AMERICAN HEALTH CONSULTANTS®

HOSPITAL CASE MANAGEMENT™

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

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The only thing certain: Large changes lurk for case management's future

More elderly, fewer nurses lead to interesting times

The question has never been whether health care will change. Its evolution is continual, and predictions about its future often are about as accurate as 1930s science fiction. Even so, several trends already have emerged that some experts claim provide an interesting glimpse of what's to come — both in case management and in the industry at large.

Two of the largest trends seem to be on a collision course: The aging of the so-called "baby-boom" generation, and the worsening nursing shortage. Aging boomers very well could reverse the current trend of decreased patient days at a time when there are fewer nurses to care for them.

> *"Length of stay might need to increase, and your job is to moderate the rate of increase, rather than [ask] 'how much lower can we go?'"*

"[There will be] more than 1 million [baby boomers] turning 65 each year for the next 20 years, and they will be consumers with high expectations. Patient satisfaction is going to be a big deal," predicts health care futurist **Russell C. Coile**, MBA, vice president and national strategy advisor for Superior Consultant Co. in Plano, TX.

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COMING IN FUTURE ISSUES

- How hospitalists can help with quality improvement efforts
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Coile's recent book, *Futurescan 2001: A Millennium Forecast of Healthcare Trends 2001-2005,* published in cooperation with the Society for Healthcare Strategy and Market Development (SHSMD) in Chicago, makes several specific predictions for the health care landscape over the next five years.

He and his team surveyed the 4,000-plus membership of SHSMD, as well as the 30,000 members of the American College of Healthcare Executives, also in Chicago, to create a panel of about 500 respondents.

The book covers seven themes: the health care consumer, technology, cost and clinical performance, managed care, health policy, human resources, and integration. Many of these indicators will have a great impact on hospital case management, Coile notes.

Managing the 'older and sicker' patient

"[One] thing is a predicted increase in patient days, which is counter to the trends, or at least the past trends. There's a message here for case managers about older and sicker patients: They're going to need more time, and they're going to cost more money," he explains.

"Length of stay [LOS] might need to increase, and your job is to moderate the rate of increase, rather than [ask] 'how much lower can we go?'" Coile points out.

On the other hand, **Judy Homa-Lowry**, RN, MS, CPHQ, president of Homa-Lowry Healthcare Consulting in Canton, MI, is optimistic that the future might hold fewer inpatient days.

"I guess you can look at it both ways," she says. "With the advances in technology, and depending on the direction health care plans and reimbursement will take, we might see more of a link between prevention and services. . . . I think health plans may try to incentivize people to get prevention in place and identify issues early so that they may be managed more effectively and so that there won't be as big a need for [inpatient] services down the road."

Homa-Lowry points out some present-day examples that suggest preventive action will be stressed more in the future.

"You're starting to see higher premiums if you're a smoker," for instance. And there was a surge in colonoscopies after recent national publicity efforts created new awareness of the preventive action's effectiveness. Encouraging these measures is especially appropriate for the aging

baby-boom population, she adds.

One of the goals for acute care case managers can be to help usher in that era of preventive care through the establishment of community case management programs. **(For more information about community case management, see *Hospital Case Management*, March 2001, pp. 33-36, and December 2000, pp. 177-180.)**

Coile's prediction is that, one way or another, LOS is going to be an important indicator. His survey shows that in the future, hospital rankings are going to be watched carefully both by consumers and providers.

"The data are going to be public, and competing on these rankings is going to be a big deal. Case managers, your indicators, particularly LOS, will be among the important national ratings that will be compared among the best of the best," he says. "The numbers matter."

The numbers also will matter in the areas of cost and clinical performance, Coile and his colleagues predict. "The good news is that hospital finances will improve, not so much based on cost performance as on revenues," due to the easing of Medicare payment cuts in the Balanced Budget Act, better fee schedules from managed care plans, and increases in volume, Coile explains.

"The challenge, of course, will be to keep costs down while you've got these increases, so you can actually make money off operations," he points out. "There certainly will be pressure to improve operational profits."

One way to do that is with intensive, on-site, integrated care management. "The focus is clinical. The . . . first priority in care management has to be error reduction. I think every hospital is going to be doing this. It's not going to be just a case management system; it's really a care management system," Coile says.

Case management's contributions

Case managers, of course, play a big role in that initiative as the communicative link among the different segments of health care. "I agree with the prediction and believe this is great news," says **Jackie Birmingham**, RN, MS, vice president of clinical design for CuraSpan, in Needham, MA, and a consulting associate for the Center for Case Management in South Natick, MA.

"Refocusing on [clinical needs], particularly as the variety of treatment modalities grows daily, will strengthen the contribution of case management in the delivery of health care. The very need for case management services in hospitals occurs when the clinical resources need to be directed to the patient," she explains.

Homa-Lowry also hopes for a front-end piece of the care management puzzle to come into play. "Case managers need to have a bigger role in physician offices. With all the requirements and what payers are paying for visits, it would be nice to have someone really coordinate the care so that the patient understands [his or her] responsibility, how to move into the continuum, and maybe prevent that visit to the emergency room," she says. "It's no secret that in certain types of capitated environments, physicians don't have time to do the teaching and follow-up."

There are several other components to Coile's health care prediction for 2005. Among them:

- **Electronic medical records will become universal.** "We won't be paperless, and it may not happen tomorrow afternoon, but within the next five years is the theory," Coile says. The survey also found that the era of telemedicine finally may be arriving. The increasing use of the Internet by physicians and other health care professionals indicates that in the near future, health plans as well as federal programs will have to consider ways to pay for telemedicine visits.
- **Congress will remain divided.** "A closely divided Congress is likely to spend more time arguing than legislating in the next two years," Coile says. The panel of survey respondents, he explains, "is sure this will be a food fight right out of 'Animal House,' and very little will get done."

Coile says he is only moderately more optimistic but hopeful that things like the Patient's Bill of Rights and more money in the children's health program will be accomplished. "The other big set of regulations is HIPAA [the Health Insurance Portability and Accountability Act]," Coile says. "And case managers are very active users of the medical record, so [HIPAA] might make their lives modestly more complicated."

Birmingham adds that although the HIPAA regulations are back on the drawing board as of press time, with the privacy section on hold and sent to a committee for review at the request of Health and Human Services Secretary Tommy Thompson, the privacy standard should survive in some format. "It will complicate the lives of

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IOM's wish list: Sweeping changes in health care quality

IOM: Congress should devote $1 billion to fix

In a new report, "Crossing the Quality Chasm: A New Health System for the 21st Century," the Institute of Medicine's (IOM) Committee on the Quality of Health Care in America issued an urgent call for major overhaul of the health care delivery system in this country: "American health care is beset by serious problems, but they are not intractable."

Thirteen recommendations, including a proposal that Congress create a $1 billion "innovation fund" for health care's revision process, make up the crux of the committee's forward-looking report, which was unveiled with much fanfare, including a news conference and public webcast on www.nationalacademies.org.

'Control should reside with the patient'

"Today we cannot guarantee that patients will receive state-of-the-art care," says **Donald Berwick**, MD, MPP, president and CEO of the Institute for Healthcare Improvement and one of the study's authors. "We need to develop a system where we can guarantee patients will receive the best care that exists."

The committee calls upon not only the legislative community but health care institutions, practitioners, purchasers, and regulators, "indeed, the entire health care enterprise to make significant improvement" in the health care system. Specifically, it says:

- ✔ Control should reside with the patient. Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them.
- ✔ Patients should have unfettered access to their own medical information and to clinical knowledge.
- ✔ The health system should anticipate patient needs rather than simply reacting to events.
- ✔ The Agency for Healthcare Research and Quality should identify a list of "Priority Conditions" to use as a starting point for improvement. That is to say, only 15 to 25 conditions, most of them chronic, account for a sizeable portion of the nation's health burden and expenditures. The committee believes that the health care system must focus greater attention to care for those common conditions.
- ✔ Congress should establish a Health Care Quality Innovation Fund to support projects that contribute to the overall improvement of the system.

"Americans now annually invest $1.1 trillion in the health care sector," noted **William Richardson**, chair of the committee, in his opening remarks.

"The committee believes a sizeable commitment, on the order of $1 billion over three to five years, is needed to strongly communicate the need for rapid and significant change in the health care system and to help initiate the transition," he added.

- ✔ The secretary of the Department of Health and Human Services should establish and maintain a process "aimed at making scientific evidence more useful and accessible to clinicians and patients." Currently, the authors explain, scientific knowledge about best care is not applied systematically or effectively to clinical practice.
- ✔ Information technology must play a central role in the redesign of the health care system, with the support of leaders in Congress, the White House, public and private health care purchasers, and health informatics associations and vendors. The hope is the cooperative effort will lead to the elimination of most handwritten clinical data by the end of the decade.
- ✔ Private and public purchasers should examine their current payment methods to remove barriers, which currently impede quality improvement, and build in stronger incentives for quality enhancement.

The IOM's Committee on the Quality of Health Care in America was formed in June 1998 to advise the government on the quality of U.S. health care, with an eye for improvement, over the next 10 years.

The quality report is available in a downloadable format at the National Academies' web site: www.national academies.org. ■

case managers on a daily basis since they will need to use a method of transferring information that is considered secure. The use of the Internet for secure transmission will become the standard of communication, and faxes and e-mail will be used simply for notification of information and not for transmission of personal health information," she predicts.

• **The trend toward integrated health systems soon may be over.** *Futurescan* reports that some of the largest integrated delivery systems are downsizing. "The prediction is that larger systems will get smaller, and some will break up altogether," Coile says, explaining that in the last 10 years, the larger health systems haven't necessarily proven that being large is the best way to manage patients.

[Editor's note: Copies of Futurescan 2001 *are available for purchase, at $25 for members of the Society for Healthcare Strategy and Market Development or the AHA; $50 for nonmembers. To order, call (800) AHA-2626, fax your order to (312) 422-4505, or order online at www.ahaonlinestore.org.*

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CMs respond to national caseload survey

Acute care yields largest number of participants

Caseloads are a primary factor in the quality of case management outcomes. Setting appropriate case management caseloads always has been a hotly debated issue.

In December 2000, Atlanta-based American Health Consultants, publisher of *Hospital Case Management*, and the Case Management Society of America (CMSA) in Little Rock, AR, conducted a national survey of case managers to help clarify some of the issues surrounding the caseload debate.

More than 500 case managers, representing all practice settings, responded to the survey and revealed important information regarding this topic.

When it comes to setting case management caseloads, there is no magic number. Average caseloads vary widely, with most falling somewhere between 16 and 75 active cases each month, according to the 2000 Case Management Caseload Survey.

Specific findings include:

• 12.3% reported managing one to 15 active cases each month.

• 23.9% reported managing 16 to 30 active cases each month.

• 14.8% reported managing 31 to 50 active cases each month.

• 21.6% reported managing 51 to 75 active cases each month.

• 10.5% reported managing 76 to 100 active cases each month.

• 16.9% reported managing more than 100 active cases each month.

Naturally, how many cases a case manager can manage comfortably also depends largely on how the case manager interacts with patients and providers, our experts say. It's simply common sense that a telephonic case manager will manage a larger monthly caseload than an on-site case manager.

Finding that perfect caseload for case managers in your own organization depends on your definition of case management, as well as your case management goals, industry leaders say.

"In addition to being a primary factor in the outcomes of case management, caseloads also are a measure of workload and productivity. They can negatively impact outcomes if they are set too high and the cost of case management services if set too low," notes **Sandra L. Lowery**, RN, BSN, CRRN, CCM, president of CCMI Associates (formerly Consultants in Case Management Intervention) in Francestown, NH, and president of CMSA.

Historically, Lowery explains, finding the appropriate caseload that optimizes both case manager productivity and case management outcomes depends on several factors, including:

• level of preparation for the case management role;

• the need for case managers to perform multiple roles within their organizations;

• the work environment;

• the use of tools for case management;
• the availability of resources.

"We also intuitively know that the acuity of the population served will have an impact on the number of cases a case manager can effectively manage," says Lowery.

"The relationship between the variables and the outcome is truly the only reliable way to demonstrate what functions are necessary for effective case management, which can the set the standard for an organization's caseload determinations," she explains.

How we did it

The Caseload Survey was distributed in the December 2000 issues of several American Health Consultants newsletters, including *Hospital Case Management*. In addition, the survey tool was available on-line at www.ahcpub.com and www.cmsa.org through mid-January 2001.

A total of 522 case managers, representing a wide range of practice settings, responded either on-line or by fax. The largest response rate came from acute care case managers, who composed 36.5% of the total respondents, compared to home health case managers, who composed less than 2% of the total.

Among the other case managers represented in the data set:

• Roughly 3% were corporation- or employer-based case managers.
• Nearly 13% of respondents were employed by independent case management companies.
• Just less than 2% were Medicaid or Medicare case managers.
• Roughly 22% were health plan or health insurance case managers.
• Just less than 2% were disability or long-term care case managers.
• Roughly 13% of those responding were workers' comp case managers.
• Nearly 5% were skilled nursing facility or rehabilitation facility case managers.
• Roughly 3% were community- or physician-based case managers.

An executive summary of the entire data set will be available on-line at the end of March.

[To find the executive summary, visit www. ahcpub. com (click on the "Hot Topics in Healthcare" section) or www.cmsa.org. In addition, a white paper analyzing the data set by practice setting will be released in June 2001.] ■

CM BASICS

Need help sorting out observation status?

HCFA, private insurance differ in definitions

If you've been frustrated with the many facets of the term "observation," you're not alone. Hospital case managers and utilization managers report spending hours chasing paperwork for this complicated reimbursement issue.

The Health Care Financing Administration (HCFA) defines observation status as "those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient.

Such services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. Most observation services do not exceed one day."[1]

Examining the definitions

The problem is, HCFA's definition doesn't necessarily match the definitions of other insurance and managed care companies, says **Onnie Davis**, RN, utilization specialist at St. Vincent Hospital in Santa Fe, NM. In cases where the patient develops complications after an outpatient surgery and needs to stay longer than 24 hours, you can run into problems.

"We can possibly do patients a disservice if we don't consider the various rules set up by insurance companies," she points out. "If we change them to inpatient, it really changes the patient's benefit. Their inpatient benefit might have a different copayment, for instance."

Davis sees confusion on the part of the physicians, as well, she says. The doctor's office calls ahead to say, "This patient will come in tomorrow and will be observation status," she explains, "but according to HCFA, it's not appropriate to order

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CRITICAL PATH NETWORK™

Laparoscopic nephrectomy pathway sees great outcomes

Patients go home on day two

Imagine nephrectomy patients having surgery one day and going home the next. It can and is being done at Vanderbilt University Medical Center in Nashville, TN, thanks to the work of Elspeth McDougall, MD.

McDougall joined the urology faculty at Vanderbilt, bringing with her eight years of experience working with one of the well-known pioneers in laparoscopic urology and, therefore, new clinical pathways for urologic surgeries including nephrectomy, cyst decortication (polycystic kidney disease or other cysts that need treatment), pyeloplasty, and pelvic lymph node dissections.

> *"We can just see from [McDougall's] 18 months here that there's no doubt these patients are much different; they get back to activity quicker, return to their normal diet, and go home faster than our open patients."*

Bringing this kind of surgery into common practice is very cutting-edge, says clinical coordinator **Sonya Moore**, RN, BSN, CDE. "People refer to us from all across the Southeast because there aren't many urologists who perform surgery laparoscopically," she says.

With the nephrectomy pathway, Vanderbilt has seen a distinct improvement in patient outcomes, Moore says.

"We can just see from [McDougall's] 18 months here that there's no doubt these patients are much different; they get back to activity quicker, return to their normal diet, and go home faster than our open patients." Average length of stay (LOS) with the open nephrectomy was four days, she adds. **(See home care instructions, p. 72.)**

The pathway calls for preoperative work, including lab work, EKGs, and chest X-rays if they are indicated, and of course, take-home patient education about the minimally invasive procedure.

Its postoperative goals include ambulation and fluids by mouth within 24 hours, and oral analgesic immediately following surgery. **(For further detail, see pathway, p. 73.)**

Although aggregate data are not yet available for the new pathway (the department's data collection systems are in the process of being revised), individual patient data show specific improvements in ambulation, Moore says.

"We like to get them up walking the evening of the surgery, which is a big difference from the open procedure. Probably at least 90% [of laparoscopy patients] are ambulating by breakfast the next morning, if not the evening of surgery," she explains.

Back to normal in a jiffy

Diet is not as negatively affected by the laparoscopy as by the open procedure, because the bowels aren't manipulated during surgery.

"Even though they've had general anesthesia, which can cause some nausea, the bowels return to work faster," Moore notes.

That means a speedy return to a regular diet: clear liquids by the evening of surgery, and

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Laparoscopic Urologic Surgery

HOME CARE INSTRUCTIONS

You may shower every day but do not sit in a tub of water. Pat incisions dry after your shower.

Walking is good exercise to help you regain your strength and prevent complications. You may climb stairs and do other kinds of normal activities that you feel you can do safely.

You may remove the Steri-strips from your incision in 14 days if they have not fallen off.

Do not drive if you are taking pain medicine.

Take extra-strength Tylenol for pain. If you have more severe pain, take the pain medicine that was prescribed for you.

This medicine may cause constipation. To control constipation, take Milk of Magnesia or Mag Citrate, which can be bought without a prescription. Also, drink six to eight glasses of water a day and make sure your diet includes fruits, vegetables and whole grain foods.

Call your doctor if you have...

- fever higher than 101 ℉
- redness around your wound and increased tenderness
- nausea or vomiting that gets worse
- any other problems or questions

DOCTOR _____ **(615) 322-2880**

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VANDERBILT UNIVERSITY MEDICAL CENTER

Laparoscopic Urology

DRG Number: _____
ELOS: _____

	Pre-Op	Day of Surgery HR-Post-Op	POD 1(possible discharge)	POD 2 Discharge	Post-Op Follow-Up
Entrance Date/Time/ Initial	Date: _____ Time: _____ Initial:	Date: _____ Time: _____ Initial:	Date: _____ Time: _____ Initial:	Date: _____ Time: _____ Initial:	Date: _____ Time: _____ Initial:
Goals	Informed consent process ..completed /forms signed Pre-op testing completed within 30 ..days prior to surgery Pt/family verbalize understanding ..of pre-op teaching	Pain controlled Incision/dressing no/minimal drainage/bleeding Recovers uneventfully from anesthesia Tolerates operation w/o complications *Maintains T<101 degrees F*	Tolerates diet Pain controlled Incision/dressing no/ minimal draining/bleeding Tolerates ambulation Tolerates operation w/o complications *Maintains T<101° F*	Tolerates diet Pain controlled Incision/dressing no/minimal drainage/bleeding Tolerates operation w/o complications *Maintains T<101° F*	Pain controlled Wound healing is adequate Tolerates baseline activity
Care Remind	Height and weight	Vital signs and temp q 4h x 24h Intake and output q 4h	Vital signs & temp q 8h Intake and output q 4h	Vital signs & temp q 8h Intake and output q 4h	Vital signs & temp
Treatments	H&P Consent signed Type and screen	Foley to BSB Incentive spirometer q 1h W/A TED Hose - thigh high Turn/cough/deep breathe q 2 h Sequential compression device .(SCD) *On 7 hours, off 1 hour*	Foley to BSB d/c @ 0600 Incentive spirometer q2h W/A TED Hose -- thigh high Turn/cough/deep breathe q 2h Sequential compression device (SCD) on 7 hours. off 1 hour	Incentive spirometer q2h W/A TED hose -- thigh high Turn/cough/deep breathe q 2h Sequential compression device (SCD) *..on 7 hours, off 1 hour*	
Activ	Ad lib	*This p.m.* Ambulate	Ambulate tid	Ambulate tid, ad lib	Ad lib
Diet	Nothing by mouth after midnight Clear liquid diet dinner	Clear liquid diet *advance as tolerated*	Regular diet	Regular diet	Regular diet
Labs/Tests	CT scan ECG/EKG *if >50* Chest PA & LAT XR CBC/PLT CT Serum calcium, potassium, and creatinine C&S urine PT/PTT Type and screen		Serum Creatinine @0500		Serum creatinine (if S/P lap nephrectomy)
Meds/IV	1 bottle Magnesium Citrate for bowel prep day before surgery	MED: Misc. *See MAR/CDS for individual* Cefazolin INJ: *Ancef prep* 1 gm IV Ciprofloxacin INJ: Cipro prep (if Cyst Decort only) *500 mg IV* LR: Lactated Ringers @100cc/hr Morphine injection: q3-4h prn 1-2mg IV Oxycodone with acetaminophen q4-6h prn 1-2 PO Promethazine: Phenergan q4-6h prn 12.5mg IV or PO Acetaminophen: Tylenol q6h prn 650 mg PO If creatinine <1.8 - Toradol 30 mg IV x 1 followed by 15 mg PO q6h x 4 doses	MED: Misc. *See MAR/CDS for individualization* LR:Lactated Ringers @ 100cc/hr, *saline lock when taking PO* Ciprofloxacin: Cipro x 5 days (if Cyst Decort only) 500mg (1/2 tablet) PO BID Oxycodone with acetaminophen q4-6h prn 1-2 PO Promethazine: Phenergan q4-6h prn 12.5mg IV or PO Acetaminophen: Tylenol q6h prn 650 mg PO Saline lock *DC prior to discharge*	Saline lock DC prior to discharge Promethazine: Phenergan q4-6h prn 12.5mg or PO Acetaminophen: Tylenol q6h prn 650 mg PO Ciprofloxacin: Cipro x 5 days (if Cyst Decort only) 500mg (1/2 tablet) PO BID Oxycodone with acetaminophen q4-6h prn 1-2 PO	
Cons	PreAnesthesia Clinic Case Manager	Respiratory care for incentive spirometer			
Teaching/ Continuum of Care Plan	Tch: Orientation to VUMC *Where family will wait, parking, etc.* Tch: Physician instructs re procedure anticipated, risks & benefits, etc. Tch: Pre-op processes: *When and where to arrive for surgery* CCP: Anticipated LOS and plan of care per pathway CCP: Initiate d/c planning *Notify CM/CNS of pt/families w/special needs*	Tch: Post-op processes *routines to anticipate, TC&DB, incentive spirometer (by RT), etc.* Tch: When/how to request pain medication CCP: Adm/psychosocial DB & Multi-Disciplinary CCP *Initiate*	Tch: Post-op processes *routines to anticipate, TC& DB, incentive spirometer (by RT), etc.* Tch: When/how to request pain medication	Tch: Discharge self-care & activity *Shower daily, pat incision sites dry. Remove steri strips in 14 days. No restriction on activity.* Tch: D/C meds: *MOM or mag citrate for constipation, extra strength Tylenol or Percocet for pain, continue w/Cipro (Cyst decort only)* Tch: Reportable S&Sx, how and when to contact HCP for T>101°F, wound erythema, increased tenderness or abd pain CCP: D/C prescription(s) written and received by pt/family CCP: F/U appts. scheduled & confirmed w/pt./family	

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Source: Vanderbilt University Medical Center, Nashville, TN.

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usually a regular breakfast by next day, she says.

In fact, Moore notes, "It can be even better, depending on the approach. For example, if the laparoscope goes in retroperitoneally, rather than from the abdomen, and the patients have the surgery first thing in the morning, they're eating Big Macs for dinner and ready to go home. Of course, we don't let them go until the next morning."

The laparoscopic nephrectomy pathway typically improves patient pain, as well, Moore explains.

"Most open patients come out of surgery with a patient-controlled analgesic (PCA) pump, and they may have it up to 24 hours before they get put on oral pain relief. Our [laparoscopy] patients do not have a PCA pump and usually are relieved with oral pain pills," she says.

> *"It's more about patient quality of life. I'm sure eventually, because length of stay is shortened and the need for IV antibiotics reduced, it will save money."*

"Of course, intravenous pain medication is ordered if they need it, but usually by post-op day one, they're on pain pills, which means that a minimum of 90% of our laparoscopic patients go home on or before day two, and at least a good 75% of them go home on post-op day one, Moore adds. "They truly can have a kidney out today and go home tomorrow," she says.

Improving patients' quality of life

The only length of time that is increased with the laparoscopy pathway can be actual surgery time, which probably causes a higher operating cost, she notes.

The technology involved also plays a part in the cost to the hospital, but Vanderbilt "made a commitment to being a leader in the field of minimally invasive surgery," Moore says, and so cost wasn't really an issue when this program was implemented.

"It's more about patient quality of life. I'm sure eventually, because length of stay is shortened and the need for IV antibiotics reduced, it will save money," she points out.

Meanwhile, "We're doing continuous quality improvement and data collection on every single patient so we can continue to fine-tune the pathway and make changes as we identify them," Moore stresses.

Ongoing education

And staff education is an ongoing process. "We have periodic inservices with the floor nurses, with respect to 'what to expect with the pathway,' the necessary radiology procedures, expected discharge, and that type of thing. We want to make sure people keep apprised of what the different procedures call for," she says.

"The goal of any pathway is to increase efficiency while maintaining quality," Moore adds.

With this procedure, Vanderbilt has shortened LOS, and therefore lowered costs and resource utilization. Most important, patients achieve faster pain control, return to work, and quality of life, she says.

[For more information, contact:

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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 your 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

Elusive cancer-related fatigue is easy to conquer

Awareness of cancer-related fatigue is the first step to managing its symptoms, according to experts. Medical staff, cancer patients, and the general public need to know that it might impact from between 75% to 90% of the cancer population and should be assessed, says **Marnie McHale**, RN, MS, AOCN, manager of community relations at the Robert H. Lurie Comprehensive Cancer Center at Northwestern University in Chicago.

"It is almost a universal side effect when [patients are] on active cancer treatment such as chemo-therapy or radiation. It is a rarity when they don't experience fatigue," she says.

Most people think of fatigue from a physical standpoint not realizing that symptoms can be cognitive, emotional, and social as well; therefore, they fail to recognize it and seek help, says McHale. Patients and health care workers need to learn the different areas where symptoms might be identified. Physically, people often report a total body tiredness with lack of strength in their arms and legs. For example, they may not have the strength to lift a toothbrush.

Cognitively, they may experience difficulty in retaining information, making decisions, or solving problems. "They feel like their brain is fogged up by the cancer treatment they are receiving," explains McHale. At an emotional level, fatigue can result in irritability, impatience, sadness, anxiety, and depression. Fatigue also can impact people socially, causing them to withdraw or pull back from their relationships because they don't have the energy to enjoy the company of others.

It's important to help patients address the symptoms of fatigue caused by cancer and its treatment because it affects the whole person and can greatly impact quality of life. It can impede the healing process in many ways, says **Susan Scritchfield**, MA, MSW, LISW, coordinator of consumer health education at the James Cancer Hospital and Solove Research Institute in Columbus, OH.

Although fatigue has a high impact on the functional well-being of an individual and leads to emotional distress, it is very underreported. "Often, fatigue can be mistakenly diagnosed as one of its outcomes — depression — unless it is carefully explored," says Scritchfield.

The best tool to combat fatigue is education of health care providers and their patients, says **Andrea M. Barsevick**, DNSc, RN, AOCN, director of nursing research and education at Fox Chase Cancer Center in Philadelphia. "One of the things our patients tell us when we interview them is they don't want to tell their health care providers they are fatigued because they are worried they will cut back on their treatment," she says. Also, patients worry that the fatigue is a sign their cancer is progressing, and they don't want to face that possibility, or they may decide that the fatigue isn't really that important.

In an effort to allay some of the fears, it might be best to educate patients about what to expect, especially when the fatigue is treatment-related, says Barsevick. Let them know when they might experience the fatigue and what the pattern is likely to be. "We know that patients adapt much better if they can get information upfront in a preparatory kind of way instead of having to discover it themselves through trial and error," she explains.

To help educate patients about cancer fatigue and how to identify it, an interdisciplinary group at the James Cancer Hospital and Solove Research Institute created a pamphlet, which provides ideas for self-assessment. In addition, it gives many different interventions patients experiencing cancer-related fatigue might try to improve their quality of life, says **Molly Moran**, MS, RN, CS, a hematology / medical oncology clinical nurse specialist at the hospital. For example, have patients keep a log to determine what activities might sap their strength or identify the time of day they have the least energy so they can plan accordingly. **(For steps to help cancer patients address their fatigue, see article, p. 76.)**

While many interventions currently are being used, research has not yet proven whether they are effective. Barsevick is conducting a study on energy conservation and activity management to determine if there is any reduction in fatigue or improvement of quality of life as a result. To help patients best plan the use of their energy resources to minimize the effect of fatigue on their life, they are asked to keep a diary for one week, noting when they are the most and the least fatigued and symptoms they are having. "At the end of the week, we help them plan a schedule that makes sense based on their energy levels," she says. They are taught to prioritize activities, delegate to others, and how to be the most active at the times they have peak energy. Often, physicians and nurses tell patients who complain of fatigue to cut back on activities and prioritize tasks. "We have no clue if it is helpful to patients; so that is one reason why we are evaluating it in this research," she adds.

Anna Schwartz, PhD, ARNP, an associate professor at Oregon Health Sciences University School of Nursing in Portland, says low-intensity to moderate exercise can help manage cancer-related fatigue.

"Exercise is kind of counterintuitive; [patients] think that if they are tired, they shouldn't exercise because it will make them more tired. "What we found consistently, not only in my research but research by others in this country and in Europe, is that exercise actually did give them more energy and reduces their fatigue."

The research also determined that cancer patients who don't exercise have a chaotic fatigue pattern, making it difficult to manage. Those who exercise have a much more orderly pattern to their fatigue. Schwartz helps patients create an exercise program according to their fitness level, making adjustments to the intensity at the times they will be receiving chemotherapy. ■

Use pain as model to assess fatigue

There is no formula for treating cancer-related fatigue because there are multiple causes for the symptoms. These include the cancer itself; treatments such as chemotherapy, radiation therapy, and surgery; quality of sleep or nutrition; prescribed medications; and pre-existing conditions such as heart disease or diabetes.

It is important for health care professionals to assess each patient experiencing fatigue to determine a strategy to help combat it and improve the patient's quality of life. "We have learned a lot about how to manage pain, and we could use pain as the model for tackling this symptom," says **Grace Dean**, RN, MSN, a research specialist at City of Hope National Medical Center in Duarte, CA. With pain management, patients are asked to rate their pain on a scale of one to 10, and this same method can be used to rate cancer fatigue. If patients are experiencing mild fatigue of three or less, they might be given some energy conservation tips, such as delegating tasks to save energy, and information on balancing rest and activity. If the fatigue were rated at four or higher, patients would receive a complete physical along with a focused history to uncover possible causes.

The history would include such questions as, "When did your fatigue start? Patients might learn that they are fatigued right after chemotherapy, and a week later, they are feeling better and can do more so they can plan for those variances," says Dean.

There are factors that are a direct cause and effect of fatigue, such as anemia. When there is a medical problem, it could be managed properly to increase a patient's stamina. For emotional distress, patients might be referred to a social worker or counselor.

At the James Cancer Hospital and Solove Research Institute in Columbus, OH, an interdisciplinary group decided to use "PQRST" to assess patients for fatigue, says **Molly Moran**, MS, RN, CS, a hematology/medical oncology clinical nurse specialist at the medical facility. **(See editor's note, below, regarding the PQRST technique.)**

"PQRST" involves asking patients:

- **P** (provoke). What provokes the symptoms, or makes them better or worse?
- **Q** (quality). What is the quality or level of the symptoms that you are experiencing?
- **R** (regional). Is the fatigue regional, general, or mental?
- **S** (severity). On a scale of zero to 10, how do you rate the fatigue?
- **T** (timing). When did you first notice the fatigue, and how long have you experienced it?

A good assessment will help health care professionals at the facility determine appropriate interventions, says Moran. These might include a consult with a dietitian; suggested complementary therapies such as guided imagery, biofeedback, or aromatherapy; or restorative activities that revive a person, such as bird-watching or reading books.

[Editor's note: The PQRST assessment tool selected by the team was adapted from Health Assessment & Physical Examination *by Mary Ellen Zator Estes, Delmar Publishers, New York City, which was published in 1998. The publication costs $72.95, and can be ordered by calling: (800) 347-7707.]* ■

(Continued from page 70)

observation status before the patient has the procedure." On the other hand, some private insurance companies will approve them, she adds.

Davis' goal is to know the variations among all the managed care companies.

"Every insurance company has its own take on it — its own policy. Some even call and say, 'We don't recognize observation.' It's rare, but it happens." Most frustrating to Davis is that even representatives from the companies sometimes don't know their own policies. "I've not found it very simple to ask insurance companies; they don't have a sense of . . . what the benefits are," she says.

Quick fix: Don't use it

According to **Betty Goularte**, RN, BSN, CPHQ, director of inpatient and outpatient case management at University Health System in San Antonio, you can make it very simple.

"For the most part, I discourage using observation status after traditional outpatient procedures," she says.

"Built into your payment on those, for most people, is a recovery time. So if I've got regular recovery, regardless of whether the doctor decides it's three hours or 10 hours, it's part and parcel of the procedure.

"On the other hand, we do tell our physicians [that] post-surgery, when you feel the patient is really not stable, then yes, place them in observation status," Goularte says. "For that I will bill the payer, but I've got medical necessity backing it up. If you're going to keep them over that 24-hour period, you're going to have to justify it to our case managers."

At Wellstar Health System in Marietta, GA, "Basically we have to individualize each case," explains **Claire Housholder**, RN, utilization management manager. "In some instances, [the Medicare HMO payer] will go ahead and approve 48 hours, and in other cases, you'll get a medical necessity denial, and you pursue an appeal if you feel it's appropriate," she explains.

Housholder points out, of course, that launching an appeal process creates extra work and sometimes frustration for the case manager or utilization manager. "It's very difficult because the other side of the coin is based on what your contract reads. If you have a capitated contract — part of ours is, because we have physicians in a network, so we accept a flat rate per member, per month, rather than being paid per diem or per procedure performed — so it's all very complex and tedious," she says.

At Wellstar, case managers determine whether the claim falls under capitation or not, and if not, they weigh the options: to appeal or not to appeal, Housholder says.

Physician reviewers play a role

Housholder says running the appeals process is easier when on-site medical reviewers are available. "We have stressed to our on-site reviewers that they're to speak with the nurse responsible for the unit where the patient is, and also if there's a denial, to talk to the coordinator at the facility.

Of course, other managed care plans don't have an on-site reviewer. "That's a source where you leave a voice mail message, and at their discretion, they'll get back to you," Housholder says. "It's even harder when you deal with companies that don't even have a voice mail option. Then you have to repeatedly call back and try to get the information."

Davis' department is working on a policy that will help staff understand the different observation status programs and rules. "It's a mess; I am really concerned about coming up with a solid policy until we really understand what everybody is looking at and what it will mean in the long run, financially." But establishing a policy is what she would like to do, she says, "because it just leaves room for so much more error if you don't have one."

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Reference

1. Department of Health and Human Services, HCFA. *Medicare Hospital Manual.* Transmittal 761, Section 230.6, Sept. 15, 2000. Web site: www.hcfa.gov/pubforms/. ■

For safety's sake, bill aims to eliminate overtime

RN staffing solution also a retention strategy

Ohio nurses could get relief from some of their work force woes, if a recently introduced bill passes through the state's legislative branch.

Ohio House Bill 78, sponsored by Rep. Ann Womer Benjamin (R-District 75), would accomplish two much-needed goals, according to the Ohio Nurses' Association (ONA):

1. require a health care facility to meet minimum staffing requirements based on a system that assesses patient health needs;

2. prohibit health care facilities from mandating that a nurse work overtime.

"This is not the first attempt to address staffing by any means, but it is the first comprehensive bill," says **Peggy Noble**, RN, government affairs specialist for the ONA. Other states, like California, have passed staffing laws to try to reduce the patient-nurse ratio. "We don't think that's so smart, really, because five patients may be all very critically ill and require constant nursing attention, or they may be all ready to go home and self-sufficient. Each day you need a different level of nursing, so a ratio is not the best approach," she says.

"We want to make sure the staffing systems are valid and reliable, and they're out there according to industry standards. And we want to have the hospital check every six months to make sure it works for them," she explains.

HB 78 has several components, including:

• A health care facility shall require each patient care unit in the facility to meet or exceed minimum staffing requirements established for each work shift by an assessment of patient health care needs conducted by an RN using the patient classification system. The staffing requirements shall be implemented through a staffing plan that is developed for each patient care unit.

• The staffing plan developed for each patient care unit for each work shift must be consistent with acceptable and prevailing standards of safe nursing care and with the American Nurses Association's principles for nurse staffing.

• When comparing staffing requirements to other staffing requirements established under another provision of the Revised Code or an administrative rule, the facility shall comply with the more stringent staffing requirement.

• Each health care facility shall establish a committee, at least one-half comprised by RNs who provide direct care to patients, for the purpose of selecting the patient classification system to be used in establishing staffing requirements.

• Each health care facility's patient classification committee shall develop an internal review mechanism. Not later than six months after the effective date of this section, each committee shall complete its development of the internal review mechanism and conduct an internal review of the patient classification system it has selected. Thereafter, the committee shall conduct an internal review of the system at least once each year.

• Notwithstanding any provision of state or federal law to the contrary, a health care facility shall not require an RN to work overtime.

In a report from the ONA, the nurse staffing situation was compared to the requirements for airline pilots and flight attendants, who are given a maximum amount of time each day they can work.

Pilots are responsible for the safety of those under their watch, just as hospital patients are under the watch of hospital nurses. When they are overworked or overtired, safety is compromised. Noble notes, "A nurse in her 19th hour on the job may make a mistake in giving medication — and that mistake could be deadly."

Will case management feel the effects of this much talked about nursing shortage? **Russell C. Coile Jr.**, MBA, a well-known health care futurist and author of the new book, *Futurescan 2001: A Millennium Forecast of Healthcare Trends 2001-2005*, says it's a possibility. "There's a shortage of everybody," he says.

"If staffing shortages continue to get worse, eventually even the more attractive nursing positions [like case management] would feel some pinch, but I think they would out-compete many other nursing opportunities. Everyone is going to try to work toward retention strategies," he adds.

Noble agrees. "This bill [HB 78] is also a bill for retention, so that the nurses we have can count on a day soon when there's no mandatory overtime and no unsafe staffing levels . . . so that they will stay the course. California's retention is going up due to its bill, and I assume that ours would, too," she says. "You've got to retain; that's the highest initiative."

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NEWS BRIEFS

Upper-level hiring in health care looks strong

People looking for executive and professional positions in the health care field should have little trouble finding a job, according to a recent hiring survey conducted by search and recruitment firm Management Recruiters International Inc. (MRI) of Cleveland.

The survey reported that 54.3% of the health care executives with responsibility for hiring said they plan to increase their staffs in the first half of this year, up 8.5 percentage points from the 45.8% level of the second half of 2000.

Another 42.5% of those surveyed said they plan to maintain current staff size, up 10.3 points from second-half 2000, while only 3.2% plan staff decreases, which is a decline of 18.8 points from last year's second half.

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Cancer patients survive longer with home care

A study in the December *Journal of the American Geriatrics Society* found that elderly cancer patients who received home care from advanced practice nurses lived an average of seven months longer than patients who received standard care.

The four-year study was conducted at the University of Pennsylvania School of Nursing from 1992 to 1996 and followed 375 elderly patients newly discharged from the hospital after cancer surgery.

Some patients received standard care while an experimental group received three home visits and five telephone contacts with an advanced practice nurse, who also educated family members about caregiving.

Advanced practice nurses are specially trained registered nurses, usually holding master's degrees, who can provide such highly skilled care as medication prescription and physical examinations.

Nurse averted complications

The study focused on elderly patients, who are more likely to experience postoperative complications. This problem is exacerbated by a trend to discharge patients rapidly after surgery. The interventions of the advanced practice nurse served to avert or address complications rapidly. In contrast, some patients in the standard care group died prematurely from surgical complications, such as infections.

The authors speculate that survival may also have been enhanced in the experimental group by the psychosocial support that nurses gave patients and families.

The findings were especially significant because the patients in the group who received the special nursing care tended to be in later stages of their cancer than the group that received standard care.

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The assumption made by the researchers would be that these later-stage patients would die sooner, but the reverse happened. ■

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. ■