AMERICAN HEALTH CONSULTANTS

HOSPITAL CASE MANAGEMENT™

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

IN THIS ISSUE

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Case management models, not staffing formulas, dictate caseload

Variations in functions make benchmarking difficult

Case managers often attempt to benchmark caseloads, but variation in the functions case managers perform can make it difficult to come up with reliable numbers. "It is a difficult problem, because what case managers do in one facility is different from what they do in another," says **Patrice Spath**, ART, BA, president of Brown-Spath & Associates, a health care quality consulting firm based in Forest Grove, OR. "When you try to develop caseload ratios, you often end up with apples and oranges."

For example, some case managers perform utilization review and correspond with insurance companies, while others have separate utilization review teams that perform those tasks. "That is probably one of the most significant differences in terms of caseload," Spath says. When case managers don't perform these tasks, they have more time to manage cases, she says. On the other hand, when the case manager does perform utilization review, it can minimize duplication. For example, two people may be looking at the chart and trying to find the same pieces of information.

While there are pros and cons to each approach, Spath says she leans toward having case managers focus on the clinical tasks they are trained to do and use medical records professionals such as utilization managers to review charts, collect data, and make phone calls.

Whatever the case, it is important to remember that you can't benchmark effectively unless you know what case managers do, Spath says. If it turns out that a limited number of case managers are responsible for a large number of patients, it may be necessary to transfer some of their responsibilities to give them more time on clinical aspects.

"Benchmarks are helpful in a general sense in that they give you a place to start, but regardless of the hospital or setting, you have to look at everything, from the care management process to the staff activities to the organization structure, and to the optimum outcome goals," says **Julia Rieve**, president of CQI Healthcare Management Consulting in San Diego.

According to Rieve, redesigning a hospital case management program begins with evaluating the duties of the full-time case management and support staffs and identifying the case management model that facility managers are considering. It is not uncommon to find case managers saddled with clerical tasks for which they are overqualified and overpaid, she says. "I want to see if there are duties that can be redirected to support staff so that case managers can put more focus on clinical responsibilities and possibly increase the number of patients that can be handled," Rieve says. "About 80% of the time, I find case managers who are responsible for tasks beyond clinical duties."

The patient load should decrease if case managers are responsible for tasks beyond clinical care, including utilization review, discharge planning, or DRG optimization, she says. In an acute care facility where the average length of stay is about six to seven days, a case manager generally should handle fewer cases to maximize care coordination efforts, Rieve says.

Maryellen Reilly, MS, MT, director of clinical resource management and social work at the University of Pennsylvania Medical Center in Philadelphia, says that caseload depends on several factors. One major variable is the percentage of managed care penetration, because that often will dictate the size and function of the utilization management program that is required.

In fact, one hospital was able to eliminate all of the utilization management nurses for this reason, she says. "They have no managed care, so they don't have to talk to any of the third-party payers." Even under that scenario, Reilly says she would rather maintain the utilization management function in another department. Regardless, it demonstrates the dramatic difference between a highly penetrated market and a market where there is no managed care, she says.

"If you have no utilization management function per se in your organization, then the caseload per case manager would be very different because essentially they would be looking at issues around the continuum of care and doing the discharge planning," she explains. "They would not have the whole utilization management function."

Another factor that affects caseload is the design of the program, Reilly says. For example, she has managed programs where the case manager has responsibility for the full continuum of care, she says. "They do utilization review and quality monitoring, and they look for risk management issues as well as all the discharge planning."

On the other hand, Reilly says she also has managed other models where she has had a split nurse and social work function. Under that model, the nurse does utilization management and discharge planning to home, including setting up home care, durable medical equipment, and other services, and social workers do the more complicated discharge planning, such as placement to a skilled nursing facility or establishing contact with the community agencies.

"They are two very different roles," Reilly explains. In the first model, the caseload has to be much smaller. If the nurse case managers are supported by social work, then they essentially are removed as soon as a nursing home placement or a skilled placement is identified. "That person's caseload can be much higher," she says.

Yet a third model would have nurses perform utilization management and social workers perform all of the discharge planning, including home care. Alternatively, Reilly says, nurses can perform utilization management, social workers can do discharge planning to placement, and discharge planning nurses can do all the home care.

"You can't compare those three models [in terms of caseloads]," she says. "It would be comparing apples and oranges."

However, if the same functions do exist, you can make some comparisons, Reilly says. The

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most general rule-of-thumb ratio would be 1:20 or 1:25, she adds. "But if the case managers are only doing utilization management, you could go up to 1:60."

According to Reilly, another important factor is how involved case managers are in the reimbursement function. For example, if they call the third-party payer or manage the denial and appeal process, that department will require a lot of resources to maintain the requisite staff.

"There is a lot of clear evidence out there that suggests if you are not keeping that department well staffed and watching your vacancies, you can lose inordinate amounts of revenue. If you don't call the payer and get the day approved, you don't get paid for the day. It is very simple. If you are running a system that is reimbursed mostly on DRGs and you are not managing your length of stay, then you are not securing revenue sufficiently related to your DRGs," she adds.

Three-tiered system

Some hospitals have designed a three-tiered system in which bedside staff manage day-to-day aspects of a patient's care. The second level involves patients who require more in the way of discharge planning and financial analysis, while a third level addresses more serious cases that involve multiple resources.

Reilly says her facility uses such a three-tiered system. "It is very straightforward, and it is all designed around the patient's discharge planning needs." For example, if a 35-year-old patient requiring wound care has support at home and does not require home care, the primary care nurse can finalize the discharge plan. "There is nothing to set up because the patient is not getting services at home," she says.

The next level may be patients who require wound care and physical therapy as well as antibiotics. If patients can receive the resources in their home, the center has a clinical resource coordinator, who is a nurse, set up that care.

If patients' needs become even more complicated and they cannot return home until they receive rehab therapy, that means contacting the external agencies and transferring insurance information and financial information, Reilly says. "That is the most complex form of discharge planning, and that is performed by social workers."

Yet another model assigns case managers to specific units such as the cardiac unit where case managers are specifically trained for those patients.

Lynn Eastes, RN, MS, ACNP, trauma case manager at Oregon Health & Science University in Portland, says that between 15 and 17 patients is a reasonable caseload in this scenario.

"If you ask 15 different people their definition of case management, every answer will be different," Eastes warns. Even some specialty case managers in her facility have a somewhat different focus when it comes to discharge planning and utilization review, she adds.

"My definition of case management is fairly comprehensive," Eastes says. It includes working with attending physicians to reduce variability and making sure that patients who fit a certain protocol are placed in that protocol, she adds. "We also do discharge planning and utilization review." Eastes says her facility made the determination years ago that, with more than 17 patients, it is impossible to accomplish all those tasks with every patient. "Under that model, anything over that becomes crisis management."

Eastes' reasoning is fairly simple. "I have nothing scientific to base that on. But if you spend 30 minutes with each patient, it basically eats up your entire day."

Rieve agrees that if the model is specialty-based, the rule of thumb is about 18 patients per case manager. However, on the surgery unit, the number could reach as high as 28, since many hospitals now have clinical paths for the more common surgical procedures, which reduces the amount of time a case manager must be involved daily. Hospital medical units generally require lower caseloads, usually 15 to 20 patients, because medical cases require more daily attention from the case managers.

Case managers working in hospital mental health units generally can manage up to 25 patients, because they usually work with social workers who handle discharge planning, Rieve says. On the other hand, a health plan or internal workers' compensation case manager sometimes can have up to 150 patients on an active caseload, because some cases are active for two or more years and the case manager is not dealing with each case daily.

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Hospital quantifies workload and caseload

If no case manager is working weekends, there is the potential to have an increased workload on Mondays and Fridays in preparation for a well-coordinated discharge from hospital as well as screening new patients for case management needs, says **Lisa Zerull**, MS, RN, program director at Valley Health System in Winchester, VA.

"Even within one acute care facility, you will find that caseloads will vary from service to service because the needs of patients will vary," Zerull says. She argues that more staff reviewing the chart often translates into decreased efficiency because of duplication. "Also, the patients are confused about who is truly responsible for coordinating their care," she says.

According to Zerull, the patient and physician preference is to have a clinically focused case manager available on a given unit or service because it provides continuity of care. "If the case managers are required to work in an office using the phone or computer to negotiate coverage for a patient, they are not available to patients and staff in the clinical area."

The architectural layout of a unit also can be an important consideration, she says. "At Winchester Medical Center, the smaller units have 20 beds and the larger units have 40 beds. It seemed a natural choice to have one case manager for up to 20 beds."

When her facility addressed these questions, Zerull says that some case managers thought they could handle many more patients then others. "We actually did a time-engineered study," she reports. "We found great differences between what a case manager on a renal unit does from another case manager on a medical cardiac unit."

The study also looked at other responsibilities of case managers that affect potential caseload. For example. In one instance, a case manager was serving on as many as eight subcommittees.

Zerull has designed a reference table that she says came out of her system asking those questions. It can be used when defining the case manager responsibilities and in determining caseloads. **(See table, below.)**

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Workload/Caseload Reference Table

WORKLOAD (responsibilities)	CASELOAD (# of patients)
⇑ Workload = ⇓ Caseload	⇑ Workload = ⇓ Caseload
⇑ Intensity of services = ⇑ Workload	⇑ Workload = ⇓ Caseload
⇑ Complexity of patient needs = ⇑ Workload (e.g., older adult or chronically ill population may have physical, financial, and psychosocial needs)	⇑ Complexity of patient needs = ⇓ Caseload
Surgical population = ⇓ Workload (most surgical populations follow a predictable progression toward health; there may be some exceptions such as with transplants)	Surgical population = ⇑ Caseload
⇓ LOS = ⇑ Workload (more to do in shorter length of time)	⇓ LOS = ⇓ Caseload
⇓ RN staffing = ⇑ Workload (case manager may be expected to provide patient care or take on charge nurse role)	⇓ RN staffing = ⇓ Caseload
⇑ System responsibilities (i.e., performance improvement or other hospital committees) = ⇑ Workload	⇑ System responsibilities = ⇓ Caseload
⇓ Social work support = ⇑ RN case manager workload (i.e., discharge planning and LTC placement)	⇓ Social work support = ⇓ Caseload

Knowledge of home care key for case managers

Managing physician interactions is key

Home care may be a vital component of the health care continuum for case managers. But that doesn't mean that home care is vital to physicians, despite the important role they play in this area. "It's a real quandary," says veteran home care consultant **Elizabeth Hogue**, JD, in Burtonsville, MD, who says that many case managers lack a real understanding of this area.

If the case manager is trying to get a patient referred for home care or get a particularly difficult and complex patient cared for — such as a chronic obstructive pulmonary disease patient or a congestive heart failure patient — one of the things he or she has to manage is physicians and physician interaction, says **Constance Row**, executive director of the American Academy of Home Care Physicians (AAHCP) in Edgewood, MD.

According to a recent study by the Health and Human Services' Office of Inspector General (OIG), physicians are heavily involved in identifying the specific home health services their patients need. More than half say they work with hospital staff and home health agencies to determine the services patients will receive. Many also are involved in finalizing the initial plan of care.

At the same time, the OIG reports that physicians have a limited knowledge of key Medicare rules regarding home health and are very uncomfortable with the new prospective payment system (PPS). While 83% of physicians know that Medicare expects them to ensure that only medically necessary services are on the plan of care, only 48% say they are able to accomplish that.

"Not only is it difficult to get doctors to devote the time it deserves, but even when physicians say they understand home health, they often do not," Hogue says. Instead, doctors often rely on others to help them understand the eligibility criteria on a case-by-case basis.

Notably, doctors report that hospital staff, such as discharge planners, are by far the most important source of information and guidance on home health (76%). Another 55% seek guidance from home health agencies. However, very few rely on guidance from Medicare (11%) or periodicals (16%).

That makes it imperative for case managers to create opportunities to educate physicians about home health, Hogue says. There is often a disconnect between the very real need for physician understanding of home health and the mechanisms available for educating them, she adds.

Worse yet, the variety of tools that typically are used often, such as meetings of medical staff, do not work very well. "The only thing that works is one-on-one interaction," she asserts. That means case managers must use every opportunity to create those conditions.

Physicians must know the answers to the most frequently asked questions, Row says. Those are: What am I supposed to do and how am I supposed to do it? How is this the same or different from the way it was prior to PPS? In addition, she says, there are typical fact situations that doctors must be familiar with.

"If case managers run into a situation where physicians do not know or are resistant to getting involved with home health agencies, the only way to overcome that is to know what they need to know to do to get them there," Row says.

If physicians want a primer in this area, the AAHCP has a booklet, *Making Home Care Work in Your Practice*. "If case managers are able to use that information in answering physician questions, they probably will be doing as much as they can do," Row says. (*To order the booklet, go to www.aahcp.org.*)

According to Hogue, the real problem runs even deeper. She says many case managers often have viewed home care as a stepchild. Under cost-based reimbursement, the only thing case managers simply had to do to place a patient in home care was call an agency.

As a result, they never had to learn about eligibility criteria. "We almost have a whole additional group of people who need to be educated as well," she contends.

The way to begin an education process for case managers is to have credible providers come in and sit down to explain eligibility criteria for various payer sources, Hogue says. "That is where I would start if I were a case manager," she says.

That is often easier to accomplish then bringing physicians to the table. "We have had better luck with that then we have had with doctors," she says. "Case managers are much more amenable to sitting down and spending the necessary time on this issue."

According to Hogue, an understanding of home health is becoming increasingly important for case managers because some health policy

analysts are beginning to develop a model of community-based health care that puts home care agencies at the center of the delivery system.

This creates significant challenges for case managers, because case management is a relatively new discipline and the role of case managers in home care is very poorly defined. The role of the hospital-based case manager is still very different from a home health agency's employment of a case manager, says case management consultant **Louis Feuer**, MA, MSW, in Pembroke Pines, FL.

Often, the hospital-based case manager is not involved with the patient after the discharge, and the scope of his or her involvement with the patient is very much controlled by how long the patient is in the hospital and the severity of the illness, he says. Alternatively, the payer-based case manager may oversee all of this operation from the hospitalization and discharge to what happens in the home care setting.

Home health case managers typically have to work with the hospital case managers because they may not pick up that case until the day of discharge, Feuer says. That makes it likely that the patient has more than one case manager.

According to Feuer, while home health agencies often use the title case manager, the question is whether they have a licensed or certified case manager in their home health agency. In practice, there is a strong possibility that many of these agencies are not funding a full-time case manager, he says.

Feuer reports that hospitals currently are using a variety of methods to establish this function. Years ago, they often accomplished this through the social work departments. But some of those departments literally changed their names to case management departments or continuing care departments. "Their responsibility is to arrange for appropriate quality care after the patient is discharged from the hospital. The problem is that their involvement after the patient leaves the hospital is often zero," he says.

That is the reason the third-party payer industry has employed so many case managers, Feuer says. It also is the reason for many of the conflicts between hospital-based case managers and payer-based case managers.

"They are often looking at this from a very different perspective," he says. "The payer-based case managers do not have the opportunity to see the patient face to face because they are sitting in the corporate office in Hartford." ■

GUEST COLUMN

How to appraise your teamwork performance

By **Patrice Spath**, RHIT
Brown-Spath & Associates
Forest Grove, OR

Teamwork is an important component of case management. Case managers must closely collaborate with other caregivers and providers as well as other members of the case management department. It is sometimes difficult to separate individual contributions from those of other people involved in patient care activities. A department director who only measures and recognizes individual performance may find that teamwork is jeopardized because it appears to be ignored. By measuring an individual's team performance, you can promote personnel development and also focus staff on achieving collaboration goals. The director and case management staff can use the performance appraisal process to:

- plan departmental, individual performance;
- set individual goals that are aligned with departmental goals;
- establish performance expectations;
- measure actual departmental and individual performance against desired performance;
- determine staff developmental and training needs;
- provide feedback on performance;
- provide a basis for recognizing departmental and individual performance.

It is possible to measure performance of work done by an individual and also evaluate that person's contribution to the patient care team. For example, a process measure of an employee's team contribution might include whether or how well the case manager cooperates with other caregivers. The accuracy of information supplied to other care team members by the case manager is an example of an outcome measure.

Case managers can be appraised on how well they work with care team members. Examples of measures used to evaluate "team-supportive" behaviors could include the degree to which the case manager:

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Bioterror response requires targeted disaster plan

Stanford initiative draws nationwide attention

It's not enough merely to update the bioterrorism component of your current disaster preparedness plan, experts say; you must create a detailed bioterrorism response plan that stands on its own.

That's precisely the philosophy behind the Bioterrorism Response Preparedness Plan for Stanford (CA) Hospital and Clinics and Lucile Packard Children's Hospital in Palo Alto, CA, which is gaining widespread recognition as a model for such plans. In fact, several Kaiser Permanente facilities in California already have adopted the plan.

"You need a separate [bioterrorism] plan," asserts **Eric A. Weiss**, MD, assistant professor of emergency medicine at Stanford, associate director of trauma at Stanford Hospital, and chairman of the disaster committee and bioterrorism task force. **(See guideline and clinical pathway, pp. 40-41.)**

"During most disasters, for instance, you don't rely on the microbiology lab to identify pathogens," he points out. "Also, infectious disease and infection control staff take on a major, heightened role."

In disasters such as an earthquake, Weiss notes, you don't have to worry about the quarantine of patients or the spread of infectious agents, you do not have to put on protective clothing, or worry about cross-contamination of existing patients who may be immunosuppressed.

The plan, which is available on the Stanford web site (www.stanfordhospital.com), is incredibly detailed, including sections such as:

- Bioterrorism Response Preparedness Plan;
- Emergency Department Triage Guideline;
- Suspected Exposure to Bioterrorism Agent Clinic Triage Guideline;
- Specimen Collection for Suspected Bioterrorism Agent Diseases;
- Bioterrorism Agent Exposure Epidemiology Tracking Form;
- Anthrax Information Sheet;
- Summary of Laboratory Resources Related to Bioterrorism Agents;
- Infection Control Precautions for Suspected Bioterrorism Agent Disease;
- Clinical Pathways for Cutaneous Anthrax, Inhalational Anthrax, and Smallpox.

Revisiting a 'skeleton' plan

A bioterrorism plan had been in place prior to 2001, Weiss says, "but it was really just a skeleton plan — not very comprehensive. It was part of a larger disaster preparedness plan, but a plan to deal with mass casualties from bioterrorism is very different."

When you have a major disaster such as the collapse of the World Trade Center, Weiss notes, local health care providers are likely to come to the hospital and offer to chip in and help wherever they can. "But what happens when the word goes out that patients are walking around with smallpox?" he poses. "Are providers going to want to stream down to the hospital and potentially infect themselves and their families? You need a response plan to address the safety of health care providers, so they will feel comfortable and want to show up for work."

To create such a plan, the Bioterrorism Planning Task Force was formed about 18 months ago, incorporating personnel from 30 or more different departments at both facilities, including infectious

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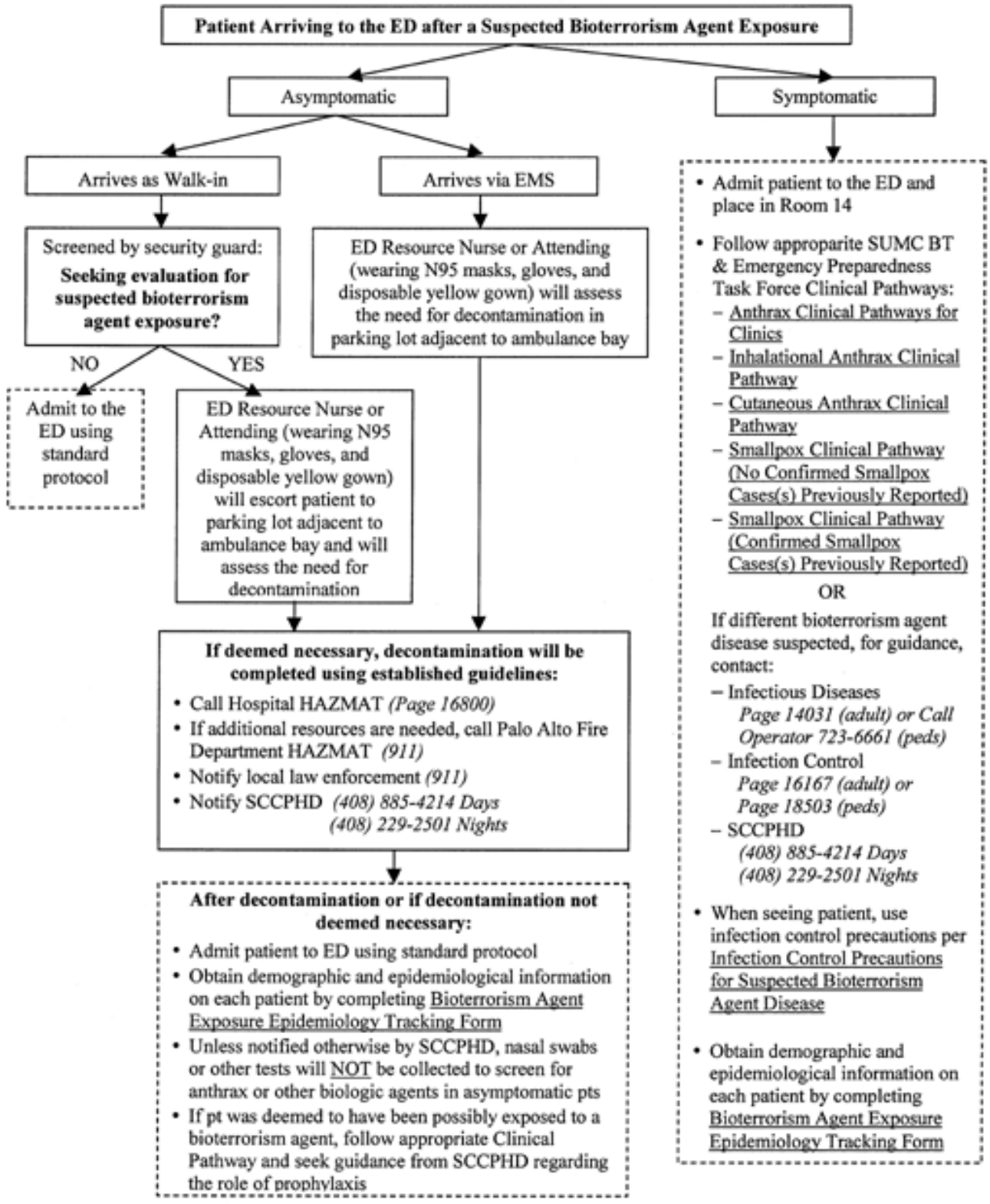
STANFORD UNIVERSITY MEDICAL CENTER

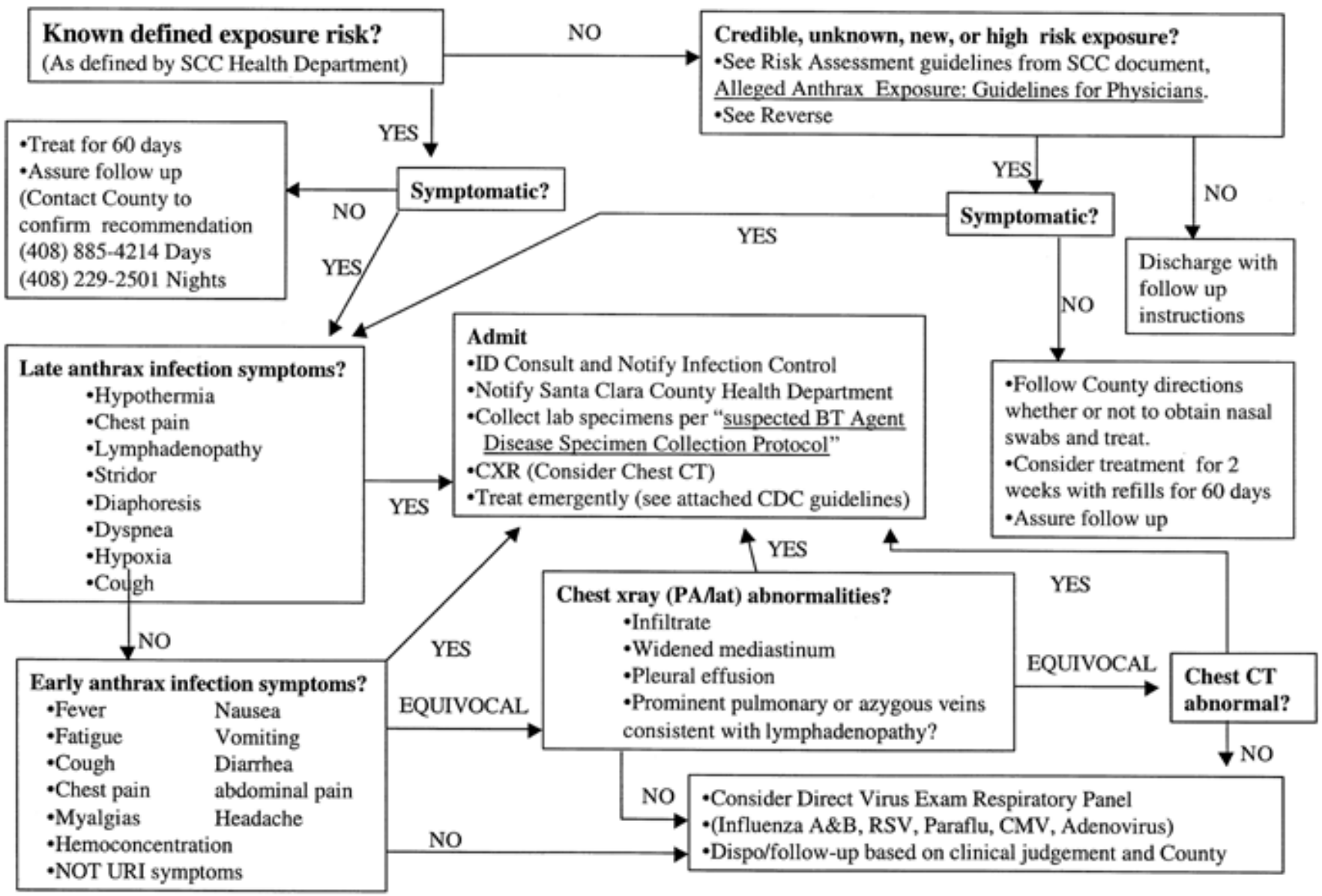
Stanford Hospital & Clinics
Lucile Salter Packard Children's Hospital

SUSPECTED EXPOSURE TO BIOTERRORISM AGENT
EMERGENCY DEPARTMENT TRIAGE GUIDELINE (Updated 12/08/01)
SUMC Bioterrorism & Emergency Preparedness Task Force



IMPORTANT: If at any time, the number of patients arriving to the emergency department from a bioterrorism incident exceeds the staff's ability to care for them with the resources available, activate Code Zebra.

Source: Eric A. Weiss, Stanford (CA) University Medical Center.



(Continued from page 39)

diseases, infection control, emergency medicine, pediatrics, critical care, ICUs, nursing and hospital administration, dermatology, psychology, social services, environmental health and safety, and so forth.

"We began putting the plan together when we identified the fact that the current plan was not adequate," Weiss notes. "We accelerated our activities after Sept. 11. After Sept. 11, everybody wanted to be part of it."

Weiss and his task force set out three major goals:

- Develop a comprehensive plan that would protect both the staff and its patients.
- Develop a plan to provide appropriate care for the people in the surrounding community.
- Develop a plan that potentially would mitigate the spread of infectious diseases related to the event.

The entire committee had input into the structure of the plan — i.e., which clinical pathways should be included and what guidelines and tracking forms were needed. "Then, we developed subcommittees to deal with the specific pathways," Weiss says.

"We brought their recommendations back to the task force for approval," he adds.

While anthrax was a logical choice for inclusion, it also was determined that smallpox should be addressed. "Anthrax is a good example of a pathogen that is not contagious, but we also wanted to address one that is," Weiss explains.

"The two are markedly different, and each is a quintessential example. When we have a mechanism in place to deal with both, we have all the bases covered."

Looking to the future

Weiss anticipates additions to the plan in the near future. "We are now dealing with nuances with other diseases like plague and tularemia," he notes. "But having addressed two of the major components [anthrax and smallpox], we'll just have to tweak the existing plan."

The task force also is planning to hold a drill soon. "We're trying to coordinate with representatives from the [Centers for Disease Control and Prevention], which we hope will come out and participate, as well as with state and local officials," Weiss says. "To test the plan, you have to test the response of state and federal agencies in conjunction with the hospital."

Weiss suggests this would be a good model for hospitals throughout the United States. "Every hospital will require input from these organizations," he notes.

He said it was not originally his plan to share the task force's work with other facilities. "Originally, that was not our mission," he says, "but once we got pretty far into it, we started to receive calls, word had gotten out, and people asked if they could use it or see it." Now, he says, the plan is not only available on the web site, but in a printed, bound version as well.

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AMBULATORY CARE
QUARTERLY

Find optimal staffing for outpatient surgery

By **Stephen W. Earnhart**, MS
President and CEO
Earnhart & Associates, Dallas

If there is anything constant in this business, it is the inconsistency we have in our staffing levels. So, what's the deal here? The American Society of PeriAnesthesia Nurses in Cherry Hill, NJ, and the Association of periOperative Registered Nurses in Denver have staffing ratios.

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, is concerned that we don't have enough nurses to staff our hospitals. Our staff tell us it isn't in their job description, and the administrator is saying we have too many people. The sky is falling; it hit me on the head!

No one can tell you what is "optimal," but you sure can tell when you have too many or not enough staff. In our industry, the tendency is to overstaff — it's human nature. In accordance, rare is the facility we visit that is understaffed. But the consistent problem is overstaffing in all the wrong areas and for the wrong reasons.

I know that cross-training is a "no-no" to many nurses, but it is time to wake up and see what is happening.

There are 200 surgery centers being built this year, according to SMG Marketing Group in Chicago, and I estimate that the full-time equivalents (FTEs) for an "average" outpatient surgery program is 22. Do the math: That is another 4,400 experienced staff required.

Unless you believe in the "spontaneous generation" theory, they have to come from somewhere. Chances are high that they are coming from one hospital or surgery center to another — maybe yours, maybe mine.

So it might be time to figure out if we are at risk. This exercise is more difficult for hospital folks because often the postoperative ambulatory care unit (PACU) does not come under the operating room (OR) budget, but you still can work it.

We have to assume that your staff are cross-trained; otherwise you will be completely overstaffed from day one. We assume you are doing 6,000 cases per year (approximately 1,200 cases per OR per year). Start with the number of ORs, and you can adjust up or down depending upon your situation. Just as revenue is the driver for your budgets, the number of ORs is the driver for staffing.

Starting with the basic needs

Start with the basics. You need one RN for each OR. Five ORs then equal five RNs. You now need one tech (or another RN) per OR for a scrub. You now have 10 FTEs for a normal eight-hour day. (Normal?) That is your core staffing. Now you need to front fill and backload your support staff.

No one better take offense at being considered a "support staff." I am the support staff to my company, and we all should be considered the support staff to the surgeons.

Assuming you do your own registration, you need to add in the front-desk personnel. On average, your staff should require no more than 15 minutes to register a patient on the day of surgery. You have five ORs, and you have your patients come in about 60 minutes before surgery, so ideally you need two FTEs to handle the registration, schedule cases, and answer the phone. Once they have finished the morning rush of patients, they can assist in the billing and correspondence work that never goes away.

Overseeing all of this is the business office manager. That is your front desk, scheduling, accounts / payable, and accounts / receivable. You can embellish it the way you want to. I only can guarantee that you will add staff to it because you will not believe you can do it with only three staff members. You can, but it's your call.

Obviously, we need to take the patients to

change clothes, have their pre-op interview, and be prepped for the OR. Anesthesia should be checking to make sure lab results are there, etc.

Two RNs can handle that caseload in the morning rush if your patients have been properly screened, anesthesia is doing their job, and the pre-op phone call was made giving them your instructions, etc.

Air traffic control

The OR is covered, and now they leave there and go to PACU. You have to do your planning here. I like to use the analogy of a busy airport and the role of the "air-traffic controller" for PACU.

A good anesthesia department, working with the administrator or PACU charge nurse, can make a real difference in keeping your PACU from becoming overwhelmed with incoming patients and the resulting tendency to overstaff.

You can control the number of patients coming into PACU by working with the circulating nurse in each OR and releasing those OR cases in an orderly fashion. Don't allow yourself to get backed up by not controlling the situation.

You need to exercise good judgment here in the sense that you don't want to "hold" patients in the OR because of staff coffee breaks or because your weren't staying on top of the situation.

Control the flow for the right reasons. Avoid holding up a room when you know the surgeon has three more cases to follow in the same room. Instead, hold up the case when the next patient coming into that OR isn't scheduled for another 45 minutes.

Pick your "holding pattern" well. Your criteria should change case by case and situation by situation, not by some silly blanket policy. If you can control that flow and maximize your pre-op nurses, you can run those cases on three RNs. Yeah, I know. You don't agree.

Instrument prep and inventory / materials management is the role of the surgical techs whose cases are starting to wind down after lunch. Depending upon your specialties, you might be able to justify a full-time instrument tech. Put one in there, but assume you can cross-train that position.

That gives us a total of 19 FTEs. Now add your administrator and nurse manager, and you are up to 21 FTEs.

Due to the nature of the business, add another 40 hours per week to fill in gaps with a "float." You now have 22 FTEs for your department.

Now, that does not mean 22 bodies. Oh, no — that could mean 45 people. The shortage of nurses is in the full-time block. You want to recruit the part-time "I only want to work 15 hours a week" people. And yes, they are out there. You are going to need more staffing than we described above on certain days and less on others.

The key of a good administrator is to work that staffing level based upon projected need and not the budget. Through attrition, try to slowly reduce your staffing levels to a basic function and then adjust on a PRN basis. I think you will find that less is more.

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Earnhart can be reached at 5905 Tree Shadow Place, Suite 1200, Dallas, TX 75252. E-mail: searnhart.com. Web site: www.earnhart.com.) ■

Ambulatory programs call for different type of CQI

Schedule, patients who leave add to challenge

One more chore. One more piece of paper to complete. One more thing that pulls nurses away from patient care. One more way for managers to find fault with staff members. One more thing that you have to do for accreditation. Well, it is required for accreditation, but a continuous quality improvement (CQI) program doesn't have to be the arduous busy work or the negative task that some staff members think it is.

"For a CQI program to be really effective, it has to be meaningful to staff members," says **Sheryl Walker**, MD, medical director of The SurgiCenter of Baltimore in Owings Mill, MD. "CQI activities should never be punitive, and they should always present an opportunity for staff members to suggest ways to improve."

The most important reason for an ambulatory surgery program to have a CQI process is to improve itself, Walker says. "None of us can get better if we don't have a way to identify the areas where improvement is needed," she explains.

The second reason is accreditation, Walker says.

But even if an ambulatory surgery program is not undergoing an accreditation process, the self-improvement is reason enough for CQI, she says.

QI in ambulatory surgery is different from CQI in an inpatient surgery program, Walker says. "We have a different patient population, a different caseload, different techniques, and most importantly, our patients go home after the procedure," she explains.

These differences mean that measuring different aspects of the patient's recovery such as pain management or infection is difficult, but there are several other areas that are important and easier for ambulatory surgery programs to monitor, Walker adds.

"Everyone should monitor complication rates," Walker says. Death, transfers to a hospital or intensive care unit, and returns to the operating room (OR) from the post-anesthesia care unit are critical to document and evaluate, she states. "Your anesthesia service should also be tracking any dental or eye damage as well as untoward neurological aftereffects," Walker adds.

Use your time efficiently

Time management is another key area for ambulatory surgery programs, she says. "It is important for us to start cases on time, turn over rooms quickly, and reduce lengths of stay in recovery," she explains. "The efficient use of time impacts staff morale, financial success, and the program's ability to keep surgeons on staff."

The areas on which you focus your CQI efforts depend on your program, she states. "All same-day surgery programs are not equal," Walker says. A program that performs predominantly gynecological procedures probably will not focus on dental damage during anesthesia, just as an eye surgery center will not focus on problems that are related to general anesthesia, she says.

The key to making a CQI program accepted and welcomed by all staff members is to keep the measurement tools simple so staff members don't feel that they are spending more time on paperwork for quality measurement than they spend on quality patient care, Walker emphasizes.

Simple is a good way to describe the *Nursing Concern Form* used in the ambulatory surgery program at Fairfax Hospital in McLean, VA. A place for the date, the topic, and the name of person to whom the form is submitted is at the top of the 8½ by 11-inch form that is mostly composed of blank lines on which the staff member can write. The person submitting the form signs at the bottom, then there is a small space to describe the action taken.

"We used to have risk management forms that OR nurses would complete if they encountered something like a room that wasn't properly cleaned," says **Paula R. Graling**, RN, MSN, CNOR, clinical specialist at Fairfax Hospital.

Putting concerns in writing

Because these forms are used as a formal method of collecting data for risk management and quality improvement, they had to travel through different department supervisors and often resulted in up to a three-week delay in solving problems, Graling says. Now, if the problem is not a unitwide or consistent problem, the *Nursing Concern Form* is used.

"The *Nursing Concern Form* is used within our own department," Graling says. "It can go directly to the person overseeing housekeepers in the OR for the example of the improperly cleaned room, or directly to the chairman of the surgery department if the concern is a chronically late surgeon," she says.

"The form is not used to collect data; it is used to solve problems," explains Graling. The person submitting the form is supposed to state the concern very specifically and whenever possible, suggest ideas to correct it, she says.

"These forms make it easy for people to communicate directly with each other and find solutions that meet everyone's needs," Graling explains.

Although clinical managers review the completed forms, after solutions are reached, they do not get involved unless there are problems reaching a solution or the solution requires a manager's authorization. Review of the forms gives the managers an overview of what is happening in the fast-paced same-day surgery program, adds Graling. This overview can lead to suggestions of activities that CQI might want to monitor in a more formal manner.

When you monitor different activities, it is often difficult to find benchmarks that apply specifically to same-day surgery, says **Nell Wood**, director of marketing and communications for the Quality Indicator Project at the Elkridge-based Association of Maryland Hospitals & Health Systems (MHA).

This project collects data from participants across the country and builds a database of

national data. The fee ranges from $1,390 to $3,800 per year.

While the majority of measurements are related more to acute care, there are some categories that address same-day surgery interests, Wood says.

Admission to an inpatient unit for observation following same-day surgery or diagnostic endoscopy, cancellation of procedure on the day of surgery, and type of sedation or analgesia used for endoscopic procedures are examples of categories related to outpatient, she explains.

The Accreditation Association for Ambulatory Health Care's Institute for Quality Improvement in Wilmette, IL, offers a variety of benchmark studies that can provide information for CQI programs, says **Naomi Kuznets**, PhD, managing director of the institute. **(See contact information at the end of this article for more information.)** Studies cover areas such as tumescent liposuction, patient satisfaction, and cataract extraction.

Whether you choose to incorporate national benchmarks into your CQI program or not, Walker says, "A CQI program can be most meaningful when everyone views it as a learning process that will improve the work environment and patient care."

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CE questions

Save your monthly issues with the CE questions in order to take the two semester tests in the June and December issues. A Scantron sheet will be inserted in those issues, but the questions will not be repeated.

9. According to Julia Rieve, RN, president, CQI Healthcare in San Diego, case managers working hospital mental health units generally can manage up to how many patients?
   A. 15
   B. 20
   C. 25
   D. more than 30

10. According to Lisa Zerull, MS, RN, program director at Valley Health System in Winchester, VA, if there is no case manager working on the weekend, increased workload is likely on which of the following days?
    A. Mondays
    B. Fridays
    C. Mondays and Tuesdays
    D. Mondays and Fridays

11. According to a report from the Health and Human Services Office of Inspector General, what percentage of physicians know that Medicare expects them to ensure that only medically necessary services are on the plan of care?
    A. 83%
    B. 75%
    C. 62%
    D. 53%

12. According to Patrice Spath, RHIT, president of Brown-Spath & Associates, directors of case management and case management staff can use the performance appraisal process to do which of the following?
    A. plan departmental and individual performance
    B. set individual goals that are aligned within departmental goals
    C. establish performance expectations
    D. all of the above

(Continued from page 38)

• participates in patient care team meetings;
• volunteers for patient care improvement projects;
• communicates with members in a constructive and nonthreatening manner;
• is perceived by other caregivers as pleasant to work with and cooperative.

Case managers must have good interpersonal skills. This behavior contributes to effective care team performance but can be difficult to evaluate objectively. Here are example criteria for evaluation purposes to assess interpersonal skills:

EMPLOYEE MEETS STANDARD

1. with few exceptions, interacts effectively, tactfully, and cooperatively with all levels of the organization;
2. routinely expresses support for the value of diverse opinions;
3. routinely establishes rapport in initial contacts with others at all levels;
4. routinely gains support for ideas or suggestions through effective negotiation skills;
5. spends sufficient time cultivating contacts with caregivers and providers to get timely information or resolve issues outside formal channels;
6. routinely keeps care team members, patients, families, and other appropriate parties informed of significant patient care developments.

EMPLOYEE EXCEEDS STANDARD

Meets above criteria plus:

1. consistently wins the support and confidence of others in one-on-one and group situations;
2. presents positions with force and diplomacy, achieving agreement despite initial opposition;
3. handles confrontations and hostile reactions calmly, in a way that defuses the situation.

The behavior standards for case managers should describe conduct that can be reasonably measured and controlled at the employee's level. Such behaviors represent the case manager's contributions to the care team's activities. The results of case management activities that contribute to overall patient outcomes can be assessed and verified. Examples of measures to assess a case manager's work results include:

• ratio of correct to incorrect recommendations;
• timeliness of the employee's interventions;
• number of patient care improvement suggestions made by employee;
• accuracy of the information the employee provided to the team.

Here are examples of criteria to evaluate the case manager's ability to give professional advice and recommendations — an important team supportive skill for case managers.

EMPLOYEE MEETS STANDARD

1. provides expert advice to other health care team members that usually is accurate and timely;
2. provides advice that usually is meaningful and contributes to the success of the patient care experience.

EMPLOYEE EXCEEDS STANDARD

Meets above criteria plus:

1. Advice contains innovative approaches and

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Editorial Questions

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solutions to patient care problems.

2. Improved accomplishment of patient care goals results from employee's unusual initiative and accomplished case management expertise.

3. Patients, families, and other caregivers seek out employee for advice and expertise.

4. Employee voluntarily completes a significant amount of additional work or special assignments.

The importance of team performance can be emphasized through the creation of appropriate rewards. When standards are measurable and achievable, the case management department may wish to establish incentives that are awarded to employees who help achieve teamwork goals.

Working well together

The case management department also can be appraised on its internal group processes to judge the level of teamwork within the department. Work assignments and performance measures could include how well:

- case managers work together as a group;
- departmental meetings are planned and run, and if they're on time;
- case managers reach consensus on departmental issues;
- case managers use problem-solving techniques to improve internal process.

Clearly defined roles for employees are important to the teamwork of the case management department.

The following criteria can be used to evaluate this attribute:

1. Everyone in the department understands his or her duties and knows who is responsible for specific issues and tasks.

2. Everyone has the skills needed to accomplish his or her responsibilities.

3. Everyone understands which roles belong to one person and which are shared.

4. The talents of all employees are valued and all are involved in departmental activities so that no one feels left out or taken advantage of.

The case management department should regularly measure individual and group team performance to assess teamwork contributions.

Teamwork measurements are valuable performance management tools that help in clarifying individual, team, and departmental goals and keep everyone pointed in the right direction. Such efforts support and produce better collaboration within the department and among caregivers. ■

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. ■