager take?

a) wrap the knee and have him return to work

b) record the injury on the OSHA 200 log

c) ask him to describe how the injury occurred

d) discuss a temporary work modification for him with his supervisor

[correct answer is c]

12. Care Manager Certified (CMC)

National Academy of Certified Care Managers, P.O. Box 669, 244 Upton Road, Colchester, CT 06415-0669 Telephone: (800) 962-2260 Fax: (860) 537-8288. Web site: www.home.earthlink.net/~rogergoodman/naccm/naccm.html.

Eligibility criteria:

Candidates must meet one of the following three criteria:

— a minimum of two years of supervised, paid, full-time care management experience that includes face-to-face interviewing, assessment, care planning, problem solving and follow-up. This experience must be subsequent to obtaining a master's degree in a field related to care management (social work, nursing, counseling, gerontology, or psychology).

OR

— a minimum of four years of paid, full-time direct experience with clients in fields such as social work, nursing, mental health, counseling or care management, two years of which must be supervised, paid, full-time care management experience that includes face-to-face interaction as described above. This experience must be subsequent to obtaining a bachelor's degree in a field related to care management (social work, nursing, counseling, mental health, psychology, or gerontology).

OR

— a minimum of six years of paid, full-time, direct experience with clients in fields such as social work, nursing, mental health, counseling or care management, two years of which must be supervised, paid,

full-time care management experience as described above. This experience must be subsequent to obtaining a minimum of a high school diploma or any degree unrelated to the field of care management.

Registration fee: $225; additional $20 for candidate handbook and application forms (required); $20 for reprocessing of incomplete or incorrect applications.

Testing dates: As arranged with local Sylvan Technology Center. **Testing sites:** More than 300 Sylvan Technology Centers in North America.

Recertification: Certification must be renewed every three years. Recertification fee is $150. Candidates must provide proof of 45 contact hours of continuing education over three years.

Exam content outline: The exam includes 200 multiple-choice questions. It covers five major domains: assessment; establishing goals and a plan of care; coordinating and linking formal and informal resources to meet goals and implement plan of care; managing and monitoring ongoing provision and need for care; legal and ethical issues.

Sample question: A consumer living in supervised housing becomes psychologically unstable and is returned to a local mental hospital. What is the appropriate procedure to follow during the consumer's hospitalization?

More credentials of interest

Depending on your practice setting and background, there are several other certifications you may want to research. Those include:

❑ **Certified Professional Utilization Review (CPUR).**

This certification is geared toward utilization managers. For more information on this credential, contact McKesson HBOC, Interqual Products Group, 293 Boston Post Road W., Suite 180, West Marbourough, MA 01752. Telephone: (800) 582-1738. Fax: (508) 481-2393. E-mail: iq@interqual.com. Web site: www.interqual.com.

❑ **Certified Rehabilitation Counselor (CRC).**

This certification is for rehabilitation counselors. For more information, contact Commission on Rehabilitation Counselor Certification, 1835 Rohlwing Road, Suite E, Rolling Meadows, IL 60008. Telephone: (847) 394-2104. Web site: www.crccertification.org.

❑ **Certified Healthcare Management Professional (CHMP).**

This certification is designed for frontline managers in health care organizations. For more information, call the American Institute of Healthcare Management at (888) 799-2446. E-mail: chmp@aihm.org. Web site: www.aihm.org.

❑ **Certified Brain Injury Specialist (CBIS).**

This certification is for direct care staff, nurses and case managers, and health care organization directors who work with brain-injured clients. For more information, contact the American Academy for the Certification of Brain Injury Specialists (AACBIS), Brain Injury Association, 1776 Massachusetts Ave. N.W., Suite 100, Washington, DC 20036. Telephone: (202) 296-6443.