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HOSPITAL CASE MANAGEMENT™

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

IN THIS ISSUE

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Combining roles: Balance clinical and financial responsibilities

Streamlining systems can work, but skill set, support are crucial

Increasingly, hospital-based case managers have had to take on a conglomeration of duties, serving as utilization manager, discharge planner, and clinical case manager, among other things. When the caseload is reasonable, the case manager's skill set well rounded, and the department empowered, the integration of functions is highly successful, says **Maria Hill,** RN, MS, CMAC, senior consultant with the Center for Case Management in South Natick, MA. If those pieces aren't in place, Hill cautions, the results can be less than desirable.

"There is good and bad [to combining the three roles]," she explains. "The good part is that you are streamlining systems so that when the case manager is looking at the medical record and patient/family, that individual can ask, 'What is the primary diagnosis? What are the comorbidities that may complicate the case? Do the treatments, tests, and medications being administered meet the criteria for a hospital stay? What resources will be used during the hospitalization?'"

Understanding the severity of illness, the intensity of service, and the complexity of the plan of care helps the case manager craft the clinical outcomes to be achieved and the discharge plan to be put in place, Hill says.

The overriding challenge is to balance clinical and financial considerations, she points out. This can be accomplished if the case manager has a manageable caseload, is not required to cover too many inpatient units, and has administrative support, Hill adds.

Difficulty arises when case managers are asked to see too many patients and to cover too much geography, she notes, as when one case manager is given responsibility for the emergency department,

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the intensive care unit, and the general care units. The challenge becomes even more overwhelming when case managers also are expected to address such issues as length of stay, denied days, and costs of care without data and administrative support, Hill notes.

The proper ratio is one case manager to between 20 and 25 patients, as long as no extraneous duties are added to the workload, she says. If the case manager also is charged with doing infectious disease reports or collecting quality measurement data, that person won't have sufficient time to perform well the three central functions, Hill points out.

Besides adequate time to do the job well, she suggests, the case manager who successfully does utilization review (UR), discharge planning, and clinical resource management must have a well-developed skill set that includes the following:

• Know the UR criteria that the hospital uses internally, as well as those used by the higher-volume payers.

"The goal is to ensure the right level of care at the right place at the right time within the typical clinical trajectory for the diagnosis," Hill says. "By having a detailed knowledge of the UR criteria, the case manager can negotiate — through conversation with the payers — the appropriate place for the patient."

Without that knowledge, the case manager won't have the ability to properly articulate the reasons the patient whose condition is borderline — when compared to the standard criteria — should be in the acute care setting, she adds.

• Ensure, as part of the clinical case management function, that daily outcomes are achieved and the patient is making progress in line with the care plan for the hospital stay.

It is essential that the case manager establish procedures to manage care on a daily basis and against a standardized plan of care for the stay, Hill says. "A targeted length of stay by diagnosis is essential."

The case manager also is charged with reviewing the care of both the individual patient and the aggregate population — all the hospital's stroke patients, for example — against this plan of care for the stay, she says.

With stroke patients, for example, the case manager should be looking at a four- or five-day expected length of stay, and should make sure that within an hour of presentation to the ED the patient who meets criteria is given an antithrombic agent, Hill says. Within 12 to 24 hours, the case manager should ensure that:

— The patient is evaluated by a speech pathologist.

— A plan for communication and nutrition is established.

— The patient's blood pressure parameters are set, and blood pressure is managed within this range.

— The patient is evaluated by a physical therapist and an occupational therapist, and the resulting plan is written in the chart and acted on.

— Immediate communication is established with the physician to review complications and exceptions to the stroke clinical plan of care for the stay.

• Understand all aspects of discharge planning.

What's key here is crafting "Plan A" and "Plan B" for the high-risk patient so that if Plan A fails, Plan B may succeed. It's also crucial that the case manager know enough about the patient to measure the effectiveness of Plan A and know the proper time to put Plan B into place, Hill says.

Plan A for a stroke patient, for example, might be to send the patient home after discharge from the hospital. Part of the skill set required here involves working with the therapy staff to know what the predicted functionality of the patient will be at the end of the four- or five-day acute care stay, Hill says. "That should be judged within the first 24 hours of admittance to an inpatient setting."

Another crucial component is evaluating family members' ability to assist the patient in the home, and also evaluating their willingness to change their schedules in order to do so, Hill points out. "Once you know they're able, [determine if they're] willing to provide the assistance

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and surveillance necessary for the patient to function in the home."

In approximately 25% of cases, family members either get home and are overwhelmed at the prospect of caring for their loved one — in which case the person is readmitted — or they realize at the last minute that they can't do it, she says. That's why Plan B, the backup plan, must be highly viable, Hill says.

"The on-top-of-it case manager will have the ability to place a person in a skilled nursing facility or a rehab setting within 24 hours," she says. Knowledge of community resources is important, including good programs available for "special interest" patients, such as those with significant brain injuries, significant functional motor loss, or dependence on a ventilator, she adds.

Look out for 'red flags'

Ideally, the case manager will have taken steps to avoid that last-minute regrouping, Hill explains. A "big red flag" to look out for is family members who insist they can take the stroke patient home but haven't spent any time in the hospital, she adds.

Something Hill recommends, but which she says isn't done enough, is for the case manager to have the family members come to the hospital and observe them taking care of the patient. "[The case manager should] instruct them on how to care for the patient — helping mobilize, feed, give medication — and then observe them as they do these tasks," she notes. "I have had case managers do it, and [the family members] get a better picture of what the workload is, what their knowledge base needs to be, and whether they can actually manage their family member at home."

Another red flag is discord within the family, Hill adds. "One person really wants to take mom home but can't provide all the care, but another sibling is not interested in assisting." In those cases, the case manager should try to arrange a family meeting and present the different views he or she is hearing from the members, she suggests.

"The key in these situations is to have an excellent relationship with a clinical social worker who can help a family adjust to the new diagnosis and change in the person's functional ability," Hill says. "This helps the family know realistically what it can and can't provide."

She suggests that all stroke patients be assessed by a social worker within 24 hours of admittance to the hospital.

It's important to have family members look at placement options, even when they're thinking of taking the patient home after discharge, Hill says. "If you think Plan A might fail, encourage family to visit facilities within their community. Let them know that you're looking to the future, when they may need to put their family member in this setting for a short time."

In situations that are less than ideal, where the case manager is responsible for more than a reasonable number of patients, he or she will have to prioritize, she points out.

"You have to perform utilization review on all patients every day or every other day, but you may do a good job with care planning and discharge planning only on the higher-risk patients," Hill says. "You would have to delegate to the unit manager or bedside clinicians the cases for which they would create a care plan and a discharge plan."

Role negotiations should be at the administrative level, with oversight provided by a steering committee that helps establish policies and procedures. That committee, Hill suggests, would include such participants as the director of case management, the vice president of patient care services, and the vice president of medical management, she adds. ■

Pilot project: Proactive protocol for diabetes

Can CM make a differences in diabetes outcomes?

When Lovelace Clinic Foundation and Lovelace Health System's case management department jointly initiated a pilot project on diabetes three years ago, they wanted to find out whether intensive case management of high-cost health plan members with diabetes had an impact on key health outcomes and on costs.

The early results are that it can, says **Margaret Gunter**, PhD, who heads the Lovelace Clinic Foundation, a nonprofit health research institute closely affiliated with Lovelace Health Systems, a large integrated system based in Albuquerque, NM.

Gunter says the pilot, sponsored by the Centers for Medicare and Medicaid Services (CMS), also showed improved guideline compliance among patients as well as improved knowledge of guidelines by case managers. Referrals to

diet counseling improved, along with improved glucose control. In addition to decreased hospital and emergency department costs, there was clear evidence of improved physical function and improved quality of life among patients with diabetes, she reports.

The pilot has paved the way for the actual demonstrations, and its design and methods hold important lessons for case managers struggling to contain costs associated with diabetes.

According to Gunter, the first objective was to demonstrate that case management makes a difference in quality of care, outcomes, and costs. The second objective was the creation of an actual diabetes-specific case management protocol for the proactive management of the patients. "We wanted to pilot test it and see if it made sense and to work out some of the bugs," she reports. Finally, Gunter and her colleagues wanted to assess the feasibility of providing standardized case management services that integrated both nurses and social workers.

The pilot's data sources included a relational database or electronic administrative database that contained inpatient and outpatient claims. Patients also filled out health status questionnaires, and case managers collected information. "That gives us an ability to look at the impact of disease management and case management programs on health care utilization," explains Gunter.

Using this electronic database, the pilot randomly selected 160 patients using ICD-9 codes. "We looked at all of the costs because we know diabetes patients usually don't just have diabetes," she says. "It is other things, including cardiac conditions, that drive their costs up, so we looked at the most costly quarter of all patients that had diabetes." Patients were stratified by age and cost and then randomly assigned to either full case management or control, she adds.

Gunter warns that getting people with a lot of expertise and practice in implementing case management to try something very specialized is no easy task. To address that, the team that was responsible for the pilot initiated case management training and staff preparation. The most effective tool was asking specialists to come in and talk to the staff, she reports. For example, endocrinologists explained various aspects of diabetes, and a nurse practitioner who acts as a diabetes educator explained her role in the process.

The team wanted to make sure the training was specific to diabetes as well as some overflow on other diseases, Gunter says. To accomplish that, it developed a checklist for case managers to use every time they had contact with the patient. It also developed reference material as well as "motivation interviewing tools" that looked at the pros and cons of behavior change and the obstacles to behavior change.

Among the initial tasks, the pilot had to establish informed consent, identify key measures, develop instruments, and perform a human subject review. In order to recruit patients, the pilot team developed a baseline interview with data collection. "We wanted to identify a treatment plan that we could go over with the physician," says **Zandra Rise**, RN, a specialty case manager in the cardiology and pulmonary departments at Lovelace.

Getting an overview of patient's status

Baseline interviewing of patients included typical elements that most hospitals use in assessment but utilized an electronic system. By performing the initial review of all medical records that were electronically available, the case manager attained a general overview of the patient's medical status. When the patient came in for the initial assessment, the case manager already knew the weak areas of management and could start to steer patients toward making changes, Rise says.

The team also wanted to gauge how adherent the system was to the episodes of care protocol, such as whether the laboratory tests, eye exams, and podiatry care were done properly and whether the diabetes educators were involved. It also looked at use of prescription drugs, over-the-counter drugs, and alternative medications and other dietary supplements.

The pilot also included a clinic visit that involved the patient, the case manager, and family members. "What we wanted to focus on is how [peoplr are] going to absorb the information," explains Rise. "Are they going to be incentivized by fear or encouragement?" The pilot also looked at the patients' environment, including an inventory of food in their home and a list of restaurants they visit. It also helped determine if they needed a referral to cardiac rehabilitation, pulmonary rehabilitation, or simply an exercise area to continue to provide safe behavior changes, she says.

Rise says the pilot sought to individualize the treatment plan. "We put together a dictation of the

treatment plan on our electronic system so that every provider had a copy of what we were working on," she reports. That way, each provider who had contact with the patient knew the game plan and could provide support in the areas that were specific to his or her specialty.

The pilot team also sought to convert all the goals that patients established with the case managers into a numerical system. "If it was physical activity, we knew that a patient was going from a 500 calorie exercise week to a 1,000 calorie exercise week," she explains. "We also wanted to quantify the nutritional plan and quantify any changes into a numerical factor so people could see what they were doing."

Ongoing monitoring included a weekly contact as well as a six-month review. "We definitely found that patients appreciated reinforcement in their behavior changes," says Rise. "Patients may not have met their goal, but maybe they were 50% there, and it was useful for them to look at where they started and where they are now."

When patients were terminated from the study, Rise says, many expressed a desire to continue the program. At termination, team members attempted to determine what the patient had learned from the study and what areas they wanted more help with.

"We did a satisfaction survey with patients, and we did a feedback session with our case managers to identify what it is that they wanted," she explains.

Under the pilot, Gunter says the average hemoglobin UNC went from 7.7 to 7.4. Equally importantly, 70% of all the patients showed some decrease in hemoglobin A_{1C}. "That was again a clinical measurement that was really important to us," she says.

Inpatient costs were cut approximately in half, from $2,171 per patient to $1,113. However, Gunter points out that reducing the costs of a few very costly patients can skew results among a limited numbers of patients. Some outpatient costs went up, but that is to be expected when people are coming in for services that they have not been getting, Gunter says. "We hope that will keep them out of the emergency room and the hospital," she explains.

"These cost reductions would probably not be enough to pay for the costs of case management," says Gunter. On the other hand, she notes that the first six-month period is the most intensive time for case management, and if these patients were maintained over a longer period of time, the results could be far more significant. "We hope to do that in the upcoming [CMS] projects," she says.

She says the most significant learning point derived from case managers was that they wanted more supervision. "They wanted someone who could coach them as far as looking at all of the data."

They also wanted clarification on the role of the case manager, Gunter adds. Some of the case managers felt overwhelmed by so much information about diabetes that they wanted to know where the role of case management stops and other professions take over. ■

Structured interviews improves hiring decisions

Recent clinical experience, global viewpoint wanted

One of the most significant challenges facing case management departments is how to hire a team of effective case managers to meet ever-changing demands. **Vicki Alexander**, RN, CCM, a team leader in the case management department at Community Hospitals in Indianapolis, says two key criteria that she looks for are recent clinical experience and a global viewpoint of the managed care industry.

"We have not had good luck hiring people who have been in only one venue their entire career," she reports.

Alexander, who is responsible for case management operations in the hospital's inpatient services, says it is also important to find case managers who can communicate effectively with a variety of audiences. For example, some case managers are reluctant to challenge physicians. Some applicants even indicate that if a physician writes an order, they won't challenge it. "That doesn't work very well in our business," she contends.

On the other hand, some case managers may be able to communicate effectively with physicians as well as the multidisciplinary team but do a poor job at the patient's bedside or with families facing a crisis situation. Alexander also seeks case managers who have appropriate delegation skills. "The workload ebbs and flows," she points out. "You have to be someone who is able to delegate to individuals."

In order to identify the right type of case manager, Community has developed a structured interview process. "No matter who performs the

first-round interview, they use the same format," says Alexander. The hospital uses a scoring system to help assess résumés of qualified applicants, because if two dozen applicants are interviewed, it is very difficult to recall the specifics of each applicant, she notes.

Community then uses a ranking system of 1 to 4. A 4 indicates there is something obviously wrong with that candidate, while a 3 indicates at least a serious flaw. A 2 is used for someone who reveals positive attributes and can be trained, while a 1 is the ideal candidate.

The hospital then uses a team evaluation process after the first round of interviews to develop initial impressions and pinpoint areas to explore on the second round of interviews. Alexander says she tries to perform the first round of interviews herself, along with managers from various hospitals.

The hospital often uses team interviews as well. For example, if a general case management RN is being interviewed, several managers may sit in on the initial interview. If it is a specialty position for an area such as cardiac or rehabilitation, the hospital frequently will add someone on staff from that area. Social workers typically are interviewed by several other social workers.

According to Alexander, it is also important to present an honest portrayal of the position. "Sometimes, you feel like you are selling the job to the employee," she explains. To avoid that problem, Community sometimes uses what it calls "employee shadowing" where selected applicants are asked to spend a full day with the case manager to see firsthand what that case manager does.

"We have found shadowing to be very beneficial for the applicant," she says. "But we only do this when we are down to the final applicants and can't make a decision."

The hospital uses standard interview questions as well as customized questions for each position. It also differentiates the questions it uses based on the facility. Alexander says that is because some facilities have a more rural flavor and very different culture than the larger urban tertiary facilities that are more specialized and have a different type of patient and physician.

Here is a sample of questions and discussion points that Community poses to applicants:

• **Discuss a recent case management decision you made and how it impacted that case.** "We can learn a lot about what type of person we are dealing with and what [his or her] experience has been just from that question alone," Alexander says.

CE questions

13. According to Maria Hill, RN, MS, CMAC, senior consultant with the Center for Case Management in South Natick, MA, within 12 to 24 of a stroke patient presenting to the ED, which of the following should occur?
    A. The patient is evaluated by a speech pathologist.
    B. A plan for communication and nutrition is established.
    C. The patient's blood pressure parameters are set and blood pressure is managed within this range.
    D. all of the above.

14. According to Maria Hill, RN, MS, CMAC, stroke patients should be assessed by a social worker within how many hours of admittance to the hospital?
    A. 1 hour
    B. 6 hours
    C. 12 hours
    D. 24 hours

15. In a pilot project on diabetes initiated by Lovelace Clinic Foundation and Lovelace Health System's case management department, what percentage of diabetes patients showed some decrease in hemoglobin A_{1c}?
    A. 70%
    B. 56%
    C. 35%
    D. 23%

16. List one sample question used at Community Hospitals in Indianapolis, when interviewing potential applicants for a case management position.
    A. What did you like least about your previous employer?
    B. How do you define a difficult manager?
    C. Have you ever been convicted of a crime?
    D. None of the above

• **How do you define a difficult manager?** "We don't want to have people come in and find out that we are difficult managers," says Alexander. "We want to know what they think a difficult manager is so we will know if that might be us."

(Continued on page 159)

CRITICAL PATH NETWORK™

Hospital public health: Protocol for immunizing inpatients

Locked in traditional health care delivery roles, many acute care hospitals are missing critical opportunities to immunize their at-risk adult patients against pneumonia and influenza. As another flu season nears, case managers looking for an effective quality improvement project may want to consider the program designed by two infection control practitioners in Idaho.

Such an effort is not hard to justify in terms of morbidity and mortality. Pneumonia and influenza reap a terrible toll on the nation's elderly every year, accounting for the fifth leading cause of death for age 65 and older. Indeed, pneumococcal infection accounts for more deaths than all other vaccine-preventable diseases combined. About half of those deaths could be prevented with an available vaccine.

By the same token, the influenza vaccine usually is 50% to 60% effective in preventing hospitalization and 80% effective in preventing death.

About two-thirds of patients with severe pneumococcal disease have typically been hospitalized within the preceding three to five years but have not been immunized. Similarly, flu-vulnerable patients may come and go from hospitals during the flu season without being offered a vaccine that could prevent illness and transmission to others.

The Centers for Disease Control and Prevention's Healthy People 2010 initiative is aiming for 90% vaccination rate for pneumonia and flu in all high-risk patients.

"The national immunizations rates right now are a far cry from that," says **Jennifer Jones**, BS, CIC, MPH, infection control specialist at Saint Alphonsus Regional Medical Center in Boise, ID. "It is not often that acute care hospital settings take on public health undertakings. But hospitals and other acute care settings really need to jump in with both feet to help public health reach those goals."

In 1998, Jones and colleague **Jennifer Trip**, BS, MT(ASCP), CIC, infection control specialist at Saint Alphonsus, began exploring the idea of offering flu and pneumococcal immunizations to susceptible adult patients.

"We wanted to really focus in on adult immunizations," Jones says. "We felt there was already so much effort and attention on childhood immunizations in the community and at the hospital. You just don't hear of a lot of groups advocating adult immunizations."

Looking at their baseline situation, they found few adult patients were reporting the need for any vaccines during an admission assessment that simply asked if their immunizations were current.

"I really felt that patients were answering that with childhood vaccines in mind." says Trip. "They knew they had their measles, mumps, rubella [shots], but were not really thinking about flu and pneumococcal as adult vaccines. So we really weren't screening for adult vaccinations at all."

As plans were worked up, an algorithm based on current immunization guidelines was developed to ease the process. **(See final version of form, p. 152.)** Patient education packets were created, and free vaccine was secured through a foundation grant. However, after piloting the approach on a single unit in 1999, they identified barriers and obstacles that had to be overcome if the program was going to go hospitalwide.

"We found after that pilot study that so many patients needed these vaccines," Jones says. "At

(Continued on page 153)

Saint Alphonsus Regional Medical Center
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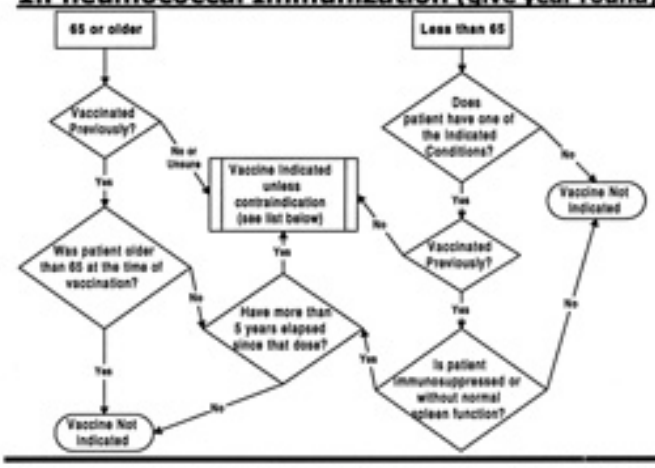
Adult Immunization Protocol

addressograph

1. Pneumococcal Immunization (give year round)

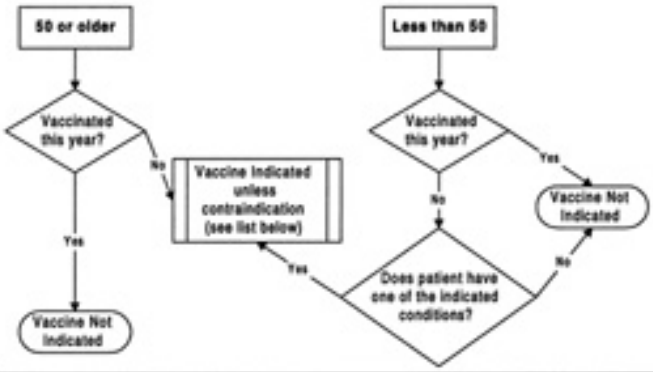


Pneumococcal Indicated Conditions:
People under 65 who have chronic illness or other risk factors such as cardiovascular disease, pulmonary disease, splenic dysfunction or absence (including sickle cell disease), chronic liver disease, cirrhosis, alcoholism, diabetes mellitus, CSF leaks, as well as persons living in special environments or social settings (including Alaska natives and certain Native American populations). Others at risk include immunocompromised persons such as those with HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, those receiving immunosuppressive chemotherapy (including corticosteroids), and those who received an organ or bone marrow transplant.

Must check one:

- ☐ **Pneumococcal Vaccine Indicated** and information sheet given to patient
- ☐ **Pneumococcal Vaccine Not Indicated** (go to 2, skip 3)

2. Influenza Immunization (give October – March)



Influenza Indicated Conditions:

- People under 50 with medical problems such as heart disease, lung disease (including asthma), diabetes, renal dysfunction, hemoglobinopathies, immunosuppression, and/or those living in chronic care facilities. People (>6 mos. of age) working or living with these people should be vaccinated as well.
- All health care workers
- Healthy pregnant women who will be in their 2nd or 3rd trimesters during the influenza season. Pregnant women who have underlying medical conditions should be vaccinated before the flu season, regardless of the stage of pregnancy
- Anyone who wishes to reduce the likelihood of becoming ill with influenza

Must check one:

- ☐ **Influenza Vaccine Indicated** and information sheet given to patient
- ☐ **Influenza Vaccine Not Indicated** (skip 4, go to 5)

3. Must check one box (if Pneum vaccine indicated):

- ☐ **Pneumococcal Vaccine Given** w/ patient's consent, administration documented on MAR (include vaccine lot #)
- ☐ **Pneumococcal Vaccine Indicated *but* Not Given** for the following reason (darken as many circles as apply):
  - ○ CONTRAINDICATION
    - ○ Allergy to thimerosal or mercury
    - ○ Previous severe reaction to pneumococcal vaccine
    - ○ Active fever (>100.4°F)
    - ○ Terminal Condition
    - ○ Pregnancy
  - ○ PATIENT REFUSED
    - ○ Believes not at risk for pneumococcal disease
    - ○ Fear of adverse effects
    - ○ Believes vaccine won't work
    - ○ Wants further advice (e.g., MD or family)
    - ○ Other _____
  - ○ PHYSICIAN ORDER NOT TO VACCINATE

4. Must check one box (if influenza vaccine indicated):

- ☐ **Influenza Vaccine Given** w/patient's consent, administration documented on MAR(include vaccine lot#)
- ☐ **Influenza Vaccine Indicated *but* Not Given** for the following reason (darken as many circles as apply):
  - ○ CONTRAINDICATION
    - ○ Allergy to eggs, thimerosal or mercury
    - ○ Previous severe reaction to influenza vaccine
    - ○ Active fever (>100.4°F)
    - ○ Terminal Condition
    - ○ Latex allergy (prefilled syringe-NO; multidose-OK)
  - ○ PATIENT REFUSED
    - ○ Believes not at risk for flu
    - ○ Fear of adverse effects
    - ○ Believes vaccine won't work
    - ○ Wants further advice (e.g., MD or family)
    - ○ Other _____
  - ○ PHYSICIAN ORDER NOT TO VACCINATE

5. Assessing RN Signature _____ **Date** _____

6. (skip if none given) **Administering Nurse Signature** _____ **Date** _____

White to Chart; Yellow to QI; Pink to Pharmacy

2-26-01

MR-1083

the time, about a quarter of them needed the pneumococcal vaccine and almost a fifth needed the influenza vaccine — and that was at the end of the flu season."

With physicians forgetting to sign vaccination approval for their patients about 30% of the time, a case was successfully made to the executive medical committee that standing orders for immunization were needed. The order would also smooth things over with the hospital nurses, who not surprisingly, had concerns about the additional workload of administering the program. With the standing order in place, nurses could immunize patients with their consent rather than waiting for the physician approval.

"Anytime you add to a nurse's workload, you are going to have some pushback," Jones says. "That is completely valid because they have so many duties right now. We tried to streamline everything for the nurses."

In addition to securing the standing order, the original concept of vaccinating at discharge was dropped. "We had feedback from the nursing staff to please not do it at discharge," Jones says. "It is a hectic time, and the patient wants to go home."

Now the patient's vaccine status is determined on admission as part of the routine assessment process. Another nursing problem arose, however, in terms of hospital policies for RNs and licensed practical nurses (LPNs). There was no conflict with state licensing requirements, but the hospital policy was that only an RN could perform a nursing assessment of a patient. However, LPNs could assist in giving the shots to patients identified for immunizations.

"That is going to vary from state to state so we wanted other people that are looking at our program to know that," Jones notes.

Another issue that will vary by state and local laws is patient consent. The program designed was within Idaho parameters for patient consent, but health care providers will want to check their local regulations.

Rather than creating a separate consent form, Trip and Jones decided to ask patients to sign off on the assessment sheet explaining the program. Patients can check a box to indicate whether they want to receive the vaccines if that is the recommendation of their medical team.

"We really felt that an additional form would be another barrier to getting the immunizations administered," Trip says.

As the program was refined and expanded, nursing staff found that 24% of at-risk adult patients were indicated for pneumococcal vaccine. Of those, 75% agreed to be immunized. Similarly, 40% of adult patients at risk of influenza had not been immunized. Of those, 62% agreed to be immunized when offered free influenza vaccine. Physicians advised against immunizing their patients in only about 1% of cases. The remainder of patients declining vaccine felt they were not at risk or cited such factors as fear of an adverse effect.

Given recent problems with delivery of flu vaccine, Trip reminds that such delays should not affect a program that is already focusing on high-risk, high-priority patients. Doing some projections based on 219 flu patients during the 1999-2000 flu seasons, the ICPs estimated that prior immunization would have prevented 40 hospitalizations and three deaths.

The pneumococcal vaccine, which overall is 60% to 70% effective in preventing invasive disease, is generally a one-time immunization.

"People are not as familiar with it," Trip says. "It is a one-time vaccine, but there are certain circumstances [where] you may receive it [again] if more than five years have elapsed and you were less than 65 at the time of receiving it the first time."

Those interested in undertaking such a project should be aware that Trip and Jones had to work the idea through many a committee, including medical staff, nursing, clinical management, and performance improvement. The upside is the increased networking opportunities and heightened visibility in the hospital.

"It really has been a multidisciplinary team effort," Trip says. "I feel like every vaccine we give is really a major accomplishment." ■

Prevent lawsuits with protocols, documentation

The best time to evaluate your protocols, guidelines, and documentation is not when you are served with notice of a malpractice lawsuit, experts say. Examine them now, and look at them from the perspective of patients and their attorneys, they say.

If you use clinical pathways or practice guidelines, make sure they are based upon reasonable, scientific data, says **Bill Duffy**, RN, MJ, CNOR,

assistant vice president of perioperative services for Evanston (IL) Northwest Health Care. Also, make sure the guidelines allow flexibility based on the uniqueness of the patient.

"Be clear about why you deviate from the guidelines," Duffy says. For example, "obese patients are at greater risk of skin injury than average-sized patients, so you might position them differently."

Be sure all staff members understand the reasons for deviating from the guidelines so it doesn't seem as if you treated this patient differently for no reason, he explains.

Documentation can be a simple note

Documentation in the chart doesn't have to contain a lot of specifics, he says. "A note that the patient stated that her arm was in an uncomfortable position and the position was adjusted, or a note that the doctor was informed of the lab results, without specific numbers, is all that is necessary," Duffy says.

Make sure, however, that the notes are legible. "It doesn't look good for a nurse to be unable to read her own writing on the witness stand," he says.

If you use pre-printed forms in your charts, be sure that sloppy checkmarks don't create a problem, says Duffy.

For example, if you have the box marked "alert" directly above the box marked "unconscious," a sloppy checkmark might cover both boxes, creating doubt in a jury's mind. To avoid this problem, print opposites side by side rather than on top of each other, he suggests.

Have clear procedures as to how to handle patient belongings, including eyeglasses and contact lenses, says **John Romano**, JD, partner at Romano, Ericksen, and Cronin in West Palm Beach, FL. He recalls one case in which the facility did not have a procedure that ensures contact lenses were removed.

"The patient was in the hospital and underwent extensive surgery," he says. "She was not fully awake for several days, so the staff did not know the lenses were still in her eyes. By that time, the corneas developed ulcers," he says.

Romano points out that while ambulatory surgery patients are awake much sooner, they still may be disoriented and not realize the lenses are still in the eyes.

"Pain medication may keep the patient sleepy enough that he or she would leave the lenses in long enough to cause discomfort and possible injury," he says. For this reason, include removal of contact lenses on any preoperative checklist and make sure they are out of the eyes before anesthesia is administered, he suggests.

Very strict protocols for discharge are also important, says Cronin.

"Everyone has a tendency to move on and get the patients home," he says. While this is important, it's critical to be extra careful with a lethargic patient, Cronin emphasizes.

"There is a fine line between someone who is resting comfortably and someone who is almost dead," he adds. Be sure to keep the patient long enough to make sure they are not overly lethargic, he says.

This point will differ between patients, type of anesthesia, and family support, Cronin says.

Call the patient at home post-surgery

Another good practice after discharge is to call the patient's home several hours after surgery, he adds. Let the patient's family know that you will be doing this so they won't be alarmed at the call, he adds.

"Patients and their families won't call about little things, so before they are discharged, remind them they can call, and make sure they have a telephone number," Cronin says. "Not only does this reassure them that you are still available, but it gives you a chance to identify a potential complication early." ■

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:

Russ Underwood, *Hospital Case Management*, P.O. Box 740056, Atlanta, GA 30374. Telephone: (404) 262-5460. Fax: (404) 262-5447. ■

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Slash hospitalization, lengths of stay for elderly

Geriatric nurses manage high-risk patients

By case managing high-risk elderly patients, Carle Clinic Association, PC, in Mahomet, IL, has shortened lengths of stay and improved care for targeted patients.

The population served by the Partners in Care program includes 2,000 capitated Medicare managed care beneficiaries who are at high risk for mortality, functional decline, and increased use of health care resources.

Utilization reduced

Since its inception in 1998, Partners in Care has dramatically reduced the utilization of health care resources for patients in the program. For example, patients in Partners in Care were hospitalized for a total of 1,721 bed days per thousand per year, compared to 4,162 bed days per thousand per year among a similar population not in the program.

Program participants were hospitalized 433 times per thousand per year, compared to 858 times per thousand per year for patients not in the program. And Partners in Care patients visited their physicians 13.2 times a year vs. 11.8 visits for those not in the program.

Carle Clinic Association is a multispecialty physician-owned practice with 290 physicians in primary care and medical surgical specialties. The practice is part of a health care system that includes a hospital, HMO, and other service companies, such as home health, pharmacies, and durable medical equipment suppliers.

The Partners in Care program received the Models of Excellence in High-Risk Patient Management award from the American Medical Group Association, in Alexandria, VA, and New York City-based Pfizer Inc.

Nurse case managers, called Nurse Partners, are the linchpin of the Partners in Care program, says **Tuni Miller**, RN, MS, Community Nursing Organization program manager.

The primary care physicians provide geriatric care and serve as team leaders. Nurse Partners actively monitor the patients. The nurses visit the patients in multiple venues, such as their homes, the hospital, or the nursing home, in addition to the clinic. They give the information they gather during site visits back to the primary care physician.

"This really helps with the ongoing support of the patient population. It helps the patients understand what is happening, what kind of treatment and recommendations their physicians have; and it helps the patients implement the recommended treatments," says **Cheryl Schraeder**, RN, PhD, FAAN, who heads the health system research center.

More attention given to frail patients

When patients are healthier, fairly self-sufficient, and have an active lifestyle, contacts are minimal. Patients who are frailer receive a comprehensive assessment to determine all their risk factors, as well as periodic assessments and visits. For example, the Nurse Partners keep a close watch on blood sugar levels, cardiac signs and symptoms, and weight for patients with congestive heart failure.

"Early detection can ward off serious acute episodes that land the patients in the hospital," Miller says.

The Nurse Partners work with patients, families, and physicians to help the patients maintain a healthy status so they can stay at home. They teach patients self-management and better ways to take care of themselves, and help them manage chronic conditions. The Nurse Partners telephone

the patients at regular intervals, again depending on the health status of the individual. For example, the healthier patients may receive a call only once every six months. Patients who have just had an acute episode may be called once a week.

"It ebbs and flows," Miller says. "The Nurse Partners use their clinical judgment to decide how frequently the patients should be contacted. We also encourage them to call us if they have any questions or concerns."

What makes the Nurse Partner program unique is that it covers the acute care, home, and community settings. When a patient in the program is admitted to the hospital, the Nurse Partners work with the hospital case coordinator (formerly known as discharge planners) to provide information and help plan for the patient's discharge.

The Nurse Partners coordinate any services that are needed after discharge and follow up after the patient returns home. The Nurse Partners often work collaboratively with people in the hospital, the home health agency, community organizations like the Office on Aging, and the physician's office. "One issue with elders who have multiple needs is hooking them to appropriate services such as Meals on Wheels," Schraeder says. "Partners in Care really helps to provide continuity, monitoring, and support for a person with complex care needs."

Each nurse manages the patients of specific primary care physicians. There are about eight nurse partners, each of whom supports patients from five to six primary care physicians, spread out in clinics throughout the Carle Clinic Association treatment area.

The Nurse Partners are coordinated by a nurse manager and program developer and are assisted by care assistants, most of whom have worked in community agencies. Care assistants answer the telephone, take care of some administrative tasks, arrange for services, such as a homemaker service, and do some telephone monitoring, checking in with the patients and alerting the Nurse Partner if the patient needs to make an appointment. ■

Do you screen patients for alternative therapy use?

If you assume patients aren't taking herbal supplements because they don't mention it, you may be wrong. A recent study found that although 24% of patients were using complementary and alternative medicine (CAM), only 67% of users informed their health care provider about this.[1]

It is important to ask about CAM use because you can use that information to help guide care, such as planning discharge instructions, says **Patricia M. Campbell**, RN, MSN, CCRN, ANP CS, an emergency nurse practitioner at Good Samaritan Regional Medical Center in Phoenix.

Here are things to consider when screening patients for CAM use:

• **Consider drug interactions.**

If patients are taking herbal supplements, there could be interactions with prescription medications that you should consider, says Campbell. She points to the following potential drug / herb interactions:

— Central nervous system depressants taken with kava or valerian may produce excessive drowsiness.

— Corticosteroids taken with echinacea or astragalus may offset the immunosuppressive action of glucorticoids.

— Digoxin taken with hawthorn may potentiate digoxin.

— Monoamine oxidase inhibitors (MAOIs) taken with ginseng, ephedra, or St. John's wort may cause a hypertensive crisis or serotonin syndrome.

Report the use of any supplement to the physician or nurse practitioner, says **Sherri-Lynne Almeida**, RN, MSN, MEd, DrPH, CEN, president-elect of the Des Plaines, IL-based Emergency Nurses Association and vice president of client services for Team Health Southwest in Houston. "Most nurses and practitioners are not familiar with the many supplements available and would have to research the potential for a drug interaction," she notes.

Prompting may be needed

There are many herbal supplements on the market that can diminish the effects of prescription medication, adds Almeida. "This could result in a negative outcome for the patient," she says.

• **Ask specific questions about CAM use.**

When asking patients if they take over-the-counter medications, specifically mention herbal supplements, amino acids, and vitamins, Almeida says. "Sometimes patients need to be prompted as they do not consider these to be medications."

Campbell recommends asking patients these three questions:

1. Do you use any herbs, vitamins, food supplements, or homeopathic remedies?

2. Do you use complementary and alternative medicine, such as acupuncture, biofeedback, or mediation?

3. Are you under the care of a complementary and alternative medicine practitioner?

• Consider that symptoms may be caused by herbal supplements.

Patients may be taking food supplements or herbs that are actually causing some of the symptoms that they are presenting with, Campbell says. She gives the following example: If a patient presents with new onset hypertension or a cardiac arrhythmia, it is essential to ascertain if they are taking any herbs that may have caused this condition.

• Document your assessment.

Most emergency department (ED) forms do not include space to document CAM use, notes Almeida. "Out of the 16 hospitals I consult with, not one facility has a designated area on the nursing assessment sheet for this purpose," she says. "I don't think that this concept has truly hit mainstream nursing yet."

Document responses to specific questions about alternative therapy use on the patient record, says Campbell. "Most ED records do not have space for this information, but it can be documented in the 'medication' section," she suggests.

Consider CAMs as patients leave

Document any herbs, food supplements, homeopathic remedies, or vitamins, Campbell says. "Any other complimentary therapies such as acupuncture can be documented under past medical history, along with the condition they were treating."

• Address discharge planning.

Campbell recommends including CAM therapies in your discharge planning if possible. "For example, a patient with back pain who seeks relief in the ED will usually be discharged with muscle relaxants and pain medication," she says. "If a patient is open to CAM, then a referral for acupuncture may also be appropriate."

You'll also need to know about CAM use to ensure no problems occur after the patient leaves the ED, says Campbell. "In addition, if you discharge the patient on new medication but are unaware about the herbs they are taking at home, there could be an adverse reaction," she says.

Reference

1. Weiss SJ, Takakuwa KM, Ernst AA. Use, understanding, and beliefs about complementary and alternative medicines among emergency department patients. *Acad Emerg Med* 2001; 8:41-47. ■

CCMC task force looks at review process

A task force of the Commission for Case Manager Certification (CCMC) is taking a look at its eligibility review process, with regard to who is allowed to sit for the certified case manager (CCM) exam and the criteria for what makes a case manager.

"This is a process that is always ongoing," says **Susan Gilpin**, JD, chief executive officer of CCMC, based in Rolling Meadows, IL. The organization does research every five years, she says, and will do a "role and function study" next year.

The present task force, however, represents CCMC's efforts to keep current between those five-year studies and "to take a look at changes in the field," Gilpin says. "Does it make sense to review eligibility criteria? Has there been that much change?"

"What is the continuum of care?" is a key question that is being addressed, she notes. "How do you define the continuum of care across multiple environments? The task force will be looking at issues like that, [and] will try to be open to examining the criteria we have set, at how that has been defined."

Commissioners serving on the task force are case managers who practice in a variety of settings, Gilpin says. Charged with its mission in June, following the organization's annual meeting, the task force will give a preliminary report on its findings to the entire commission at the mid-year meeting in January, she adds.

Identifying research opportunities

The task force will be looking for opportunities to identify research projects that might be undertaken by CCMC's exam and research committee, Gilpin notes.

On a related subject, she adds, the commission has found that the job descriptions submitted by

people applying for CCM certification have gotten much more specific.

"This might be an industrywide trend," Gilpin suggests, "that human resources departments are doing a good job of updating descriptions and making sure they reflect what case managers are doing."

In the case of some applications, however, there is a need for more illustration of how the job fits case management criteria, she says. "We urge people to make sure when they submit an application that they take a look at the job description and make sure it accurately reflects what they do."

CCMC receives some applications, Gilpin explains, that include a single-page bullet-point job description, with a very limited list of duties. "Unless you're able to show in the job description what you really do, it may look like you only perform clerical functions."

To make the package more complete, she advises, applicants might submit a case study, and say, "Here's a case I worked on, this was my role, and this was my involvement level."

Applications that are rejected, Gilpin notes, go to a different committee for consideration during the appeals process.

[Editor's note: For more information on attaining the CCM credential, contact the Commission for Case Manager Certification, 1835 Rohlwing Road, Suite D, Rolling Meadows, IL 60008. Telephone: (847) 818-0292. E-mail: info@ccmcertification.org.] ■

New book aims to fill case management void

Looking for a manual that consistently addresses the case management process regardless of practice setting, pay system, professional affiliation, or patients served?

Case Manager Review Course: The Essence of Case Management, published in May 2001 by American Nurses Credentialing Center (ANCC) and the Institute for Research, is "the first published case management book to be inclusive of all health care disciplines in the practice of case management," according to the publishers.

The book is intended to "embrace the essence of case management across the continuum of care," says **Anne Llewellyn,** RN, C, BPSHSA, CCM, CRRN, CEAC, who co-wrote it with **Kathleen Moreo**, RN, Cm, BSN, BPSHSA, CCM, CDMS, CEAC. Llewellyn and Moreo are business partners who own PRIME Inc. in Miramar, FL.

"This is for people coming into practice to understand the whole scope of practice, as well as for the experienced case manager who may have worked in only one setting, such as the hospital or in managed care," Llewellyn adds. The book includes several case studies focusing on nursing, social work, respiratory therapy, nutrition, rehabilitation, and other specialty practice arenas, she notes.

Each chapter includes review questions and answers, with rationale, to assist in studying for national examinations, and to allow the reader to learn in a user-friendly manner, she notes.

[Editor's note: Case Manager Review Course *can be purchased by calling the ANCC at (800) 924-9053. For more information, contact Anne Llewellyn at allewellyn@primeinc.cc.]* ■

Medicare hikes pay for outpatient services

Hospitals will get a 2.3% payment hike, effective Jan. 1, 2002, under the proposed rule for the outpatient prospective payment system (OPPS) released in late August by the Centers for Medicare & Medicaid Services (CMS).

The rule would achieve the goal of making appropriate reimbursement payments given the ongoing shift of services from inpatient to outpatient setting, according to CMS Administrator Tom Scully.

While the rule outlines possible approaches for CMS in estimating payments for hospitals' use of "pass-through" devices, drugs, and biological products in outpatient services, it makes no actual estimate. Congress required Medicare to make such payments temporarily, and capped them at 2.5% of the estimated overall amount paid under OPPS.

Currently, should the estimate exceed the cap, an across-the-board cut on all pass-through payments would be required. The proposed rule can be viewed at www.hcfa.gov/regs/propcy2002.htm. ■

(Continued from page 150)

• **Discuss recent communications with physicians, both successful and unsuccessful**. Alexander says this question is especially important in a large system. "Our model is a team approach. We want to bring in people who can have that approach as well."

• **Describe what methods help you learn the best.** According to Alexander, it is helpful to learn up front how people learn because that can help structure the orientation process.

Community also asks applicants about their ideal working environment and poses several ethical scenarios. "We find it very important to give them a scenario and have them kind of work the case," Alexander explains.

"Not only does it give us an idea of the employee, but it also helps us to understand the baseline that they are coming in at," she says. ■

Lack of specialty care detrimental to diabetics

Lack of specialty care, particularly for minority patients, is a contributing factor to the continued increase in mortality for people with diabetes, according to the American Association for Clinical Endocrinologists (AACE) in Jacksonville, FL.

"Patients with diabetes have special health needs, which they and their physicians need to address. Studies have shown that patients who receive care from endocrinologists have better health outcomes. It is a critical component for managing this chronic condition," says **Rhoda H. Cobin**, MD, president of AACE.

She cited statistics from the Centers for Disease Control and Prevention (CDC) that show deaths from diabetes and its complications continue to increase.

Many patients are not even aware that there are diabetes specialists, Cobin says. "Minority patients — who are disproportionately impacted by diabetes — are the least likely to seek or have access to specialty care," she adds. ▼

Multidrug-resistant TB remains a threat

The current education and treatment of multidrug-resistant tuberculosis (MDR TB) does not adequately reflect the seriousness of the disease as a national public health concern, according to a new study.

The disease remains a threat, particularly in

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areas that are heavily populated by immigrants, the elderly, and people with immune system problems, researchers reported in the August issue of *CHEST*, the journal of the American College of Chest Physicians.

MDR TB is a deadly form of tuberculosis that is resistant to two or more of the primary drugs used to treat the disease. It is transmitted through the air and can develop because of a lack of treatment, improper treatment, or noncompliance with drug therapy in patients with active TB.

The tools are available to cure disease

"With expert care, we have the tools to diagnose and the means to cure TB and MDR strains, yet this disease continues to kill people in the U.S. and around the world," says **David Ashkin**, MD, FCCP, medical executive director at A.G. Holley State Tuberculosis Hospital in Lantana, FL, author of the study.

In the study, Ashkin examined the outcomes of Florida patients treated at least partially in a specialty treatment center and those treated only in outpatient community care.

Of the 81 patients with MDR TB (out of 5,516 cases of active TB), 45% of patients who received outpatient care died compared with 18% of patients treated in the inpatient specialty treatment facility. ▼

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Hospital closures higher this year, say consultants

During the first half of this year, 24 hospitals with 4,088 staffed beds have either closed their doors — partially or entirely — or announced plans to do so, compared with 20 for the same six months last year, according to an Ohio health care consulting firm.

Dynamis Healthcare Advisors of Cleveland said the closure trends this year are similar to those exhibited in 2000.

Five of the 2001 closures have been in rural communities, and 19 were urban hospitals. Seven of this year's closures were for-profit and 17 were not-for-profit facilities.

Geographically, most of this year's closures were in the Midwest, followed by the East Coast. Ohio led the list of closures with four closures or announcements.

At the same time last year, Ohio also led the list with five. Closures to date in 2001, according to the report, have affected 4,203 staffed beds and approximately 13,000 employees. For more information, go to www.dynamis-hc.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. ■