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

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Hospital case managers respond to World Trade Center attack

Saint Vincents' CMs cope with unique challenges in wake of tragedy

On the morning of Sept. 11, **Toni Cesta**, PhD, RN, FAAN, director of case management at Saint Vincents Hospital in Manhattan was at her desk when her secretary informed her that a Code Three had been called. Assuming the announcement was part of a routine disaster drill, Cesta asked what scenario had been given and was told an airliner had crashed into one of the twin towers of the World Trade Center. "I said, 'Oh, how silly. Couldn't they come up with something better than that?'" Cesta recalls.

Disaster Planning Audio Conference

The unimaginable has happened in New York City. At Saint Vincents Hospital, less than three miles from the site of the World Trade Center attack, the disaster plan was put to the test as dedicated professionals rose to the unique challenge of responding to the attack. American Health Consultants, publisher of *Hospital Case Management*, invites you to learn from the firsthand experience of the professionals at Saint Vincents how to take a new look at your disaster plans so that you will be ready if the unimaginable happens in your community:

- Responding to the Unimaginable: How Saint Vincents Coped with the World Trade Center Attack
- Wednesday, Nov. 14, 2001
- 2:00 to 3:40 p.m. EST
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But the scenario wasn't fictional, and this time, the disaster wasn't a drill. Within minutes, a second jet slammed into the other World Trade Center tower, and soon both buildings collapsed. In the confusing hours that followed, the number of dead and injured was unknown, and area hospitals braced for the worst.

At Saint Vincents, a Level 1 trauma center two miles from the World Trade Center Complex, dedicated professionals rose to the unique challenge of responding to the attack, treating survivors and rescue workers; offering comfort, counsel, and vital information to family members of the victims; and supporting each other at a time of crisis in their own community.

For Cesta and her case managers, there was no time for shock or disbelief. The most important and immediate consideration was to free up as many beds as possible as quickly as possible, in case of mass casualties. "We all have a place where we're expected to report, as per the disaster plan," Cesta says. "When my case managers reported to that location, we just sent them right back to the units. I said, 'Just start discharging everybody.'"

The process of rapidly discharging current patients was complicated, however, by local rescue efforts and by safety precautions being enacted beyond the hospital walls. The hospital was cordoned off, and no traffic was allowed to move in that part of the city. "We really had to work with the police department very closely and with various transportation companies" both to facilitate discharge and to get staff to the hospital for work, Cesta says.

"If we took three patients out to Staten Island, we would bring back three nurses who needed to get to work," she says. "There was a lot of coordination of transportation. That was really what I was doing for about two days."

By the second day, more transportation help was available. "But that first day was very difficult, simply because we were in a nonaccessible area, and any ambulances that were around were being used at the disaster site, which was appropriate," Cesta says. "We got into this situation where we needed to get patients out of the hospital, but we had limited resources to allow us to do that." Two babies born during that time were taken home in police cruisers.

Meanwhile, case managers were still fielding health plan calls for insurance reviews. "I told my staff, 'Don't even respond. That is not where our focus is. If we don't get paid, we don't get paid,'" she says.

Fortunately, it didn't come to that, thanks in large part to the efforts of the New York City-based Greater New York Hospital Association (GNYHA), which stepped in quickly to encourage insurers to waive precertification notifications and some medical management requirements for a period of time. "Our president sent a letter to about 24 different plans that operate in the metropolitan area, asking for their continued flexibility and support," says **Lillian Forgacs**, associate vice president for utilization management and managed care at GNYHA. "It explained to them what the exact challenges were to the hospitals, and some of those challenges actually were shared by the payers, too."

Indeed, one plan's information system was housed in the World Trade Center, "so they were totally crippled," Forgacs says. "We said to them, 'Do you want to fax us something that we get out to the membership to let them know?' and they were incredibly appreciative of that."

Cesta also was appreciative of GNYHA's efforts, which led plans to establish grace periods that ran from a few days to a few weeks in length. "They stepped in and said, 'We can't continue to conduct business as usual here. You're just going to have to certify everything, because the hospitals are not going to be able to respond in a normal fashion to the utilization requirements,'" Cesta says. "And [the plans] quickly did respond, and so we were able to know that we would not have to deal with precert issues or continued stay issues, that things would be paid for and we could keep our attention on pushing the patients through the system and deploying the staff and really do discharge planning."

Despite the distractions and difficulties they faced, Cesta and her staff were successful in

COMING IN FUTURE MONTHS

- More on case management's role in disaster planning
- Measuring the impact of case management interventions
- What does the bear market mean for your hospital?
- Values and ethics in case management
- Discharge planning in depth: What you need to know

Disaster planning: How case managers can help

No matter how many drills your facility conducts, or how comprehensive your disaster plan is, real crises virtually always present unique challenges to those charged with responding to them.

For case managers, that may mean temporarily having to perform functions that aren't traditional case manager responsibilities, says **Beverly Cunningham**, RN, MS, president of Case Management Consultants, in Toledo, OH, and a former case management director. It also means establishing and maintaining good communication with payers as well as counterparts in other levels of care so that you can help to coordinate a flexible response in unusual circumstances.

"Coordination of care is really important for case managers," she says. "Because if you're going to be inundated with patients, you've got to be able to plan 'where is the best site for this patient to be taken care of?' We know that when you have more patients in the hospital than you can handle that everyone can't be in the acute care setting."

Cunningham stresses that the key to effective coordination of care is communication. "One of the biggest challenges case managers have is that we all get so caught up in our episode of acute care that we don't talk to other levels of care, whether it's rehab or home care, and even those that are in our own continuum." It's also crucial to have an effective system of discharge planning in place before a disaster occurs. "If you don't have good communication with your families already, if you haven't done your discharge planning ahead of time, and you wait until the last minute to do it, you're not going to be able to do it very effectively," she says.

At Vanderbilt University Medical Center, a Level 1 trauma center in Nashville, TN, the standard for discharge planning is for all patients to be screened and a plan developed within 24 hours of admission, says **Evelyn Koenig**, director of case management. "If it looks like the patient isn't going to be able to easily return home and may need nursing home or rehab or something like that, referrals are begun early on," she says. So in the event of a disaster situation, "with the majority of patients, it would be very easy to look at the record, know what the discharge plan was, and begin to facilitate finalizing that, if that's possible based on the patient's condition."

Vanderbilt also maintains relationships with other local hospitals as well as with some nursing homes and rehabilitation agencies. Because Vanderbilt is the only Level 1 trauma center in the area, it typically gets a different type of casualty than other facilities. "So even with patients who cannot be discharged to the community, we have agreements whereby they can be discharged or transferred to other hospitals to free our beds for the trauma victims that only we can handle," Koenig says.

When a mass disaster is called at Vanderbilt, it's case management's responsibility to open the discharge center. Case managers immediately assess the availability of beds for potential victims, determine which current patients who could be discharged right away, and facilitate discharges, if necessary, by sending those patients to the discharge center. At the discharge center, teams of social workers and nurse case managers process patients either to another level of care or the home, as appropriate. If normal means of transportation are disabled, the medical center would have access to Vanderbilt University buses.

In addition to their other responsibilities, social workers have primary responsibility to provide support to family members whose loved ones have been injured, or who come to the hospital looking for someone. "A visitor center is opened that's actually run by our patient affairs department, but social work has primary responsibility to assist with counseling, comfort, grief, matching victims to family members, and that kind of thing," Koenig says. ■

clearing bed space. "Of course, the disappointment in all of it was that we didn't get as many patients and as many survivors as we would have liked to have gotten," Cesta notes. "That was the tragedy in this."

Many of the patients who did come in were injured rescue workers, many of them covered in the gray powder that billowed around the attack site, their throats raw and their eyes blood-red with irritation. Common problems included smoke and particle inhalation and minor injuries caused by moving among the debris.

After the first few days, however, the type of patients presenting to the hospital shifted, as local residents in various stages of coping with the disaster sought emotional support and counseling. The social workers in Cesta's department assisted in the effort to help these patients, as did Saint Vincents' supportive care program.

Like case management, supportive care had had its hands full since the attacks occurred. "We started to see in the hospital an almost immediate arrival of concerned family members," says **Eileen Hanley**, RN, MBA, manager of the program. "As soon as word got out that people were coming to Saint Vincents, we began to get calls, then people arriving here at the hospital. So our program staff did a lot of manning the phones in

the phone bank." By midafternoon of the 11th, staff realized they needed to set up a separate center outside the hospital to deal with the needs and concerns of family members.

The family crisis center was established a couple of blocks away with the help of case managers, social workers, and supportive care staff, and during the few days of its existence, it received an estimated 6,000 people. "What happened was that for a couple of days, Saint Vincents was the only place family members could come to get information, because the city's office of emergency management was damaged in the trade center collapse," Hanley says. "It took them a couple of days to set up their city center, which ultimately took over the centralized function. But for about two or three days, Saint Vincents was the hub of information for people."

At the center, hospital workers from various departments staffed tables at which family members could inquire whether their loved ones had been treated at a local hospital. "At that point, very soon after the disaster, people were looking for concrete information," Hanley says. "They weren't coming in requesting counseling. What was valuable about our staff being there was that, in the process of helping to look for a name on a list, they could do a very quick assessment of how this person was managing."

Once the city's official center was up and running, the work of the family crisis center was moved back to the hospital. By then, its function had become less to disseminate information than to provide counseling. "People were going to the city center to file missing persons reports, to bring in DNA samples, and things like that," Hanley says. "But what we were seeing were people either directly affected by the trade center disaster or people who were really anxious or scared or sad and wanting to talk to someone. So our staff, together with our spiritual care department and psychiatry department, helped to staff that center for about a week and half, around the clock."

Case management and supportive care staff helped out in the emergency department, where bereavement and grief counselors also were on hand to assist incoming patients. "One of the things that we found very helpful was that the case managers who were in the emergency department often were able to identify people they thought were appropriate for the counselors to reach out to," Hanley says.

In some cases, those considered appropriate for counseling weren't patients but staff members, all of whom had worked long hours under incredibly stressful conditions in the aftermath of a disaster in their own community. Twenty-eight Saint Vincents employees lost family members in the attack.

By the middle of the second week, when the volume of family members seeking information and counseling began to dwindle, the supportive care staff began focusing their efforts on employee support. They developed materials to help employees cope with what had happened, and at press time, they continued to circulate throughout the hospital, speaking informally to staff about how they're coping.

Cesta also turned her department's attention to staff support, because, as she says, "many of the staff had been unable to go through their own [coping] processes because they were so busy. They really put their own feelings aside, and then those issues started to have to be dealt with. So the hospital has set up workshops for staff to go to, to talk through their feelings about what happened."

A remarkable response

But as difficult as the situation was, Cesta is proud of how her hospital and her community responded in the wake of the tragedy. "People were tired. Emotions were high. But everybody stayed very calm," she says. "They really did a great job — everybody. The front end, the back end, and everything in between. People were here to do whatever had to be done and step up to the plate."

That willingness to help spilled over into the community at large as well. At one point, about 1,000 people were lined up literally around the block waiting to give blood. "Eventually, we couldn't take any more blood, and we referred people to other hospitals to give blood there," Cesta says. "Giving blood was a concrete thing that people could easily do, and so we had more blood than we needed. I wish we could have used it."

For days after the attack, Saint Vincents' hallways were plastered with photocopied pages bearing pictures and descriptions of missing loved ones. As time passed and hope for finding more survivors dwindled, the pages were taken down and moved to a single location. In time, they will be bound together in a book, and the book placed permanently in the chapel as a reminder of all those Saint Vincents never got the chance to treat. ■

Develop customer-centric hospital CM model

Establishing partnerships with physicians is key

The realities of health care today underscore the need to demonstrate measurable bottom-line outcomes. But **Stefani Daniels,** RN, MSHA, managing partner of Phoenix Medical Management (PMM), based in Pompano Beach, FL, argues that with physicians driving upward of 80% of resource costs, it's equally important that case managers understand how they can leverage the challenges confronting physicians and hospitals to create program value for enhanced funding and a competitive advantage.

Not only has patients' trust in health care practitioners waned, physicians and hospitals trust each other less as well, Daniels says. "There used to be a point in time where doctors and administrators worked together," she says. But that has been replaced by an adversarial relationship that also includes payers.

Worse yet, the doctor-patient relationship had become a myth, Daniels argues. The average time that a doctor spends with a patient is six minutes. "What kind of relationship can you build in a six-minute interview?" she asks.

According to Daniels, the single biggest challenge facing the medical profession is variation among practice patterns for the same type of patient. One recent example, which made headlines, was a finding that many women with breast cancer faced radical mastectomy, even though all the evidence showed similar outcomes when treated with a lasectomy, she says.

The reasons for this variation are threefold, Daniels says. The first is financial. "If you have an MRI, [physicians] will use the MRI [whether] the patient needs it or not." The other two determining factors are where the physicians went to school and where they did their residencies.

Daniels maintains, however, that the increasingly competitive health care environment is presenting opportunities to providers. "Consumer power is giving rise to new opportunities. Consumer expectations are going to shape the conduct and the performance of the hospital in the future, and there is a window of opportunity."

Specifically, case managers can leverage the consumer demand for value by applying customer-centric trends to their case management program, she says. And that means aligning the program with the expectations of physicians. "Without the physician, you will not have a patient," Daniels argues, adding that despite the impact of managed care, 60% of admissions come from direct physician referrals. When case managers view physicians as important customers, the benefits that result can include physician loyalty and greater market share. Moreover, if case managers influence the way physicians practice, that ultimately benefits patients as well, she says.

Bringing this about is no easy task, however. She says that it requires a radical shift in thinking about physician motives. Contrary to conventional wisdom, the motive for physicians to work with case managers should not be to reduce the cost per case but rather to save time, give them much sought-after data, and reduce payer denials, Daniels points out. **(See charts, p. 166.)**

"Together as a team, our primary customer then becomes the patient," says **Marianne Ramey**, RN, CCM, a partner at PMM. But while that looks good on paper, making it happen on a real-time, everyday basis is another matter, she adds.

Here are some of the tools case managers can employ to facilitate this shift, according to Ramey.

For starters, many case management programs have only a generic mission statement, if they have one at all. Ramey maintains that case management programs need to review their vision for case management and their purpose for being case managers.

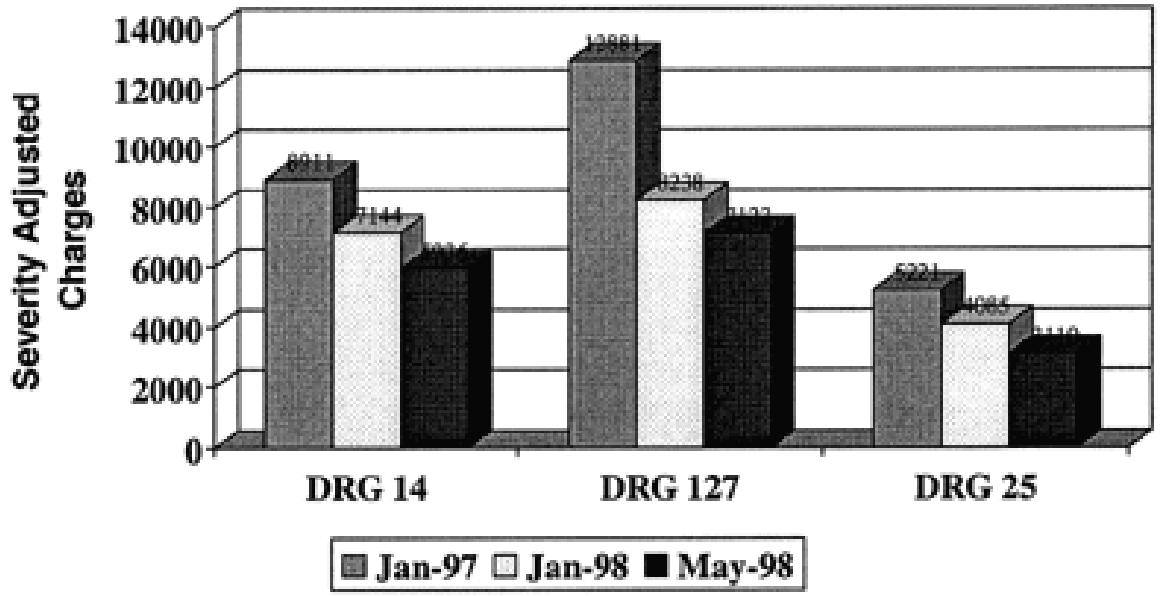
Programs then should look at their structure, Ramey says. "What we started with a few years ago might not be adequate anymore. If we truly are going to be able to partner with the physician, something has to change." For example, it is difficult for case managers to act as a real partner to the physician if they have their noses buried in the charts doing utilization review (UR) instead of making rounds with the physician, she says.

In roughly three-quarters of the programs it designs, PMM uses clerical staff to perform contractual UR. "That is what happens until you reach a point where you can reduce your denials enough to renegotiate that onerous contract," Daniels adds.

When it comes to staff reorientation, the old methods may not apply in a customer-centric model, Ramey says. "If you are truly going to be a partner [with] the physician . . . and customer-focused, you must be there for your customer."

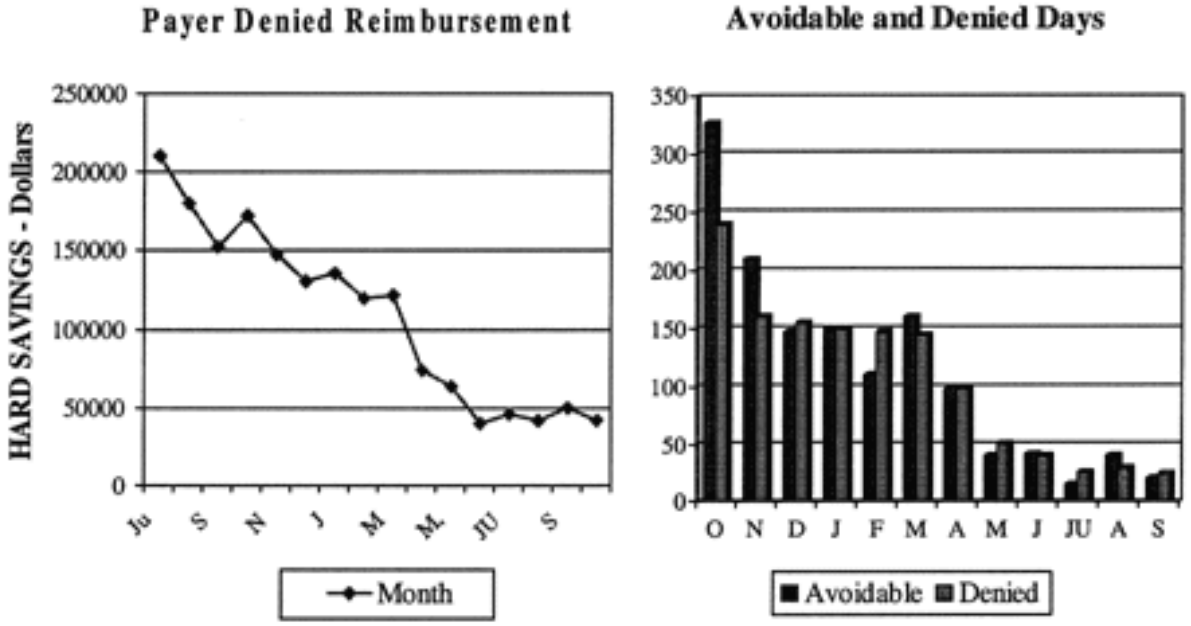
(Continued on page 173)

Severity Adjusted Resource Use for Top 3 Targeted DRGS at a Pennsylvania Hospital



Source: Phoenix Medical Management, Pompano Beach, FL.

CORRELATION BETWEEN AVOIDABLE DAYS AND DENIED REIMBURSEMENT AT A MARYLAND HOSPITAL



Source: Phoenix Medical Management, Pompano Beach, FL.

CRITICAL PATH NETWORK™

Use algorithm to treat abdominal pain

When a 52-year-old woman came to the emergency department (ED) at University of California at Irvine (UCI) Medical Center in Orange with severe abdominal pain, nausea, and a low-grade fever, staff were able to use a new abdominal pain pathway to streamline her care.

"The ED and waiting area were completely full, but her labs were returned before she ever reached the treatment area for further care," reports **Darlene Bradley**, RN, MSN, MAOM, CCRN, CEN, director of emergency/trauma services.

Based on those results, the woman was quickly diagnosed with pyelonephritis. "She received her fluids, pain control, and antibiotics, and was discharged from the ED soon after," Bradley says.

If the patient had remained in the waiting room, she would have experienced progressive illness and pain, Bradley says. "The pathway allowed her to receive treatment much earlier than she would have otherwise." **(See algorithm for Acute Abdominal Pain Adult — Male or Female, pp. 168-169.)**

> *"Patients often return to the ED because their complaints or symptoms have not resolved. In some cases, this may be attributed to the ineffectiveness of the prescribed antibiotic. With the pathway, return visits are less likely to occur."*

Here are some of the benefits of using the abdominal pain algorithm:

1. **Care is more consistent.**

Nurses are given a quarterly report on the use of the algorithm, including cost per discharge, resource utilization, and clinical indicators, says **Tania Bridgeman**, PhD, RN, the hospital's product line development manager. These data are used as a quality improvement tool for nursing, notes Bradley.

"The nurses enjoy hearing how many patients were identified in the abdominal pain program, how many had the pathway utilized, and what the outcomes of the usage were," she says.

Ensuring consistent care

The process ensures that care is consistent, says Bridgeman. "We look for patterns or trends in practice we need to address. If none are detected, we know that an established standard of care is being followed," she says.

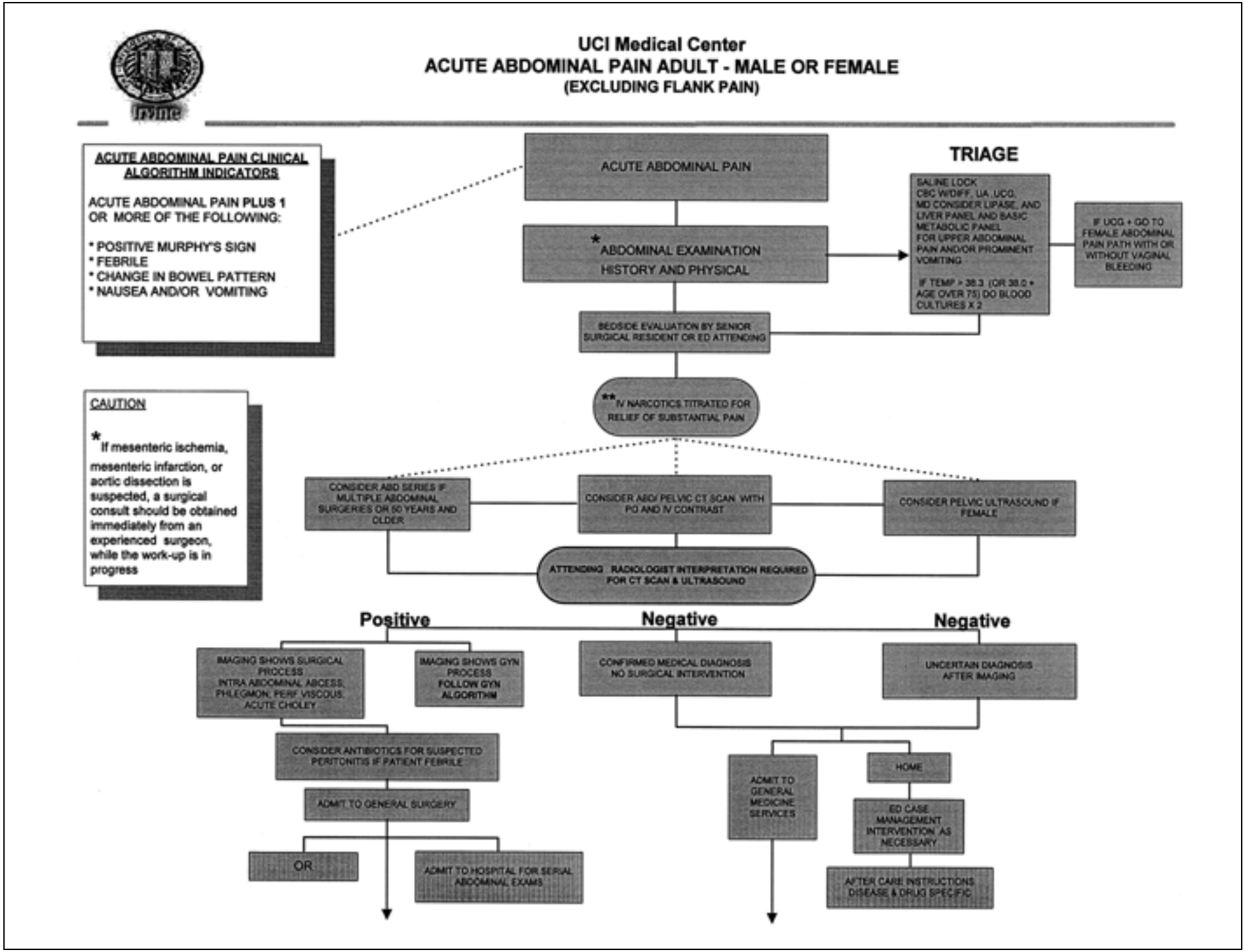
Quarterly reports determine the level of compliance, says Bradley. "The reports also maintain the high level of interest necessary for new methods of managing health care delivery," she adds.

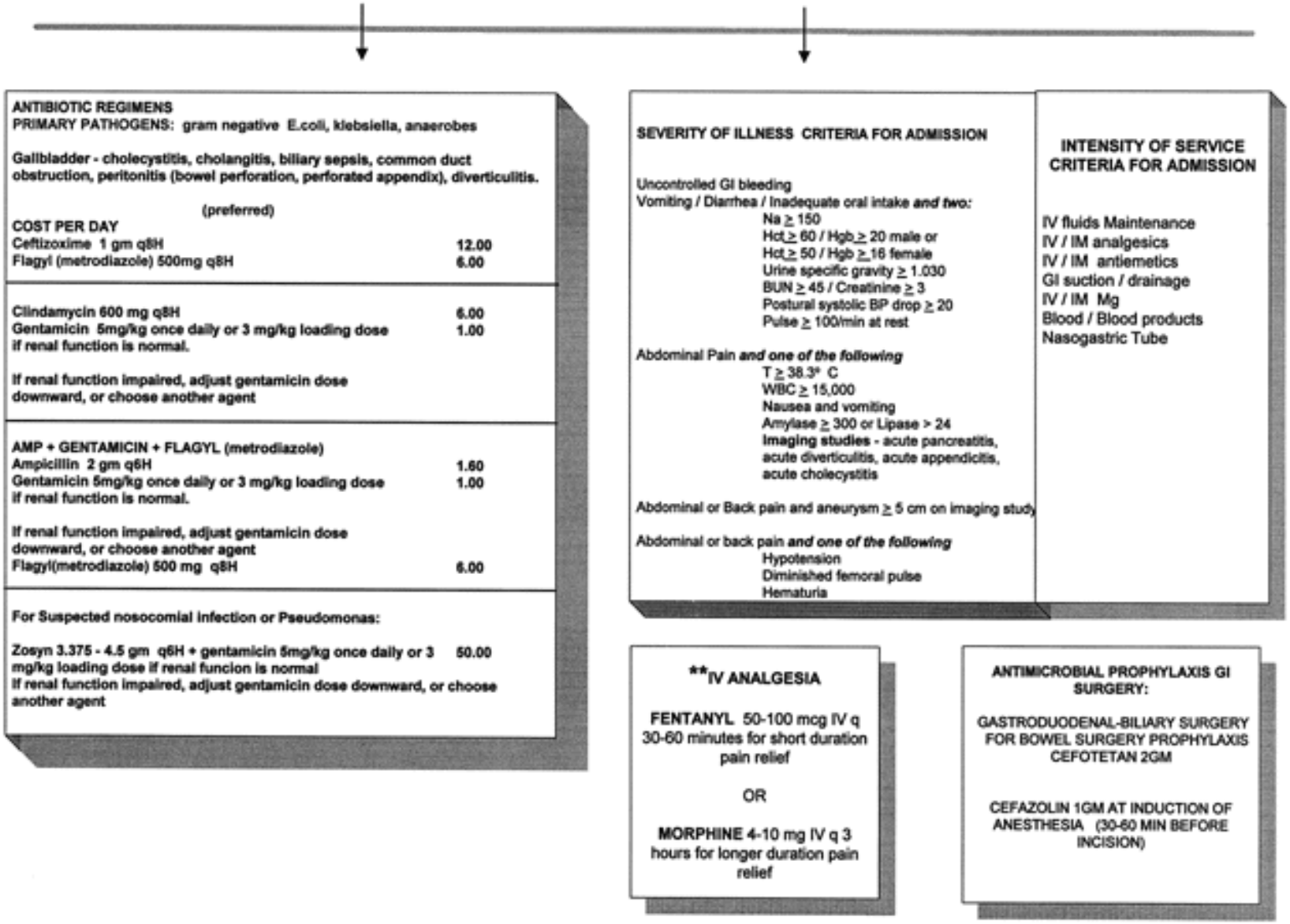
2. **There is a collaborative approach between nursing and medicine.**

Since the program was jointly developed, nurses and physicians have a mutual interest in the outcomes and the success of the program, says Bradley.

The pathway is a good learning tool, she notes. "Physicians and nurses develop an understanding of how to make a differential diagnosis, as well as the various indications for treatment," Bradley says.

(Continued on page 170)


UCI Medical Center
ACUTE ABDOMINAL PAIN ADULT - MALE OR FEMALE
(EXCLUDING FLANK PAIN)
ACUTE ABDOMINAL PAIN CLINICAL ALGORITHM INDICATORS
ACUTE ABDOMINAL PAIN PLUS 1 OR MORE OF THE FOLLOWING:
* POSITIVE MURPHY'S SIGN
* FEBRILE
* CHANGE IN BOWEL PATTERN
* NAUSEA AND/OR VOMITING
CAUTION
* If mesenteric ischemia, mesenteric infarction, or aortic dissection is suspected, a surgical consult should be obtained immediately from an experienced surgeon, while the work-up is in progress
ACUTE ABDOMINAL PAIN
TRIAGE
SALINE LOCK CBC W/DIFF, UA, UCG, MD CONSIDER LIPASE, AND LIVER PANEL AND BASIC METABOLIC PANEL FOR UPPER ABDOMINAL PAIN AND/OR PROMINENT VOMITING
IF TEMP > 38.3 (OR 38.0 + AGE OVER 75) DO BLOOD CULTURES X 2
IF UCG + GO TO FEMALE ABDOMINAL PAIN PATH WITH OR WITHOUT VAGINAL BLEEDING
* ABDOMINAL EXAMINATION HISTORY AND PHYSICAL
BEDSIDE EVALUATION BY SENIOR SURGICAL RESIDENT OR ED ATTENDING
** IV NARCOTICS TITRATED FOR RELIEF OF SUBSTANTIAL PAIN
CONSIDER ABD SERIES IF MULTIPLE ABDOMINAL SURGERIES OR 50 YEARS AND OLDER
CONSIDER ABD/ PELVIC CT SCAN WITH PO AND IV CONTRAST
CONSIDER PELVIC ULTRASOUND IF FEMALE
ATTENDING RADIOLOGIST INTERPRETATION REQUIRED FOR CT SCAN & ULTRASOUND
Positive
Negative
Negative
IMAGING SHOWS SURGICAL PROCESS INTRA ABDOMINAL ABCESS, PHLEGMON, PERF VISCOUS, ACUTE CHOLEY
IMAGING SHOWS GYN PROCESS FOLLOW GYN ALGORITHM
CONFIRMED MEDICAL DIAGNOSIS NO SURGICAL INTERVENTION
UNCERTAIN DIAGNOSIS AFTER IMAGING
CONSIDER ANTIBIOTICS FOR SUSPECTED PERITONITIS IF PATIENT FEBRILE
ADMIT TO GENERAL SURGERY
OR
ADMIT TO HOSPITAL FOR SERIAL ABDOMINAL EXAMS
ADMIT TO GENERAL MEDICINE SERVICES
HOME
ED CASE MANAGEMENT INTERVENTION AS NECESSARY
AFTER CARE INSTRUCTIONS DISEASE & DRUG SPECIFIC



Source for both charts: UCI Medical Center, Orange, CA.

(Continued from page 167)

The algorithm was developed using best-practice standards and evidence-based practice, particularly with prescribing practices, says Bradley.

"Physicians and nurses use the pathway to learn the value of order sets and the appropriate antibiotic orders and dosages for infectious diseases," she explains.

3. Length of stay is reduced.

With the pathway, patients receive treatment and evaluation procedures beginning at triage, says Bridgeman.

"If the patient cannot be moved immediately to the treatment area, at least the labs are already being processed so the physician can make a determination as to what's going on with the patient," she explains.

Bridgeman adds that this process has cut the patient's total length of stay from an average of 4.1 hours to 3.46 hours, a 16% decrease.

Because there is an associated physician order set, nurses can initiate the triage labs and tests as soon as the patient is admitted, Bridgeman points out. "They can remind physicians to utilize the order set."

The algorithm is enlarged and posted on the wall of the ED, she adds.

4. Costs are lower.

Bradley reports an average cost reduction of $100 per patient, an 11% average decrease in cost per case. The pathway ensures that antibiotics selected are low cost and that the labs and X-rays ordered are essential for the diagnosis of the patient, she explains.

"Without such a detailed pathway, providers often may order more labs or X-rays than is needed to make the diagnosis," she adds.

5. Return visits are reduced.

Bradley notes that the pathway includes a listing of antibiotics for primary pathogens: gram negatives, *E. coli*, *Klebsiella*, and anaerobes.

"Each drug has the associated costs per day, along with the preferred choices and alerts to renal problems and nosocomial infections," she says.

The goal is to prescribe the antibiotic that most likely would affect the infectious organism, she adds.

"Patients often return to the ED because their complaints or symptoms have not resolved. In some cases, this may be attributed to the ineffectiveness of the prescribed antibiotic," she says. "With the pathway, return visits are less likely to occur."

6. Patients express more satisfaction with their ED visit.

Earlier interventions are more satisfying to patients, says Bradley.

"The patient receives immediate education about the process and what will happen in their course of stay," she explains.

In the ED's customer satisfaction survey, patients often express a positive opinion about the process, according to Bradley.

"Patients comment about the rapid intervention they received, such as the labs being done much earlier in the process than would have been expected," she says.

[For more information about the abdominal pain algorithm, contact:

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*• **Tania Bridgeman**, PhD, RN, UCI Medical Center, Product Line Development, 200 S. Manchester, Suite 835, Route 163, Orange, CA 92868-3298. Telephone: (714) 456-3697. Fax: (714) 456-8968. E-mail: tbridgem @uci.edu.]* ■

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

PATIENT EDUCATION
QUARTERLY

On-line education, support is winning combination

Meet the needs of all patients

The on-line support group for cancer patients organized by the James Cancer Hospital and Solove Research Institute in Columbus, OH, is like any other support group that meets in person except that it is one dimensional, says **Pat Schmitt**, MA, CRC, program director for comprehensive oncology rehabilitation. The group meets once a month, has a facilitator, guest speaker, and handouts with more detailed information frequently available for participants to download. To participate, people contact the webmaster via e-mail to obtain a password and instructions before logging on at the designated time.

"One of the reasons we started the on-line group is because we realized that traditional support groups are not for everybody anymore. We were trying to very deliberately expand the menu of options that we were providing to our patients," says Schmitt, who acts as the group's facilitator.

To determine what people would want in an on-line support group the institute conducted a survey in the outpatient ambulatory area, which has a high volume of patients, so it's easy to collect data. Patients who were interested in trying an on-line support group said that they wanted it to be educational as well as supportive. Therefore, the project team decided the group should be professionally facilitated rather than set up as a bulletin board or open chat. They also determined that an expert on the featured topic should be invited as a guest speaker. "Because this is offered by our institution, we wanted to bring a level of clinical expertise to it," Schmitt says.

People can choose when they want to participate based on whether the topic being covered meets their specific personal issues. Those with a password are sent an e-mail reminder. The information about the support group and the monthly topic also is on the James Cancer Hospital web site. Some patients log onto the support group on a monthly basis because they like the contact with other people. Others like the anonymity of the Internet environment. Some of the topics covered, such as dealing with changes in sexuality and intimacy, work really well on-line, says Schmitt. "Some of the questions people wouldn't feel comfortable asking in person with a lot of other people around — they have no hesitation asking on-line."

Older adults are participating in the on-line support group, and the health care facility is pleased since this has been a patient group the hospital has had a hard time serving in the past. That's because older adults don't like to come back to the hospital in the evenings to access a class, clinic, or traditional support group, says Schmitt.

In addition, the on-line support group is one resource that the 30% to 40% of patients who live out of the area can take advantage of once they leave the hospital. It's convenient for chemotherapy patients who need to conserve their energy as well. The most people who have participated in the on-line support group at one time have been 12. The general attendance is between eight to 10 people with a few regulars and several one-time only participants, which fits with the support group's design. The cutoff point for the number of participants would be 15 because high numbers reduce the amount of time people actually have to communicate, says Schmitt.

To facilitate the communication process, Schmitt monitors the text, trying to ensure that people who ask questions receive a response and cutting off people when appropriate by typing something such as, "We have had many questions from Ian; let's hear from Sally." She often takes notes to keep track of who is participating.

Sometimes a participant will type in several questions in rapid succession, so Schmitt will select the question she thinks will be of interest to most people and then asks the guest speaker to answer it. If time permits the other questions are answered later.

Often the guest speaker needs help getting used to the on-line chat environment. Therefore, Schmitt has the physician, dietitian, or other member of the health care team who is speaking arrive 30 minutes early to practice. She will then spend about 20 minutes chatting via the computer with the guest speaker so that he or she can see how long it takes to type answers, how long it takes for entered text to show up on the screen, and what it is like to be reading and thinking of answers simultaneously.

To make sure the session runs smoothly, Schmitt will send e-mail messages to everyone who has a password asking them to submit their questions in advance. Then she will conduct an interview with the speaker for the first 20 minutes so that all the common questions are addressed. The physician or other guest speaker is given the questions in advance so that they can prepare brief answers. In this way, during the group session, all the participants aren't entering text at the same time barraging the speaker with a flood of questions that don't have a proper flow. Also, it cuts the amount of time when the screen is blank as the speaker types in the answers to questions.

"It is helpful to have as much structure as you can bring to the format because discussion goes really, really fast," says Schmitt. Once the speaker has had time to present the topic, Schmitt opens the discussion up for questions that pertain to information that has been covered.

While practice makes perfect, many challenges have had to be addressed in order for the on-line support group to run smoothly. For example, the firewall that protects the hospital's computer network system from hackers could not be removed to create the support group; therefore, the sessions take place off campus. The hospital had to contract with a company, and the group sessions are run from this site.

Another challenge has been finding enough generic topics to present to the general cancer group. Topics covered have included work-related issues, symptom management, and nutrition.

Also, people who participate are asking that the sessions be more frequent. "We are thinking about holding the sessions more than once a month. From the feedback we get from our participants it is too infrequent. If you are using an on-line modality on a frequent basis, a month seems like a really long time to go before you connect with people again," says Schmitt.

[For more information about facilitating an on-line support group, contact:

• ***Pat Schmitt**, MA, CRC, Program Director, Comprehensive Oncology Rehabilitation, James Cancer Hospital and Solove Research Institute, 300 W. 10th Ave., Columbus, OH 43210. E-mail: schmitt.one@osu.edu. Web: www.jamesline.com.]* ■

On-line support: Should you or shouldn't you?

Question: "Has your institution created any on-line support groups? If not, do you refer patients to existing on-line support groups? When referring to these support groups sponsored by hospitals or health care systems, how do you evaluate them? Have you had much interest in on-line support groups by patients? What are the advantages and disadvantages of going on-line for support?"

Answer: "We created an on-line version of each of our support groups," says **Deborah Pfaffenhauser**, RN, MSN, director of consumer health education at Bayhealth Medical Center in Dover, DE. The catalyst behind the on-line support groups was the desire to provide community services over the Internet. The groups are set up in bulletin-board fashion, where someone posts a question and others provide input. However, there has not been much traffic on any of them to date. To encourage their use, she had the facilitator of some of the regular sister support groups start a line of conversation, thinking that people may not want to post the first message, but the tactic did not help. This summer, she plans to do a marketing blitz to employees as well as the community to see if publicity increases traffic.

Currently, the on-line support groups have no moderators, but as traffic increases, Pfaffenhauser wants to have the appropriate educator monitor the site — the cancer educator would monitor the on-line cancer support groups.

Although USC/Norris Comprehensive Cancer Center and Hospital in Los Angeles does not sponsor on-line support groups, patients are referred to them. "In evaluating which groups we refer to, we look at the organization that the group is sponsored by and who the facilitator is. We only refer to groups that are led by a professional," says **Carol Marcusen**, LCSW, director of social services and patient education. Patients have received invalid information from chat rooms or discussion groups that were not led by professionals, she adds. ■

(Continued from page 165)

In terms of practical application, that requires a shift in behaviors and even appearance. For example, wearing lab coats out on the floor lends a clinical appearance, she says. "Perhaps we need to focus our actions and our behaviors in more of a business alignment and ditch the lab coats."

Perhaps the most fundamental change that must occur is a shift in day-to-day activities, according to Ramey. "We are not going to be able to round with our physicians. We are not going to be able to meet with our patients and families."

"The idealistic model of caring only about the patient is gone," Ramey adds. "Case managers prove their value to the team with numbers, not feelings." Collecting data on avoidable days can demonstrate a measurable outcome and lead to organizational change, she says.

On the other hand, if the organization is not going to do anything with that information, don't collect it. "Before you throw it out, take a look at what that information might be saying," she points out. The chances are that it points to numerous barriers that exist within your organization. "I am betting that those who get denied-day information can correlate their avoidable days directly with their denied days," she explains. "They can predict when they are going to happen."

According to Daniels, a popular myth is that length of stay is an accurate barometer of effective case management. "Don't be fooled by it. You must do cost per case."

By decreasing length of stay, providers often cram the same number of services into a shorter period of time, Ramey says. "We got more efficient in providing services that may not have needed to be done in the acute care setting in the first place."

What case managers must do is show a return on health care organizations' investments. "Organizations put a lot of money in their case management program, and what you want to be able to do is demonstrate a return on that investment," says Daniels. "That will generate even more investment." ■

Case managers emerge as focal point of unique team

As hospitalist teams continue to emerge, one potential team member is often omitted: the case manager. One hospital and its partners managed to solve that problem, however, by establishing case managers as integral team members and ultimately making them the leader of daily rounds.

According to **Tracy Figueredo**, RN, BSN, the group that emerged was born out of three separate entities — Kaiser-Permanente, Carolina Permanente, and Rex Hospital — which joined forces to establish the hospitalist team. "We wanted to provide hospitalist services, and we needed to bring together all three of these entities to accomplish that," she explains.

Rex Hospital is a 400-bed acute care hospital in Raleigh, NC. Carolina Permanente Medical Group was a group practice in Raleigh that worked exclusively for Kaiser-Permanente and was responsible for 65,000 commercial lives. The group was made up of 60 practitioners including physicians, nurse practitioners, health care extenders, and physician assistants. It also included internists, pediatric physicians, OB-GYNs, dermatologists, and other specialists.

Under the hospitalist team design, case managers worked for the payer and the hospital but were based at the hospital, where they worked exclusively with a group of physicians on the hospitalist team. Importantly, hospitalists were rotated to provide continuous coverage. "There was a physician there 24 hours a day, which was somewhat unique," Figueredo says.

The model also included social workers. According to Figueredo, while some people now advocate eliminating social workers, that is not always a sound practice because case managers typically are RNs who lack practical social work experience. Rather than dedicate social workers to the team, however, they were made available on an as-needed basis.

According to Figueredo, the hospitalist team saw a variety of patients but focused on adult medicine service lines. It also acted as a consultant for specialty services. In some cases, the team also saw emergency department cases and unassigned primary care patients.

Many physicians in the community already were eager for more information about what was happening to their patients while they were in the hospital as well as after they were discharged, she explains. "The physicians needed to interact with the primary care physician, and they also needed to interact with the specialist."

The hospitalist team provided that mechanism.

It also helped establish itself as a team concept, says Figueredo. "We are all a team, and to be a team, we need to sit together in the same room and talk about the patient." The other team member was the medical director who was given responsibility for oversight of hospitalist physicians and their clinical practice and also was tasked with overseeing movement of the patient along the continuum and physician education rather than micromanaging clinical treatment, she adds.

According to Figueredo, case managers had an extensive list of responsibilities, including the overall care of the patient, utilization review and utilization management activities, discharge planning, and quality screening.

Utilization review and utilization management in this scenario meant concurrent review, says Figueredo. That included a determination of why patients were admitted and the severity of illness, as well as the level of care they were receiving. Case managers also performed emergency department triage for admissions to help coordinate services in cases where a physician might otherwise admit patients if no alternative was immediately provided.

The case manager also was tasked with coordinating and orchestrating the discharge plan, which started on the first day and used a multidisciplinary approach. If patients were newly diagnosed with diabetes, that meant linking them with community resources such as a diabetes educator. If they had a new ostomy, it meant consulting an ostomy nurse early in the process. If those patients were going to receive home health services or skilled nursing, it meant contacting the necessary vendors.

The case manager also monitored readmissions and tracked whether they had occurred because of a clinical problem, a systems problem, or a compliance problem. They also performed follow-up appointment calls, an item that is frequently overlooked as patient load increases, Figueredo says.

According to Figueredo, team rounds were critical to the hospitalist team approach. All the components of the team participated in the morning rounds, including the hospitalist team physicians and the medical director. If social workers were required, they participated as well.

"We even had an exclusive relationship with a skilled nursing facility that wanted to partner with us," she adds. That often led to discharging patients to skilled nursing earlier in the process because physicians immediately became aware of the services the skilled nursing facility could provide. While the hospital was initially concerned about confidentiality issues, those concerns were successfully addressed, she explains.

CE questions

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.

17. At Vanderbilt University Medical in Nashville, TN, the standard for discharge planning is for all patients to be screened and a plan developed with how many hours of admission?
    A. 24
    B. 36
    C. 48
    D. 72

18. Which of the following is not one of the three reasons for variation among physicians' practice patterns for the same type of patient, according to Stefani Daniels, RN, MSHA, managing partner of Phoenix Medical Management?
    A. financial
    B. where the physician went to school
    C. how many years the physician has been practicing
    D. where the physician did his or her residency

19. According to Stefani Daniels, despite the impact of managed care, what percentage of admissions come from direct physician referrals?
    A. 45%
    B. 60%
    C. 75%
    D. 90%

20. At Rex Hospital in Raleigh, NC, hospitalist physicians were rotated to provide how many hours of coverage per day?
    A. six
    B. 12
    C. 18
    D. 24

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At the conclusion of this teleconference, participants will be able to list ways in which they can help their hospital comply with EMTALA.

Every case was discussed during rounds with an immediate emphasis placed on the discharge plan. Short afternoon rounds for problem cases also were performed, in part to address any concerns that might be raised in the interval by a family member or other party.

Initially, the physician was the leader of the team, Figueredo says. Not surprisingly, however, physicians were almost exclusively interested in medical issues. "The physicians were too clinically focused. We quickly decided that strategy

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Editorial Questions

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

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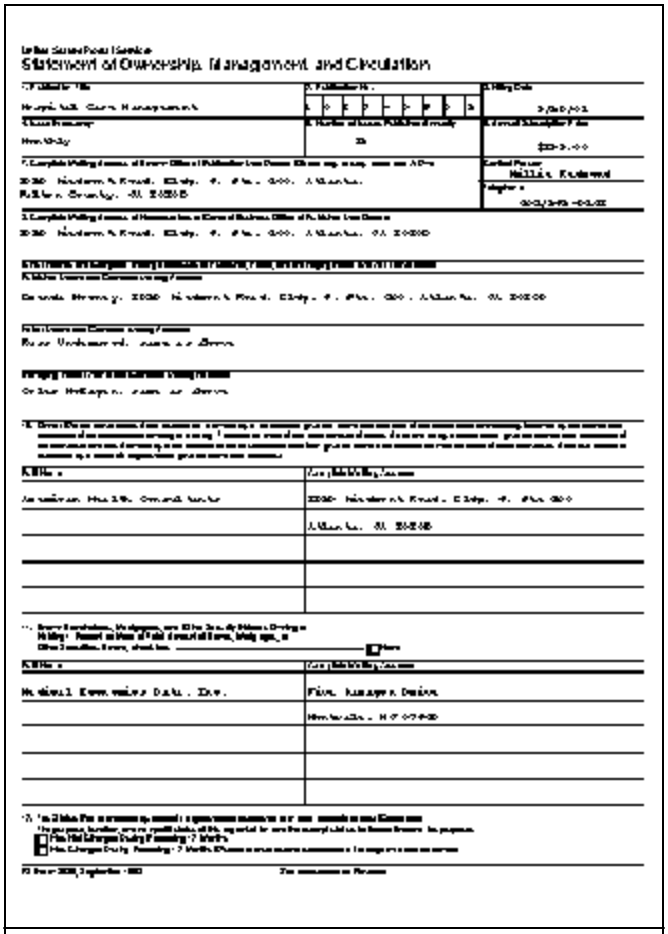
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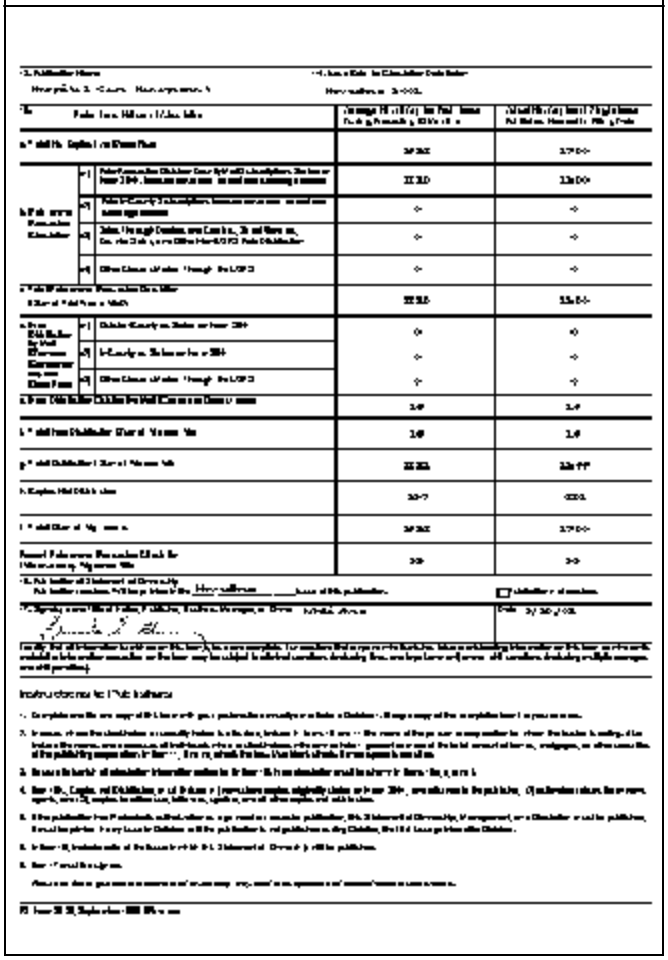


was not going to work." The medical director was viewed as a poor alternative because he was not dedicated to the team, she adds. Instead, case managers became responsible for the overall plan. "We thought the case manager was the best person to lead the team. Once we did that, it was interesting how quickly the hospitalist physicians bought into that concept."

One of the most important outcomes of the team approach was total patient care coordination, she says. "We now had a system where the social worker, the case manager, and the physicians were all working on the same team to get the job done." Physicians no longer were blamed for denials, and when readmissions did occur, both physicians and case managers became more actively involved in establishing preventive plans, she explains.

This provided continuity of care not often found when a patient is admitted by a primary care practice that includes eight or 10 partners, Figueredo says. "They often can't remember what the last person did, and nobody remembers what the case managers did." ■

2001 SALARY SURVEY RESULTS

HOSPITAL CASE MANAGEMENT™

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

How do your salary and benefits stack up against others'?

Most respondents earn $60,000 to $80,000

Whatever one does for a living, we all want to know what our colleagues around the country are making so we can gauge just how fairly we're being compensated for our efforts.

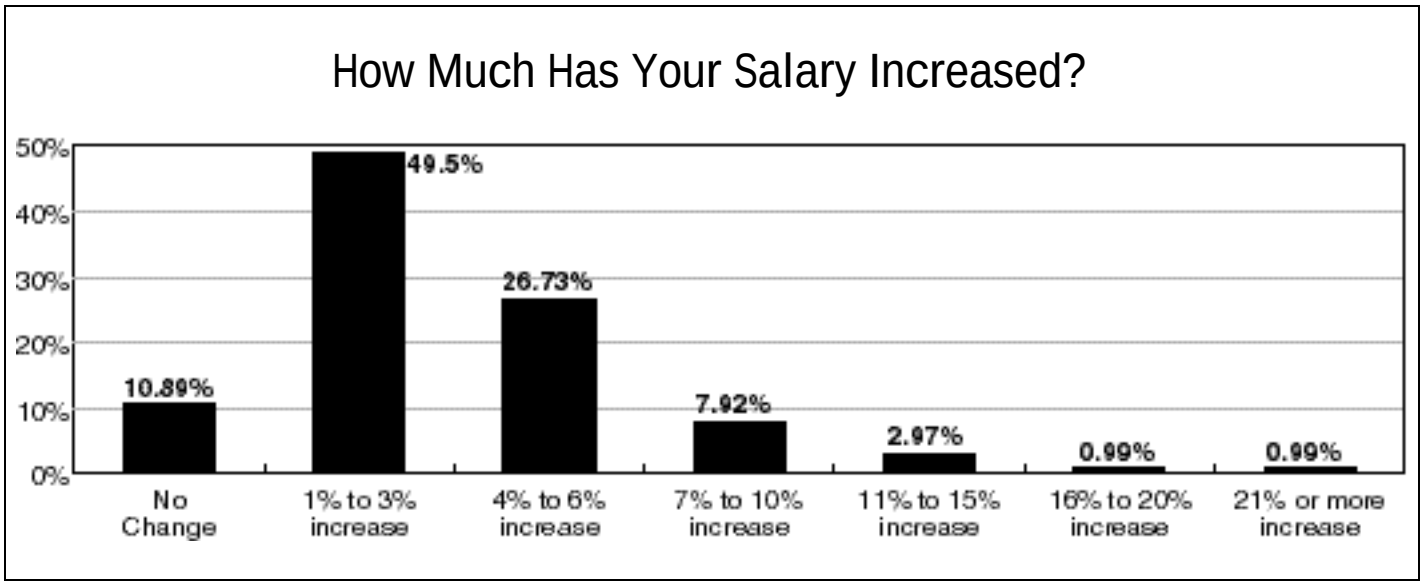
Hospital Case Management's annual salary survey was mailed to readers along with the April 2001 issue. Questionnaires, response forms, and postage-paid envelopes were inserted into that newsletter.

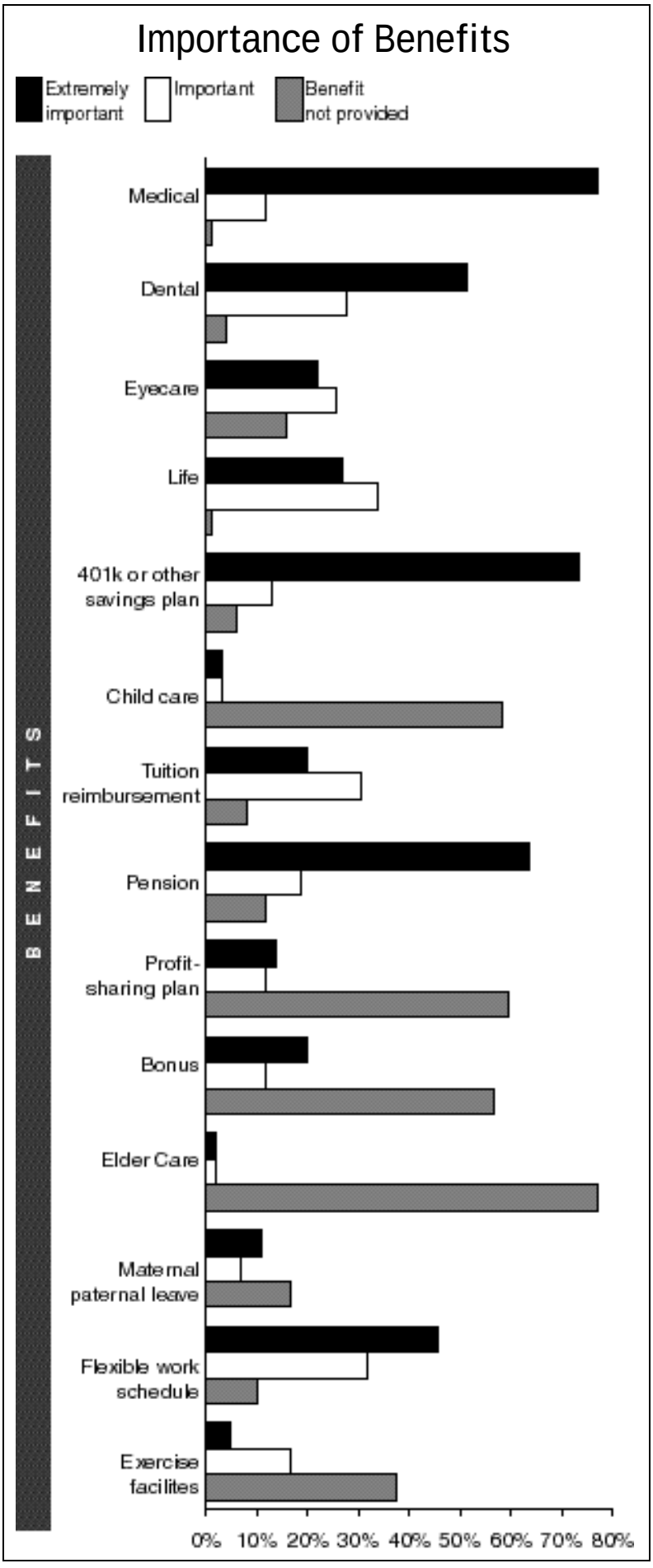
The responses contained no names unless readers wished to include them along with special comments. The surveys were compiled and analyzed by American Health Consultants in Atlanta, publisher of *HCM*.

We had a solid response — our thanks to all the readers who responded. We've tabulated some results here that we think are of the most interest. What you learn may cause you to take a second look at your situation, but bear in mind that each position is different, and pay scales depend enormously upon geographical location, facility size, your experience level, and other specifics.

Getting right to the point

Most *HCM* readers report annual earnings of somewhere between $50,000 and $80,000. **(See middle chart, p. 3)** Almost one-quarter of respondents (23.76%) earned between $60,000 and





$69,000. An identical percentage earned between $70,000 and $79,999. Another 22.8% earned between $50,000 and $59,999, and 12.8% earned between $40,000 and $49,999. Less than 1% earned less than $30,000, and about 3% earned more than $100,000.

Working more than 40-hour weeks

Most (59.4%) respondents to the survey work between 41 and 50 hours per week, although 32.67% work even longer hours.

About half received a salary increase of between 1% and 3%. Another 27% had a salary increase of between 4% and 6%. (**See chart, p. 1.)**

The greatest percentage of respondents — 24.75% — have been working in hospital case management for between four and six years. Another 20% have been working in the field between one and three years, while only 15% have worked in case management for 16 years or more. **(See bottom chart, p. 3.)**

Meanwhile, more than half (53.47%) of our respondents have been working in health care for 25 years or more. The most common titles are director of case management (51.5%), case manager (20.8%), utilization manager (8.9%), and quality manager (5.9%).

About 95% of our *HCM* reader respondents are women. Forty-seven percent are in their forties, but there are a good number in their thirties (14.9%) and fifties (34.9%) as well. About 45.5% have attained master's degrees, and another 35.7% have bachelor's. Two percent have doctorates.

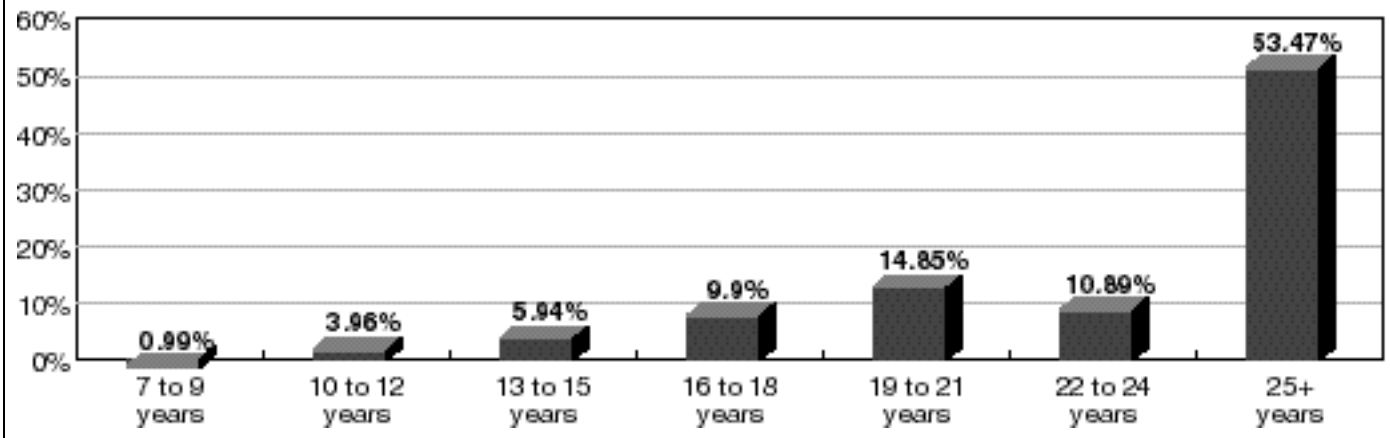
When it comes to the number of people supervised, responses ranged widely. While 22% of survey participants supervise six or fewer people, an equal number supervise between 21 and 40 people. About 5% supervise 61 people or more.

Medical coverage called most important

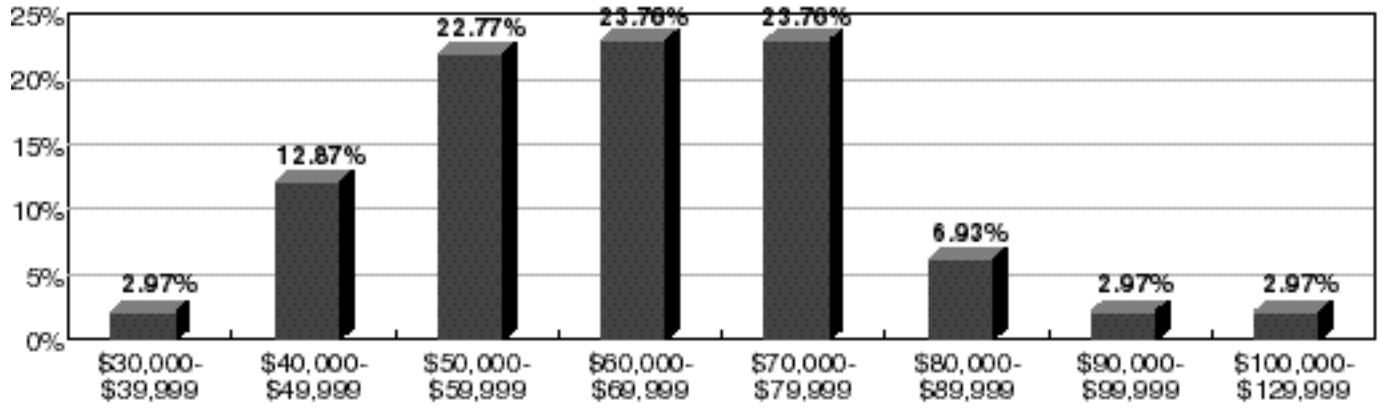
As far as job benefits go, medical coverage ranks highest among respondents' concerns (77.2% consider it "extremely important") with 401K or other savings plan coming in a close second at 73.3%. **(See chart on left.)**

About 63.4% rated pension plans as extremely important, while dental coverage came in fourth with 51.5%. Next was the

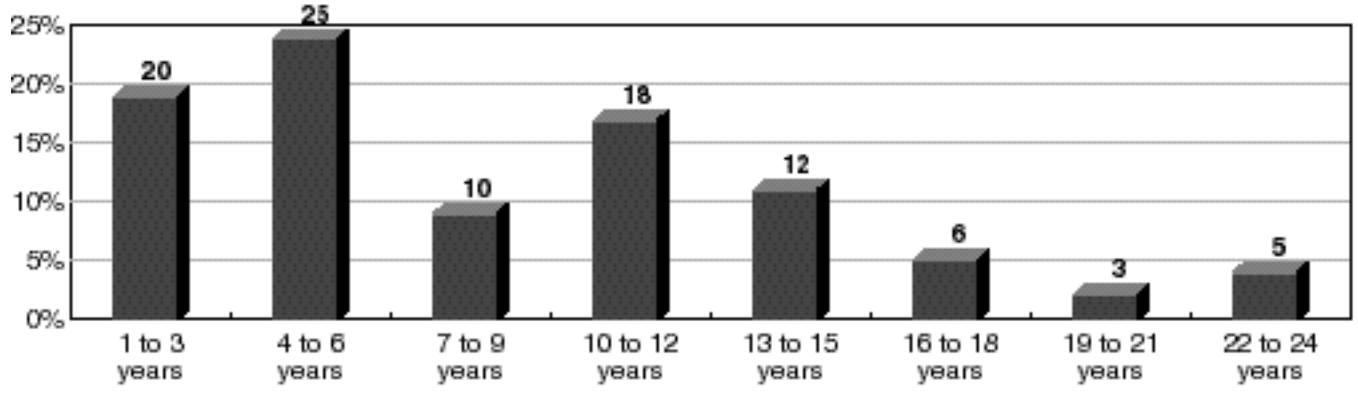
How Long Have You Worked in Health Care?



What Is Your Gross Annual Income?



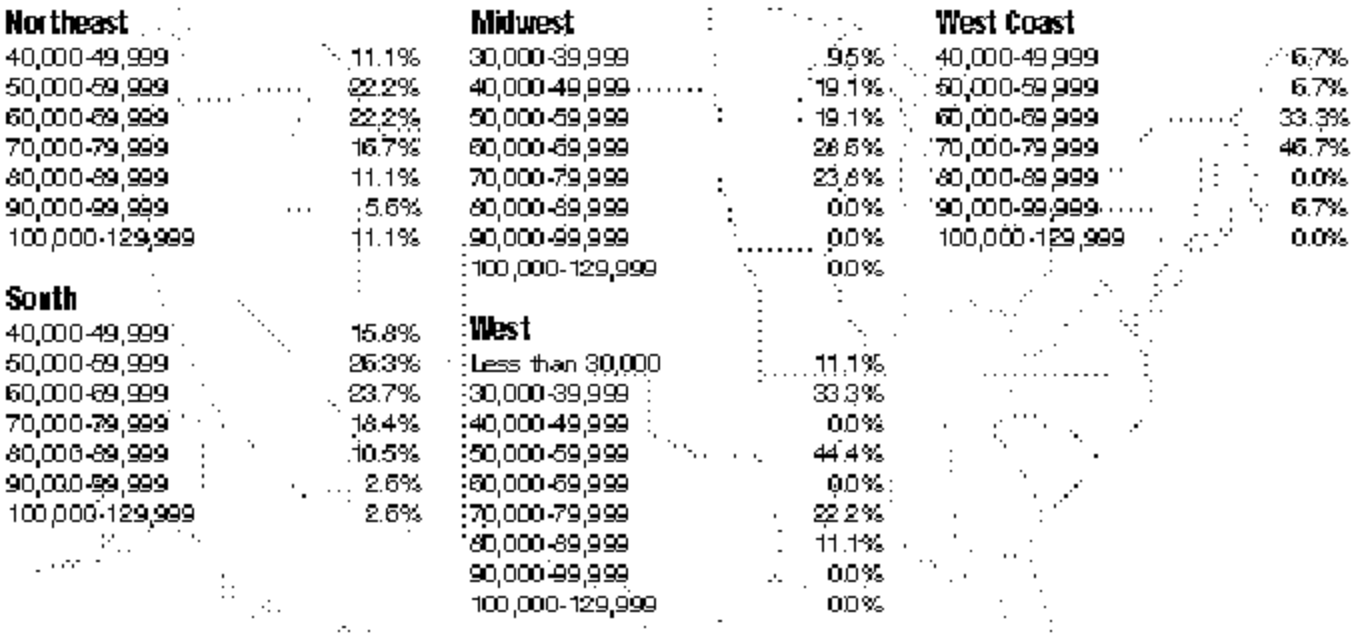
How Long Have You Worked in Same or Similar Positions?



less tangible benefit of enjoying the freedom to choose one's own schedule — 45.5% said that was "extremely important."

Least valued among the benefits we asked about were elder care (2%), child care (3%), and exercise facilities (4.9%).

Salary Ranges by Region



Northeast	
40,000-49,999	11.1%
50,000-59,999	22.2%
60,000-69,999	22.2%
70,000-79,999	16.7%
80,000-89,999	11.1%
90,000-99,999	5.6%
100,000-129,999	11.1%

South	
40,000-49,999	15.8%
50,000-59,999	26.3%
60,000-69,999	23.7%
70,000-79,999	18.4%
80,000-89,999	10.5%
90,000-99,999	2.6%
100,000-129,999	2.6%

Midwest	
30,000-39,999	9.5%
40,000-49,999	19.1%
50,000-59,999	19.1%
60,000-69,999	28.6%
70,000-79,999	23.8%
80,000-89,999	0.0%
90,000-99,999	0.0%
100,000-129,999	0.0%

West	
Less than 30,000	11.1%
30,000-39,999	33.3%
40,000-49,999	0.0%
50,000-59,999	44.4%
60,000-69,999	0.0%
70,000-79,999	22.2%
80,000-89,999	11.1%
90,000-99,999	0.0%
100,000-129,999	0.0%

West Coast	
40,000-49,999	6.7%
50,000-59,999	6.7%
60,000-69,999	33.3%
70,000-79,999	46.7%
80,000-89,999	0.0%
90,000-99,999	6.7%
100,000-129,999	0.0%

A full 66.3% of our respondents said their contribution to the cost of medical benefits had increased over the past year.

About 20% saw no change, and only about 3% had their contributions decrease. Seven percent don't receive medical benefits, and 4% don't contribute to their plan.

More than a third (37.6%) of *HCM's* readers who responded to the survey come from the southern United States, while 20.8% hail from the north-central states running from Ohio on the east to the bread-basket states on the west.

More than a third in medium-size community

About 18% of our survey participants live in the Northeast, and 23.8% are from the West or West Coast. About 36% come from hospitals in what they describe as medium-size communities; approximately 24% come from urban settings, 16% come from suburban settings, and 24% are from rural areas.

Most — 71.3% — of salary survey respondents work in nonprofit institutions, and 17.8% work in for-profit organizations.

About 8% of survey participants work for state or county government facilities, and only 3% work in either federal facilities or academic institutions.

A high percentage of our respondents — 24.8% — work in hospitals with between 101 and 200 beds. The next largest group — 22.8% — work in hospitals with between 201 and 300 beds. Another 19.8% work in hospitals with fewer than 100 beds, and 8.9% work in hospitals with 500 beds or more. About 3% of respondents don't work in a hospital setting.

What about turnover?

In answer to a question regarding hiring new employees or turnover in facilities and case management departments, 45.5% had seen an increase in the number of employees, 16.8% saw a decrease, and 37.6% saw no change over the past 12 months. ■