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INSIDE

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Special Report: Case Management Credentialing

CM credentials: It's quickly becoming a case of *when*, not *if* you must

Education requirements continue to stir controversy

Strange as it may seem, case managers have become a target market for health care quality organizations pushing a dizzying assortment of case management credentials and degree programs. Popularity comes with a price, however, and many case managers are feeling the pressure to either seek an established credential or upgrade their education simply to keep pace in an increasingly competitive job market.

Indeed, *Hospital Case Management*'s 1998 salary survey **(See *HCM*, November 1998)** found that case managers with a master of science in nursing (MSN) earned an average of about $55,000, while case managers with a bachelor of science in nursing (BSN) earned about $40,000. Those salaries jump even higher when certification is added to the picture.

"Leaders in the case management field feel very strongly that qualifications must be set at the point where case management is readily recognized as a specialty practice and evolving profession," says **Cynthia E. Whitaker**, RN, BSN, CCM, president of RNS Healthcare Consultants in Sacramento, CA, and past president of the Case Management Society of America (CMSA) in Little Rock, AR. To that end, Whitaker is pushing for the BSN to become a minimum standard for nurse case managers

"The bachelor's degree in effect says that a person has demonstrated the communication and critical thinking skills so necessary for effective case management practice," she says. "Individuals are not always taught the ability to analyze complex situations in associate or diploma programs, which tend to focus almost entirely on clinical skills."

To some case managers, particularly those who came out of associate or diploma programs in the 1970s and hold a world of experience but no BSN, those are fighting words. **Barbara A. Fuchs**, RN, CPHQ, FNAHQ, director of case management at Sacred Heart Hospital in Allentown, PA, is a diploma graduate who went on to earn both a bachelor's degree and a master's — but not in nursing. "Unless you've been in the trenches,

you don't know what you're talking about," she says. "Theoretical constructs are wonderful, but I would never hire anyone without experience just on the basis of some courses they had taken."

More important to Fuchs than a university degree is an established case management credential. To her, that proves a candidate has gone "one step beyond. It shows you don't just clock in and clock out, because credentials have continuing education requirements attached to them."

Further, most certification examinations are based on actual practice, says **Janet L. Maronde**, RN, CPHQ, executive director of the Healthcare Quality Certification Board, which oversees the CPHQ credential. "We're testing candidates' practical, on-the-job skills, rather than their ability to memorize information," Maronde says. When someone gets a credential like the CPHQ, she adds, "then the employer knows that person has good judgement and an effective way of approaching problems and real-world situations. That's the biggest strength, and it's why employers are valuing [credentials] more and more."

Maronde adds that, in her experience, breadth of experience produces a higher pass rate than any other factor, including education.

Even so, credentialing organizations are considering toughening the education requirements they impose on prospective candidates. For example, the South Natick, MA-based Center for Case Management's new Case Management Administrator Certified credential requires either a bachelor's or a master's degree plus experience in the field. Meanwhile, the American Nurses Credentialing Center in Washington, DC, requires that candidates hold at least a BSN. **(See *HCM*'s annual directory of case management credentials for complete eligibility requirements, p. 232.)**

KEY POINTS

- Many case managers feel pressured by an increasingly competitive job market to take advantage of the recent proliferation in case management credentials and degree programs. And data suggest that credentialed and better-educated case managers can bring home significantly higher salaries.
- Even so, some experts are critical of the trend toward raising the educational requirements for some of the top case management credentials. At issue is whether the bachelor of science in nursing should be regarded as a minimum standard for the practice of case management.
- Most experts agree, however, that having a credential indicates that a case manager is attempting to broaden his or her base of knowledge and stay current with trends in quality and patient care.

Do you have the wrong master's degree?

Some experts, even those in credentialing organizations, say such educational requirements may go too far. **Sharon Kemerer**, executive director of the American Board of Occupational Health Nurses (ABOHN) in Hinsdale, IL, points out that her organization's chairman would be ineligible to take the ANCC case management exam: "She has a master's degree, but it's not in nursing." That's one reason why ABOHN isn't likely to impose such requirements on candidates for its case management credential, which is now in development.

Similarly, officials at the Certification Boards, Perioperative Nursing (CBPN) in Denver have decided not to require the BSN for their CNOR exam in the year 2000. **Diane Howery**, executive director at CBPN, says the requirement was dropped in light of statistics showing that relatively few nurses actually hold a BSN. A 1996 study showed that 66% of graduate nurses came from associate and diploma programs. A full 53% of 1996 nursing graduates held associate degrees, while another 6% were diploma graduates. Of the current 30,000 CNORs, 63% don't hold a BSN.

"It's not that we don't support [the BSN] as an entry-level requirement, but until the profession catches up with it, we feel that we have to represent our universe of candidates," Howery says.

She adds that talk of a recent trend toward the BSN and MSN among nurses and case managers doesn't mesh with reality. "The situation hasn't changed," she says. "From the figures I've seen, it hasn't changed in 35 years. What has changed is that the nurses who are at the tables representing nursing in important committees, for example, all have advanced degrees. In many settings, a BSN is now required to rise beyond staff nurse."

Recently, Fuchs made inquiries at a major university to find out how she — a director of case

CM Education Programs

1. Barry University, 11300 NE Second Ave., Miami Shores, FL 33161. Telephone: (305) 899-3900.

Program: Post-graduate certificate program in case management. Applicants must have bachelor's degree. Two courses offered each eight-week cycle. Must complete six courses to receive certificate. Cost: $200 per course.

2. Lynn University, 3601 N. Military Trail, Boca Raton, FL 33431. Telephone: (561) 994-0770.

Program: Post-graduate certificate program in case management. Applicants must have bachelor's degree. Certificate requires total of 18 course credits and three credits for 500 hours of internship. Cost: about $300 per credit hour.

3. Villanova University, Villanova College of Nursing, 800 Lancaster Ave., Villanova, PA 19085. Telephone: (610) 519-4934.

Program: Two-year master's degree in nursing program. 45 credits necessary for graduation. Must have bachelor's degree. Cost: $430 per credit.

4. Vanderbilt University, Vanderbilt School of Nursing, 461 21st Ave. S., Nashville, TN 37240. Telephone: (615) 322-3800.

Program: Master's of nursing offered. Applicants with bachelor's in nursing must complete 39 credits. Applicants with bachelor's in other fields must complete a total of 85 credits. Cost: $643 per credit.

5. University of San Diego, Hahn School of Nursing, 5998 Acala Park, San Diego, CA 92110-2492. Telephone: (619) 260-4548.

Program: Offers two-year master's program in nursing. Applicants must complete 40 credits. Cost: $555 per credit.

6. Sonoma State University, Nursing Department, 1801 E. Cotati Ave., Rohernt Park, CA 94928. Telephone: (707) 664-2778.

Program: Master's of nursing in case management offered for applicants with bachelor's in nursing and RN license. Post-master's certificate in case management open to non-nurses. Master's program takes five semesters with six to seven credits per semester at cost of $180 per credit. Certificate program takes three semesters and total of 13 to 21 credits depending on applicant's master's program.

7. Johns Hopkins University, School of Nursing, 1830 N. Charles St., Baltimore, MD 21205. Telephone: (410) 955-7548.

Program: Two-year master's program in nursing. Applicants must complete 60 credits. Cost: $677 per credit.

management with a master's degree and more than 15 years experience in health care — could get a BSN. She was told the university wouldn't accept any of her courses from her hospital program. "I was going to have to challenge everything," she says. "Even if I had challenged everything successfully, they were still going to make me take two courses. It seemed to be all about money."

At this point, Fuchs says, "A BSN doesn't really mean anything to me. I'd rather see what you've done." On the other hand, Fuchs says, the presence of a credential indicates to her that a candidate is at least interested in her profession and tries to keep current.

Lori W. Heiser, LSW, CMC, a case manager at St. Joseph's Hospital and Health Center in Dickinson, ND, pursued a case management credential as part of a learning process about the field of case management. Although she had a moderate amount of medical experience, her background was predominantly social work. "I started noticing that social work was being sidestepped by nursing in terms of managing patient care," she says. "I wanted to see social work expand and take more responsibility in health care, which is a medical model-based concept."

Meanwhile, she began reading more about case management and concluded that the field "is very much like the basics of social work." From there, she enrolled in a certificate course in case management and went on to acquire the Care Manager Certified credential from the Hollywood, FL-based National Academy of Certified Care Managers.

Heiser's example underscores the fact that case managers come to credentialing from a variety of backgrounds and for a variety of reasons. Fuchs says that as a director of case management, she isn't biased toward or against a particular credential because of the field's diversity. "I don't say CPHQs are better than Certified Case Managers, or vice versa," she says. "But I will look at you a little more if you have a credential. It shows me that you're out there, and you're trying to get a broader base of knowledge than you have right now. And you're trying to keep up with the trends."

For more information, contact:

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Janet L. Maronde, RN, CPHQ, executive director, Healthcare Quality Certification Board, P.O. Box 1880, San Gabriel, CA 91778. Telephone: (626) 286-8074.

Barbara A. Fuchs, RN, CPHQ, FNAHQ, director of case management, Sacred Heart Hospital, 421 Chew St., Allentown, PA 18102. Telephone: (610) 776-4886.

Diane Howery, executive director of Certification Boards, Perioperative Nursing, 2170 South Parker Road, Suite 295, Denver, CO 80231. Telephone: (888) 257-2667. ■

Certification programs target CM departments

CARF targets acute care case management

Just when it seemed the market for case management credentials couldn't become any more glutted, certification organizations have changed tactics, designing new certifications not for individual case managers but for entire case management programs.

Both the Commission on Accreditation for Rehabilitation Facilities (CARF) in Tucson, AZ, and the American Accreditation HealthCare Commission / URAC in Washington, DC, are developing accreditation standards for case management departments that will be available sometime next year. "Certification helped us establish a benchmark for individual practice," notes **Jeanne Boling**, MSN, CRRN, CDMS, CCM, executive director of the Case Management Society of America (CMSA) in Little Rock, AR. "But we've still faced the problem of certified

KEY POINTS

- Two organizations — the Commission on Accreditation for Rehabilitation Facilities (CARF) and the American Accreditation HealthCare Commission / URAC — are developing accreditation standards for case management departments. Both will be available sometime next year.
- Just as certification has helped establish a benchmark for individual practice, these organizations hope their programs will establish larger-scale benchmarks for whole departments.
- It's expected that the CARF standards will be geared more toward acute care, while the Commission / URAC will apply more to payer-based programs.

CARF case management standards approved

The Tucson, AZ-based Commission on Accreditation for Rehabilitation Facilities' (CARF) accreditation standards for case management departments already have been approved by the organization's board of trustees and will be available to the public in January. They address:

- **Leadership.** This section addresses who is responsible for managing and directing medical rehabilitation case management. This section also outlines which leadership would be responsible for various areas of case management activity, such as fiscal management, ethics, strategy, health, safety, and transportation.
- **Information and outcomes management.** This section addresses how information is gathered at both the level of the individual and the program to determine the outcomes of work completed by case managers. It also discusses public disclosure of information gathered.
- **Rehabilitation process for persons served.** This section addresses the rights of the client and how case managers interact with the client and the rehabilitation team.

Other key concepts addressed in the CARF standards include:

- full participation of the case manager in decision making related to the services, equipment, and supplies provided to the persons served, community resources used, and efficient movement of the client through the continuum of care;
- the role of the case manager in the continuum of care and use of the continuum of care;
- coordination with all stakeholders;
- advocacy for clients. ■

Commission/URAC focuses on processes

The case management standards developed by the American Accreditation HealthCare Commission / URAC in Washington, DC, were designed to focus on the overall processes of case management programs, says **Kathleen Ward Douglas**, RN, MPA, CCM, assistant vice president for disease management for Health International, a Scottsdale, AZ-based medical management company, and chair of Commission / URAC's case management advisory committee. The standards address:

- staff training and qualifications;
- use of external resources, such as community-based services;
- oversight of staff;
- quality monitoring (outcomes, provider profiling);
- use of guidelines and protocols;
- documentation;
- process for "triaging" patients into appropriate case management;
- processes relating to risk management and analyzing costs;
- performance incentive systems;
- decision-making processes. ■

individuals practicing in a system that doesn't always understand what they do. Accreditation of case management organizations will help shape the system to help individual case managers reach the full extent of their practice capability."

Both CARF and the Commission / URAC say they are keeping the lines of communication open to avoid situations that would require case management programs to be accredited by both organizations. "We have some appropriate concerns about duplicating each other. Neither of us wants that to happen. We want to reassure the industry that we are in communication," says **Don Galvin**, PhD, president and chief executive officer of CARF. Galvin notes that CARF is primarily targeting facility-based case management programs, while the Commission / URAC focuses more on payer-based programs. **(For more information about the content of the standards, see boxes on p. 228 and at left.)**

CMSA has kept a close watch on both accreditation standards. "Of course, we want to see the two accreditation programs as streamlined as possible," notes Boling. "We don't want a case management organization to apply for CARF accreditation and then in addition have to apply for Commission / URAC accreditation. We are working with both groups in an effort to make these two programs complementary with no onerous duplication of efforts placed on case management programs."

"I really believe that this process will advance the evolution of case management as a profession into the year 2000," says **Kathleen Ward Douglas**, RN, MPA, CCM, assistant vice president for disease management for Health International, a Scottsdale, AZ-based medical management company, and chair of Commission / URAC's case management advisory committee. "It will solidify the significance of the practice of case management. Accreditation will be a mark of distinction for purchasers — a guarantee for consumers that there is a level of excellence."

To review the public comment draft of the Commission/URAC standards, visit the organization's Web site at www.urac.org or call (202) 216-9010. CARF can be contacted at (520) 325-1044. The organization's Web site address is www.carf.org. ■

Meet the new kids on the credentialing block

Three major agencies get in on credentialing

The crowded field of case management credentialing just got a little more crowded. Three major health care agencies have either already taken the plunge or are gearing up to offer brand-new credentials for case managers and other quality professionals. They are the American Nurses Credentialing Center, the Center for Case Management, and the Joint Commission on Accreditation of Healthcare Organizations.

Results of Latest RN-NCM Credentialing Test

Nursing Case Management
(Candidates taking Part A only)

Test Date	Number of items on test	Mean score	Passing score	Number of examinees	Number of examinees passing	Percent of examinees passing
October 4, 1997	100	76.5	73	115	87	75.7
June 27, 1998	150	73.8	73	62	39	62.9

Nursing Case Management
(Candidates taking Part A and Parts A + B)

Test Date	Parts	Number of items on test	Mean score	Passing score	Number of examinees	Number of examinees passing	Percent of examinees passing
October 4, 1997	A	100	74.8	73	115	32	67.6
June 27, 1998	B	50	37.8	38	62	34	47.1

Source: American Nurses Credentialing Center, Washington, DC.

Here's a status report:

• The American Nurses Credentialing Center's (ANCC) Nurse Case Manager (RN-NCM) credential.

The Washington, DC-based ANCC's nurse case management credential got off to a rocky start even before the inaugural examination in October 1997. Originally, officials from the American Board for Occupational Health Nurses (ABOHN) in Hinsdale, IL, approached ANCC about developing a case management credential jointly "so there would not be such a proliferation of certifications," says Sharon Kemerer, executive director of ABOHN. "Initial indications were that they were interested in that. But then they decided to develop [a case management credential] on their own that is very hospital-based, very medical."

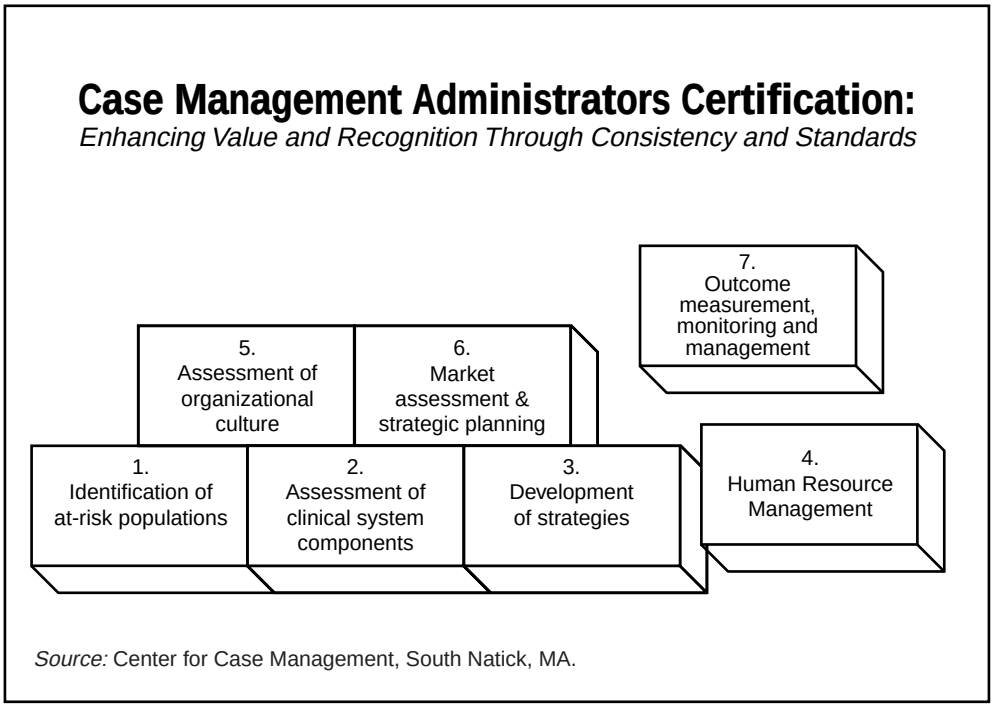
Plunging forward on its own, the ANCC ran into difficulties by failing to regard case management as a core specialty, a stance that alienated case managers. As a result of complaints over its position as well as problems with the October 1997 test, the ANCC revised its eligibility requirements this year. **(See our directory of credentials on p. 232.)** Even so, fewer than 200 case managers have taken the exam to date. **(See test results, above.)**

• The Center for Case Management's Case Management Administrator Certified (CMAC) credential.

The South Natick, MA-based Center for Case Management has been debating the value of case management certification for the last 10 years, says **Robyn Ripley**, director of consulting support services. "There are so many different certifications for case managers," she says. "There are also that many definitions of case management. As a result, there's a lot of potential for confusion around credentials and credentialing. That's why we kept our hat out of the ring for so long."

KEY POINTS

- The Washington, DC-based American Nurses Credentialing Center's nurse case manager credential continues to get a rocky reception. Following difficulties with last year's test and controversy over the credential's eligibility criteria, the number of applicants remains small.
- Meanwhile, the inaugural test for the Center for Case Management's new case management administrator certified credential took place on Oct. 24, 1998. While results are not yet available, officials at the South Natick, MA-based Center report that the diversity of candidates for the credential reflected the exam's cross-continuum focus.
- The Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations is still developing its upcoming "Diplomate of the Academy" credential, which will feature a formal curriculum and course work.



The first examination for the Case Management Administrator Certified (CMAC) credential was held Oct. 24, 1998. **(See chart listing elements of the CMAC credential, at left.)** While test results weren't available at press time, Ripley reports that the candidates who applied to take the test represented a wide variety of care settings. "The test reflects across the continuum, and so far the interest that we've received for it has gone across the continuum as well," Ripley says. "We've had payer-based case management administrators very interested in the program, as well as people from rehabilitation and acute care, so it's a nice mix."

Last year, however, officials at the Center decided the time had come to inaugurate a new credential to address what they considered a relatively ignored group: case management administrators. "Case management administration has really set itself apart and crossed those boundaries across case management realms," Ripley says. "That's where we felt that we could add some value."

Ripley acknowledges, however, that turnout for the first test was low. This may have been due in part to the credential's eligibility requirements, which include having a bachelor's degree or master's degree and years of experience either as a case manager or case management administrator.

The Center for Case Management is reviewing applications for the April 1999 examination. **(For**

Breaking News

New case management credential in the works

On Nov. 4, the leadership of the American Board for Occupational Health Nurses (ABOHN) in Hinsdale, IL, approved a plan to develop a case management credential for occupational health nurses, *Hospital Case Management* has learned.

At its board meeting in June, ABOHN (which issues the COHN, or certified occupational health nurse credential) appointed a special task force to decide whether the organization should explore such a plan. The task force conducted "extensive market research," collecting more than 1,500 pieces of survey material and talking with existing case managers and employers of case managers in occupational health, says **Sharon Kemerer**, executive director of ABOHN.

"Based on all of that information, there seemed to be a very strong indication that there is a need for an occupational health nursing case management certification," Kemerer says.

For more information about ABOHN's upcoming case management credential for occupational health nurses, contact Sharon Kemerer, executive director, American Board for Occupational Health Nurses, 201 E. Ogden Ave., Suite 114, Hinsdale, IL 60521. Telephone: (630) 789-5799. ■

more information about the CMAC, see our credentials directory, p. 232.)

• **The Joint Commission on Accreditation of Healthcare Organizations' "Diplomate of the Academy" credential.**

The Oakbrook Terrace, IL-based Joint Commission's credential is supposed to complement the CPHQ credential and apply to a broad range of health care professionals, including hospital department heads, service chiefs, medical records professionals, clinicians, and upper-level health care executives. Unlike the CPHQ, however, it's largely education-based, complete with a formal curriculum and course work.

The program model calls for 160 hours of course work, about three-quarters of which would be done through self-paced distance learning technologies. Depending on how much time each enrollee wants to spend on the distance-learning component, it would move more quickly or slowly, says **Bruce Ente**, MA, director of educational services development at the Joint Commission.

If a candidate spent four or five hours a week on the 120-hour distance learning segment, it would take about six months. That would be followed by 40 hours of graduate-level on-site seminars, either at the Joint Commission or at one of its university partners. The on-site course work could be taken in one continuous week or over two to three weekends. The courses might even be offered on a night-school basis over the course of 15 weeks per semester. The cost of the program hasn't been decided, but Ente says it will be priced similarly to comparable-length professional continuing education programs. Much of the topical content will relate to Joint Commission standards.

Janet L. Maronde, RN, CPHQ, executive director of the Healthcare Quality Certification Board in San Gabriel, CA, questions whether the Joint Commission's credential will be able to attract many candidates. She points out that the program sounds similar to the old Quality Institute developed by the National Association for Healthcare Quality a few years ago. "It was a comprehensive masters'-level course that cost well over $5,000" — a price that most quality professionals could not afford, Maronde says.

She's also concerned that the Diplomate credential may not have an experience requirement for eligibility. "It's almost like the difference between a certificate or degree, and a national certification, which is a combination of experience, education, and performance on an exam that's based on actual practice," she says.

The academy will pilot-test its curriculum and distance-learning media next year. The program will first be tested with Joint Commission surveyors, then applications will be accepted for enrollment in 2000. For more information, contact Bruce Ente, director of Educational Services Development at the Joint Commission. Telephone: (630) 792-5960. E-mail: bente@jcaho.org. ■

HCM's annual directory of the top CM credentials

Revised and updated for 1999

Here are some basic facts that should help you make decisions about which certification programs best fit your personal experience, expertise, and professional needs. Information below is summarized directly from candidate handbooks supplied by each credentialing board. For complete eligibility criteria and other relevant data, contact the appropriate credentialing board for the complete candidate handbook.

1. Nurse case manager (RN-NCM)

Credentialing board: American Nurses Credentialing Center, 600 Maryland Ave. SW, Suite 100 West, Washington, DC 20024. Telephone: (800) 284-2378.

Eligibility criteria:

Candidates who currently hold a core nursing specialty certification must:

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

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

• have functioned within the scope of a registered nurse case manager a minimum of 2,000 hours within the past two years;

• show proof of a current, core nursing specialty certification.

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

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

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

• have functioned as a registered nurse for 4,000 hours, with at least 2,000 of those hours as a nurse case manager within the past two years;

• must take an expanded version of the test, including "core specialty" questions.

Registration fee: For members of the American Nurses Association: $100. Non-members: $200. The core specialty test costs an additional $50, while late fees, alternate date fees, and special test site fees are $35 each.

1999 testing dates: June 26 and Oct. 2, 1999.

Recertification: Certification is valid for five years. Recertification requirements include:

• 1,500 hours of practice (full-time faculty can apply up to 500 hours of nursing case management didactic lecture in a baccalaureate or higher nursing program toward the practice requirement);

• a minimum of two of the following:

— 75 contact hours of continuing education;

— five academic semester hour credits (or six quarter hours);

— participation as a presenter/lecturer in five formal continuing education or professional education offerings;

— evidence of publication of one article in a refereed journal, book, chapter, or published research paper in an appropriate area of nursing;

— 120 hours of on-site case management clinical preceptorship supervision of baccalaureate or higher degree nursing students.

Exam content outline: The test covers five components: Assessment, planning, implementation, evaluation, and interaction.

2. Care manager certified (CMC)

Credentialing board: National Academy of Certified Care Managers, 3389 Sheridan St., Suite 170, Hollywood, FL 33021. Telephone: (800) 962-2260.

Eligibility criteria:

• Candidates with master's-level education in social work, nursing, gerontology, counseling, or psychology must have two years of supervised (50 hours/year) paid, full-time care management experience that includes face-to-face interviewing, assessment, care planning, problem-solving, and follow-up.

• Candidates with bachelor's-level education must have four years of paid full-time experience with clients in fields such as social work, nursing, mental health, counseling, or care management, two years of which must be supervised (50 hours/year), paid, full-time care management experience.

• Candidates with a high school diploma or any advanced degree in an area unrelated to care management must have six years of paid, full-time, direct experience with clients in fields such as social work, mental health, nursing, counseling, or care management, two years of which must be supervised (50 hours/year), paid full-time care management experience.

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

Refunds: Candidates withdrawing from the exam may receive a full refund less a $50 processing fee. Requests must be made in writing 10 working days prior to scheduled examination date.

1999 testing dates: Unlimited. Candidates may schedule the certification exam seven days a week, 365 days a year.

Testing sites: Test is computer-generated and can be taken at 250 Sylvan Testing sites nationwide.

Recertification: Three years after initial certification, candidates must demonstrate that they have maintained 1,500 hours of professional care management practice and completed 15 contact hours per year in approved continuing education. The recertification fee is not yet established, as the examination process is less than two years old.

Additional comments: NACCM recognizes the diversity of the practice of care management. The term assumes the broadest possible meaning of the roles, functions, responsibilities, and educational backgrounds of care managers. The successful applicant must have full-time direct access with persons with chronic disabilities and supervised care management experience that includes face-to-face interviewing, assessment, care planning, problem-solving, and follow-up.

Exam content outline: Test covers five major

domains or categories: assessment; establishing goals and a plan of care; coordinating and linking formal and informal resources to meet goals and implement plan of care; managing and monitoring ongoing provision and need for care; and legal and ethical issues.

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

3. Case management administrator certified (CMAC)

Credentialing board: Center for Case Management, 6 Pleasant St., South Natick, MA 01760. Telephone: (508) 651-2600.

Eligibility criteria:

Candidate must fall into one of the categories described below:

- Master's degree and one year experience in case management administration.
- Bachelor's degree and three years experience in case management administration.
- Master's degree and three years experience as a case manager.
- Bachelor's degree and five years experience as a case manager.

Registration fee: $300.

1999 testing dates: April and October, 1999. (Specific dates not yet determined.)

Additional information: "Persons considered as administrators, for the purpose of this program, are those who are accountable and responsible for management of programs that provide care coordination along the continuum. Examples of titles considered to be administrative are: Department Head, Director, Vice President, Department Coordinator, Department Supervisor, Department Manager, and others."

Exam content outline: With a focus on leadership, management, case management, and systems-thinking principles, the following content areas will be covered: 1) identification of at-risk populations; 2) assessment of clinical systems components; 3) development of strategies to manage at-risk populations; 4) assessment of organizational culture; 5) market assessment and strategic planning; 6) human resource management; 7) outcomes measurement, monitoring, and management.

4. Certified case manager (CCM)

Credentialing board: Commission for Case Manager Certification, 1835 Rohlwing Road, Suite D, Rolling Meadows, IL 60008. Telephone: (847) 818-0292. Fax: (847) 394-2172.

Eligibility criteria:

- Minimum educational requirement of post-secondary program in a field that promotes the physical, psychosocial, or vocational well-being of the persons served.
- License or certification awarded upon completion of education requirement outlined above must have been obtained by the candidate's passing an examination in his/her area of specialization.
- Completion of the education program's licensing or certification process must grant the holder of the license or certification the ability to legally and independently practice without the supervision of another licensed professional, and to perform all six essential activities of case management, including: assessment, planning, implementation, coordination, monitoring, and evaluation.
- Candidate must have verifiable employment experience in one of three categories: 1) 12 months of acceptable full-time case management employment or its equivalent under the supervision of a CCM for the 12 months; or 2) 24 months of acceptable full-time employment or its equivalent; or 3) 12 months of acceptable full-time employment or its equivalent as a supervisor, supervising the activities of individuals who provide direct case management services.
- All applicants must hold a professional license or certification that allows the holder to legally and independently practice without the supervision of another licensed professional, and to perform the six essential activities of case management listed above within each of the following five core components: coordination and service delivery, physical and psychological factors, benefit systems and cost benefit analysis, case management concepts, and community resources.

Registration fee: $130 nonrefundable application fee plus $160 examination fee, due when candidate sits for the exam, or total certification fee of $290.

(Continued on page 239)

(Continued from page 234)

Application deadline: Jan. 15, 1999, for June test; July 15, 1999, for December test.

Refunds: $130 application fee is nonrefundable.

1999 testing dates: June 5 and Dec. 4, 1999.

Testing sites: Candidates are sent a list of established testing sites roughly six weeks prior to examination date.

Recertification: Five years after initial certification, candidates must verify completion of 80 hours of approved continuing education in the past five years to avoid re-examination. There is a recertification fee of $150.

Exam content outline: Test covers the five domains described in the eligibility criteria, which include: coordination and service delivery, physical and psychological factors, benefit systems and cost-benefit analysis, case management concepts, and community resources.

Sample question: Before releasing information about a client with disabilities to an interested party, the case manager should first obtain the client's permission. In order for the client with disabilities to give consent, three elements must be satisfied. Two are voluntariness and sufficient information about what is being consented to. What is the third?

5. Certified disability management specialist (CDMS)

Credentialing board: Certification of Disability Management Specialists Commission (formerly Certification of Insurance Rehabilitation Specialists Commission), 1835 Rohlwing Road, Suite E, Rolling Meadows, IL 60008. Telephone: (847) 394-2106. Fax: (847) 394-2172.

Eligibility criteria:

Candidates must meet requirements for one of the following five eligibility categories:

1a) valid registered nurse or certified rehabilitation counselor certification / license plus a minimum of 24 months of acceptable full-time employment, or its equivalent, providing direct rehabilitation services to individuals with disabilities receiving benefits from a disability compensation system;

1b) master's or doctorate degree with very specific course requirements granted by a college or university accredited by a regional accrediting body at the time the degree was conferred plus a minimum of 24 months of acceptable full-time employment, or its equivalent, providing direct rehabilitation services to individuals with disabilities receiving benefits from a disability compensation system;

2) master's or doctorate degree with very specific course requirements granted by a college or university accredited by a regional accrediting body at the time the degree was conferred plus a minimum of 36 months of acceptable full-time employment, or its equivalent, providing direct rehabilitation services to individuals with disabilities receiving benefits from a disability compensation system (the differences between categories 1a and 2 are in the course requirements listed);

3) bachelor's degree with a major in rehabilitation granted by a college or university accredited by a regional accrediting body at the time the degree was conferred plus a minimum of 36 months of acceptable full-time employment, or its equivalent, providing direct services to individuals with disabilities receiving benefits from a disability compensation system;

4) bachelor's, master's, or doctorate degree in any discipline granted by a college or university accredited by a regional accrediting body at the time the degree was conferred plus a minimum of 60 months of acceptable full-time employment, or its equivalent, providing direct services to individuals with disabilities receiving benefits from a disability compensation system.

Registration fee: $130 nonrefundable application fee plus $160 examination fee, due when candidate sits for exam, or total certification fee of $290.

Refunds: $130 application fee is nonrefundable.

1998 testing dates: Apr. 24, 1999 (application must be postmarked by Jan. 1, 1999), and Oct. 30, 1999 (application must be postmarked by July 1, 1999).

Testing sites: Test sites are arranged on the basis of geographic distribution of the candidates sitting for each examination in order to minimize travel expenses for as many candidates as possible. Lists of established sites are sent to candidates one month prior to the examination date.

Recertification: Five years after initial certification, candidate must verify completion of 80 hours of approved continuing education in the past five years to avoid re-examination. There is a $150 certification renewal fee.

Exam content outline: Test covers job placement and vocational assessment, case management and human disabilities, rehabilitation services and care, disability legislation, and forensic rehabilitation.

Sample question: When an insurance claims representative talks to a disability management specialist about the "claim severity" of a case, what is the claims representative referring to?

6. Certified professional in health care quality (CPHQ)

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

Eligibility criteria:

• minimum of one of the following: associate, bachelor's, master's, or doctorate degree in any field, or valid RN or LPN license, or valid accreditation in medical records technology;

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

• Alternative eligibility preapplication review may be appropriate in some cases if one but not both of the above requirements are met. Request the Candidate Handbook for further details and specific requirements. Deadline to submit required materials is 90 days prior to the exam.

Registration fee: Early bird (postmarked by 6/30): $300 for non-NAHQ members, $235 for NAHQ members; regular fee (postmarked by 8/31): $350 for non-NAHQ members; $285 for NAHQ members.

Refunds: $85 of each registration fee is nonrefundable to cover processing costs. Candidates who withdraw prior to exam may receive full refund of remaining amount by making a request in writing five days prior to the examination date.

1999 testing date: Nov. 13, 1999. Non-Saturday testing for religious reasons is available.

Testing sites: More than 30 sites nationwide in multiple states. Candidates living more than 400 miles from a testing site may request a special testing site for an additional nonrefundable fee of $100.

Recertification: Candidates must apply for recertification every two years. Recertification cost is $95. Candidates must complete 30 hours or more of acceptable continuing education every two years and submit a summary of continuing education activities form. Recertification material submitted after the Jan. 31 postmark deadline must include an additional $25 penalty for a total of $120.

Exam content outline: Management and leadership; information management; education, training and communication; performance measurement and improvement; accreditation and licensure.

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

7. Certified rehabilitation registered nurse (CRRN)

Credentialing board: Rehabilitation Nursing Certification Board, 4700 W. Lake Ave., Glenview, IL 60025-1485. Telephone: (800) 229-7530.

Eligibility criteria:

• Current, unrestricted RN license plus at least two years of practice as registered professional nurse in rehabilitation nursing within the last five years. Employment must be verified by two professional colleagues, one of whom is a CRRN, or an immediate supervisor.

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

Refunds: If candidates are unable to test at a scheduled date, they must reschedule. There are no refunds.

1998 testing date: Electronic testing available at multiple sites all year long. Call Assessment Systems Inc. at (800) 470-8756 to set up an appointment. Bring application and fee in when you take the test.

Recertification: Five years after initial certification, professionals either must take the examination again or submit verification of 60 hours of continuing education or 60 points of credit in the past five years. Two-thirds of continuing education hours must be approved by national or state nursing organizations. Also, two-thirds of contact hours must be rehab-related. Recertification deadline is Sept. 30.

Exam content outline: Test covers rehabilitation and rehabilitation nursing models and theories,

(Continued on page 246)

AMBULATORY CARE
QUARTERLY

Community therapy moves rehab out of the hospital

Program prepares patients for discharge

A former rehab patient once told **Melinda Staveley**, MS, RN, "Nobody told me that in order to go home, I had to leave the hospital."

Her poignant comment illustrates how many patients feel about their transition back to their homes and communities, says Staveley, vice president of clinical services / chief operating officer at the Rehabilitation Institute at Santa Barbara (CA).

"Patients learn things in the hospital, but when they go into the community, they have a hard time translating them to the home environment," she says.

For that reason, the institute has enhanced its community-based rehab program with a goal of conducting more of the traditional therapy sessions in the community instead of within the hospital walls.

Community presents more challenges

The community-based rehab program takes into account that learning to do something in the hospital setting isn't the same as doing it in the community, where there are more distractions, more obstacles, and a constantly changing environment, Staveley points out.

"With shorter lengths of stay and fewer approvals for day and overnight passes, we don't have enough time for the learning to sustain itself if it all takes place in the hospital setting," she explains.

The institute's community-based program is far more comprehensive than the old practice of taking patients for a community outing during their rehab stay. Under the previous system, patients were grouped by diagnosis, and most were taken into the community only once during their stay.

The patients in a community-based treatment group come from all diagnoses. "It doesn't matter if you are recovering from a brain injury, spinal cord injury, or stroke if what you need is the same kind of intervention and to achieve the same functional levels," Staveley says.

The number of community-based treatments a patient receives depends on the individual patient, she says. However, the therapy staff are encouraged to take patients into the community to work on their skills as frequently as they can.

"It's probably a bit more costly than hospital-based therapy, but if it achieves the outcome in a shorter length of stay, then it's a win-win situation from the payer's perspective and our perspective," Staveley says.

The institute has virtually no fee-for-service patients. The majority of patients are on per diem or case rates, she says. The cost of running the van is the primary additional cost, she adds.

"However, from a gross productivity perspective, if a therapists can do 45-minute treatments one right after another, they can do more direct treatment in a certain time frame than if they are gathering patients, getting them into a van, driving them off campus, and driving them back. But if we do it correctly and make maximum use of the time, we can achieve outcomes more quickly," Staveley says.

For instance, the trips into the community are expected to be heavily treatment-based, including the trip in the van, during which the patient work on their verbal and cognitive skills.

Grocery store is one destination

Here's how community-based treatment works: A speech pathologist, an occupational therapist, and a physical therapist take three or four patients to the grocery store, where they will work on goals within their discipline in the community setting.

At the store, the speech pathologist may work on cognitive processing as the patient buys the

items and counts the change. The physical therapist may work on gait and ambulation, while the occupational therapist concentrates on upper body coordination as the patients put groceries into the cart.

Ideas for the community-based rehab trips are recommended in team conferences, evolve from informal conversations among therapists, or arise during hospital-based group treatments.

"Not every patient needs the same kinds of intervention, but all benefit from being in a more functional environment," Staveley says. "It's a group treatment, and they also gain a good deal from peer reinforcement."

At this point, community-based therapy groups are scheduled during regular time slots during the week.

The therapy staff are being encouraged to build more spontaneity into the process to avoid the risk of exchanging one kind of rigid schedule for another. Instead of saying "this patient could fit in with the group that is going to the beach Monday," therapists are encouraged to think about what a specific patient needs to work on and plan a trip around that.

"If you're trying to slot a particular patient into a preconceived group schedule, you may not be meeting his needs," Staveley says.

For example, in the case of a student, a lot of her therapy took place in her dormitory and classroom, where the staff helped her work on compensatory techniques so she could resume her studies. In this case, much of the therapy was one-on-one.

Community-based rehab takes a lot of commitment and effort on the part of therapists, who have to cope with the logistics of getting all the schedules to work. It's been difficult for some therapists to shift away from the old way of routinely scheduling patients at 45-minute intervals for treatment in the hospital, but others are enjoying the challenge of coming up with ways to treat the patients in the community, Staveley says.

"They are really motivated by patient successes and progress and positive outcomes," she says.

The rehab institute started the transdisciplinary approach to community-based rehab in the past year. It's too soon to have any hard data on how the change has affected outcomes, Staveley says. The move toward community-based therapy, however, has forced the administrative staff to look at productivity standards in a different way, she adds.

"We no longer look at productive or nonproductive time, but we talk about direct and indirect time, knowing a certain amount of indirect time is necessary for the planning, which in turn produces positive, enduring outcomes," Staveley explains.

For more information, contact Melinda Staveley at (805) 683-3788. ■

Outcomes, practice pattern used to set benchmarks

Aim is to identify the best practices

By tracking the practice patterns of its treatment teams and comparing costs and patient outcomes among the teams, staff at the Shepherd Center in Atlanta are working to identify practices and procedures that produce the best patient outcomes for the best costs.

"We're not trying to find cost savings by cutting people and services, but by identifying ways that we can become more efficient," says **Gary Ulicny**, PhD, chief executive officer of the hospital. Shepherd specializes in patients with spinal cord injury, acquired brain injury, multiple sclerosis and other neuromuscular disorders, and urological problems.

A hospital committee appointed to conduct the benchmarking project is in the initial stages of collecting data. Those data will be used to compare the treatment practices, procedures, and outcomes from each treatment team within a particular diagnosis with those of other teams, as well as comparing the teams in terms of cost and outcomes.

Each patient at Shepherd is on a critical pathway and is assigned to a treatment team, led by a physician and a case manager. Shepherd is reimbursed on a per diem basis for about 70% of its patients. Most of the rest are Medicare or Medicaid patients for whom Shepherd receives a case rate.

"We very rarely see fee-for-service or discounted fee-for-service patients," Ulicny says. "It's definitely in our interest to identify all opportunities to utilize resources more efficiently."

Shepherd treats many of its patients from the intensive care unit through the acute rehab stay and outpatient therapy. "When you look at global

pricing, you need to know what the cost is to provide care from day one," he says.

However, Shepherd's efforts are not exclusively designed to cut costs, he emphasizes. "There are opportunities for savings, but they are by managing care and not cost. If you focus on cost savings, you compromise the quality of care," he says.

The benchmarking process will evaluate practice patterns to learn what practices, procedures, drugs, and equipment various treatment teams use and determine whether they have an effect on outcomes.

Best costs, best outcomes

The committee will analyze the practices of the team with the best cost and best outcomes and determine what it is doing compared with what other teams are doing for the same patients. "Our goal is to identify the best practices and to set benchmarks on cost per day. Along with this, we are monitoring outcomes to make sure they don't have any negative effect on quality," Ulicny says.

The benchmarking project will include an analysis of each treatment team's variances from the hospital's critical pathways, a cost-per-day analysis for each treatment team, and an examination of the outcomes for each patient treated by the team.

At Shepherd, the critical pathway is a part of the patient chart. Staff chart by exception; in other words, they check off pathway items or chart the variances. "The examination of the critical pathways should tell us what the differences are among the teams in terms of practice patterns," he says.

In examining data for the benchmarking project, the committee will use Shepherd's cost-accounting system to compare daily costs for teams treating the same type of patients. For example, the committee will compare cost per day for team A treating paraplegics and team B treating paraplegics, analyze why costs differ, and determine what the teams are doing to affect the costs.

It took staff at Shepherd about a year to set up a cost-accounting system in which actual costs are automatically entered into the system along with the charges. The system factors in overhead and actual costs and is adjusted periodically. It produces daily reports on cost per day for each patient.

The types of medication being prescribed may be among the factors that affect the cost of care, Ulicny says. Some physicians may prescribe a certain medication because they've always used it. "We're looking at coming up with new guidelines that may make the medication less costly to patients. This is particularly important when you have bundled pricing, because the cost of medication comes out of the per diem rate."

The hospital already makes the data available to physicians and case managers so they can manage the cost of care by looking at the daily cost of treatment, Ulicny says.

Identifying benchmarks

The next step will be to identify the best practices and to set target benchmarks, possibly changing practice patterns. For example, every patient who comes into Shepherd receives X-rays on the first day. The committee may meet with treating physicians and determine that if patients have had an X-ray within three days of admission, they don't need to receive another.

At the same time, the committee will compare outcomes from Shepherd's extensive database and determine which procedure provides the best outcomes.

When cost cutting or efficiency measures are identified, Shepherd will continue to monitor the outcomes to make sure cost cutting doesn't have a negative effect, Ulicny says.

"Cost and its relationship to quality can't be separated," Ulicny says. "We have a foundation to measure both accurately, and now we are going to analyze what the relationship is and try to identify potential savings." ■

Menu-type day program is a hit with payers

Days, hours, LOS vary with each patient

Day treatment patients at Columbia St. David's Medical Center in Austin, TX, may spend as much as five hours a day, five days a week for a full regime of therapy at the rehab center, or they may spend as little as an hour a week for treatment by just one discipline. It all depends on how much and what kind of treatment they need.

"A day program is a unique treatment modality," says **Laura Hamilton**, PhD, day program

supervisor. "It's less expensive than inpatient, and our focus is on the most efficient and effective treatment to return people to the highest level of functioning as quickly as possible."

Juggling staff and patient schedules to create an individual program for each day treatment patient takes a lot of time, but the concept has paid off, says case manager **Shaley vonDoenhoff**, LMSW.

"Some payers don't include day treatment in their benefits package, but they'll work to come up with ways to fund our program. They trust us because we don't keep the patients any longer than we need to or give them therapy unless they absolutely need it," vonDoenhoff adds.

The majority of patients are being treated for strokes and head injuries. "They come here to solidify their skills that will allow them to remain independent and to improve their level of independence in the home and the community," says **Barbara Lasiter**, MOT, OTR, director of the rehabilitation center.

The Columbia St. David's program is personalized for each patient, Hamilton says. "We develop a treatment plan that depends on each patient's areas of strength and weaknesses, based on their input, the doctor's prescription, and the evaluation from each discipline." One patient may come five days a week from 9 a.m. to 3 p.m. and receive physical therapy, occupational therapy, speech therapy, recreation therapy, counseling, and vocational rehabilitation. Another may come just three days a week for half a day to work on cognitive issues. **(For more on how staff set the schedule, see box at right.)**

Patients who need to take advantage of other hospital programs can do so. For example, one patient attends the day treatment program in the mornings and a cardiac rehab program in the afternoons. Others have been seen a physical therapist from the hospital pain management program.

Patients may choose to participate in recreational activities or group sessions geared to meet the needs of a variety of patient needs**. (For details on recreational and group activities, see p. 245.)**

As soon as patients make progress and meet their goals, they are discharged from the individual discipline. For example, a patient may start out coming five days a week and receiving treatment from five disciplines. After a period of time, treatment may taper to just one day a week for speech therapy. Some patients are in the program for six weeks; others may come to day treatment for as long as a year.

Day treatment scheduling is time-consuming

Slots are filled on a case-by-case basis

Setting up the schedule for the flexible day treatment program at Columbia St. David's Medical Center in Austin, TX, is similar to fitting a puzzle together, says **Laura Hamilton**, PhD, day program supervisor.

"We set the schedules on a case-by-case basis," Hamilton says. "Each schedule matters so much to each patient that it's very satisfying to work it all out."

Each Tuesday afternoon the treatment team meets to set the schedule for the following week. Representatives from each discipline discuss the patients' needs and preferences and act as advocates for each patient's slot on the schedule. For example, a family member's schedule may make it necessary for the patient to come in at 10 a.m. instead of 9 a.m. If so, the patient isn't scheduled for a 9 a.m. treatment.

Juggling the time slots

Some patients may prefer an afternoon time slot for their thrice-weekly speech therapy, or they may be too tired after lunch every day for physical therapy. Others may come just two mornings or three afternoons a week. In addition, there are group treatments and community outings to consider.

The staff take all that into account as they juggle the time slots, patient preferences, and staff time. "It's a big investment of time to get it just right," Hamilton says. The schedules are entered on a transparency so they can be changed easily.

Once the treatment team sets the schedule, a staff member cross-checks to make sure everything on the patient and staff schedule is the same. Another staff person checks again to make sure the schedules will work. The schedules are printed, distributed to patients and staff, and posted on the weekly therapy board.

"We can't always accommodate everyone," Hamilton says. "Sometimes a patient gets a good match, and sometimes he or she has to make the best of things." ■

Day treatment includes the Quest program for younger people, some as young as 10, and the Bridges program for retirement-age people or older. Programs are tailored for the age groups. For example, the younger people participate in more strenuous recreational activities, and retirees don't receive vocational rehab services.

The program has about 20 professional staff, some of whom work on a PRN basis. "The PRN staff know the patients and the program and come in to provide continuity if the census increases," Hamilton says. The patient census is usually about 30, but it can reach 37. Each discipline tracks patient improvements over time, such as how far a person could walk, how much time was needed to transfer from a wheelchair to a mat, and how much assistance was needed at the beginning of treatment vs. the end.

Each patient undergoes neuropsychological testing at the beginning and at the end of the program to measure what kind of progress they have made. Patients also are evaluated on their ability to meet a specific goal, which is set after their evaluations. A goal might be the ability to recall auditory information with 80% accuracy.

When goals are met, the staff decide if there is a next step or if the patient may be ready for discharge from that part of the program. ■

Recreation, group therapy integral to day program

Goal is to regain quality of life

The philosophy of the day treatment program at Columbia St. David's Medical Center is to help people regain their quality of life and participate as much as possible in the activities they enjoyed before their illness or injury. "We want to help them get back to work and make the best possible use of their time instead of sitting around and being sad," says **Laura Hamilton**, PhD, day program supervisor at the Austin, TX, medical center.

If a patient enjoyed outdoor activities before his or her injury, the recreation therapy staff help create modified ways of resuming them. For example, if a patient wants to fish and doesn't have the flexibility, they can suggest adaptive poles with bigger grips.

The recreation therapist works closely with each discipline to plan activities patients enjoy and help them meet their therapeutic goals. For example, if patients need to practice ambulation or transferring, they can do so while playing golf or learning to do a salsa dance. One man's goal was to be able to walk his daughter down the aisle at her wedding. Recreation therapy is recommended for each patient, but some aren't interested.

The day treatment program also includes group sessions on a variety of topics:

❑ A brain injury education group for patients and family members provides information on types of injuries, what kinds deficits they cause, and which areas of the brain may not be affected. "We give them as much information about themselves as possible so they can be in charge of their lives," Hamilton says.

❑ A memory group does problem-solving and memory-increasing tasks. Patients in a group setting often reinforce learning for each other.

❑ A newsletter group produces a newsletter with stories and pictures. They plan themes, write articles, and edit their own and their colleagues' work.

❑ A discovery group, led by a counselor, talks about coming to terms with the losses associated with brain injury or stroke.

❑ A community group plans activities to help patients with therapy. For example, if they're working on ambulation, they might plan a trip to the zoo. If they're working on social skills, they might go to a restaurant. ■

Dental work may cause artificial joint infection

Patients who have undergone total knee replacement surgery may develop infections in their artificial joints from bacteria released during tooth extractions, root canals, or other dental surgery, according to a report in *Clinical Orthopaedics and Related Research.* Researchers at Good Samaritan Hospital and Johns Hopkins School of Medicine in Baltimore say some people with artificial knee joints should take antibiotics before having dental work. Those at risk are people with diabetes or rheumatoid arthritis and those taking corticosteroids or other immune-suppressing drugs.

In a study of 3,490 patients, 62 developed infections in their artificial joints, sometimes years after replacement surgery. Of those, 11% were associated with some kind of dental procedure, the researchers found. ■

(Continued from page 240)

functional health patterns, rehabilitation team members, community re-entry, and legislative and legal issues.

Sample question: What cranial nerve is affected in a patient who cannot smile but can chew without problems?

8. Continuity of care certification, advanced (A-CCC)

Credentialing board: National Board for Certification in Continuity of Care, 7313 Southview Court, Fairfax Station, VA 22039. Telephone: (860) 586-7525. *(Editor's note: At press time,* Hospital Case Management *had not received confirmation of the preceding address.)*

Eligibility criteria:

• open to multiple disciplines, including nursing, social work, therapy, dietitians, and physicians;

• bachelor's degree plus two years of full-time experience within the last five years in continuity of care, or equivalent part-time experience (4,000 hours) within the past five years. Verification of employment is required.

Registration fee: $300.

Application deadline: March 30, 1999 (for May test), Sept. 30, 1999 (for November test).

Refunds: Candidates who withdraw from the exam may receive a refund of $75 or reschedule for the next exam for an additional fee of $125. Requests for refunds or rescheduling must be made in writing within 30 days of testing date.

1999 testing dates: May 15 and Nov. 6, 1999.

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

Recertification: Certification is valid for five years from the date of initial certification. To achieve recertification, a candidate must: 1) provide documented evidence of at least 50 contact hours of continuing education related to continuity of care within the five-year certification period, or 2) successfully pass the certification examination. Both options require payment of recertification fee.

Additional information: "The NBCCC recognizes that continuity of care includes many factors beyond those traditionally associated with discharge planning and case management, and that these important components of the total health and social support system are included in continuity of care," according to NBCCC's Handbook for Candidates.

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

Sample question: In planning discharge services for the elderly, it is important to remember that the majority of services will be delivered in what health care setting? ■

NEWS BRIEFS

Accreditation will deal with globalization of care

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, soon will offer international accreditation services. Since 1994 the agency has offered international consultation services through Joint Commission International (JCI), a partnership between JCAHO and its consulting subsidiary Quality Healthcare Resources. Renamed Joint Commission Resources (JCR), the entity is collaborating with the International Society for Quality in Health Care to develop a set of core international principles that can be used to guide the evaluation of culture-specific standards. The Joint Commission subsidiary will serve as the umbrella entity for international accreditation services and for domestic and international consulting services.

The 1999 endeavor comes as United States-based organizations begin to expand their ownership of entities abroad, bringing with them expectations prevalent in this country. **K. Tina Donahue**, president of JCR, said in a statement, "Accreditation can help international health care organizations position themselves to deal with

emerging issues surrounding the privatization and globalization of health care." For more information on JCR, contact Jim Janeski, executive director of International Services. Telephone: (630) 268-7424. E-mail: jci@qhr-jci.com. ▼

MDs miss vital info during patient visits

Primary care physicians perform poorly when taking medical histories and performing preventive screening, according to a recently published study in the *American Journal of Medicine*. In fact, researchers found that primary care physicians often missed important information related to a patient's symptoms and medical history.

Researchers analyzed the history-taking and preventive-screening skills of 134 primary care physicians from five Northwestern states. The researchers presented physicians with standardized patient cases, individuals who were trained to present a certain medical profile to physicians. Researchers then scored physicians on the number of essential history and preventive screening items addressed during each patient visit.

Roughly 75% of physicians asked questions that described presenting symptoms, and 83% of internists and 71% of family practitioners asked about medications and allergies to medications. Other findings include:

- Only 50% of internists and family practitioners asked pertinent history questions related to the patient's current complaint.
- Only 74% of patients were asked about tobacco use.
- Only 60% of patients were asked about alcohol use.
- Only 41% of patients were asked about use of recreational drugs.
- Only 50% of all physicians reviewed medical systems or past medical history.

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Editorial Questions

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For example, 56% of physicians in the study group failed to ask a 60-year-old man with fatigue and weight loss related to undiagnosed lymphoma whether he had night sweats, which would increase suspicion of lymphoma.

In addition, researchers found that very few physicians asked about patients' sexual histories or risk factors for AIDS and other sexually transmitted diseases. Researchers concluded that physicians might improve their performance if

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they used a medical intake questionnaire to enhance medical history taking.

(See: Ramsey PG, Curtis JR, Paauw DS, et al. History taking and preventive medicine skills among primary care physicians: An assessment using standardized patients. *Am J Med* 1998; 104:152-158.) ■

CE objectives

• Define the percentage of nurses holding the CNOR credential who do not also hold a BSN degree.

• Name the department-based case management credential that will target facility-based case management programs.

• Define the number of hours of course work called for in the program model for the "Diplomate of the Academy" credential proposed by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations.

• List the 1999 testing date for the San Gabriel, CA-based Healthcare Quality Certification Board's Certified Professional in Healthcare Quality credential. ■

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Monthly	12	$359.00

7. Complete Mailing Address of Known Office of Publication *(Street, City, County, State, and ZIP+4) (Not Printer)*: 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, Fulton County, GA 30305 — Contact Name: Willie Redmond

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*: 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305 — Telephone Number: 404/262-5448

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*: Brenda Mooney, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*: Russ Underwood, same as above

Managing Editor *(Name and Complete Mailing Address)*: Susan Hasty, same as above

10. Owner *(If owned by a corporation, its name and address must be stated and also immediately thereafter the names and addresses of stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) (Do Not Leave Blank.)*

Full Name	Complete Mailing Address
American Health Consultants	3525 Piedmont Road, Bldg. 6, Ste. 400
	Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check here. ☐ None

Full Name	Complete Mailing Address
Medical Economics, Inc.	Five Paragon Drive
	Montvale, NJ 07645

12. For completion by nonprofit organizations authorized to mail at special rates. The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes: *(Check one)* ☐ Has Not Changed During Preceding 12 Months ☐ Has Changed During Preceding 12 Months *(If changed, publisher must submit explanation of change with this statement)*

PS Form **3526**, July 1995 *(See instructions on Reverse)*

13. Publication Name	14. Issue Date for Circulation Data Below
Hospital Case Management	September 1998

15. Extent and Nature of Circulation	Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*	1744	1779
b. Paid and/or Requested Circulation (1) Sales Through Dealers and Carriers, Street Vendors, and Counter Sales *(Not Mailed)*	7	7
(2) Paid or Requested Mail Subscriptions *(Include Advertisers' Proof Copies/Exchange Copies)*	1645	1579
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*	1652	1586
d. Free Distribution by Mail *(Samples, Complimentary, and Other Free)*	18	18
e. Free Distribution Outside the Mail *(Carriers or Other Means)*	0	0
f. Total Free Distribution *(Sum of 15d and 15e)*	18	18
g. Total Distribution *(Sum of 15c and 15f)*	1670	1604
h. Copies Not Distributed (1) Office Use, Leftovers, Spoiled	74	175
(2) Return from News Agents	0	0
i. Total *(Sum of 15g, 15h(1), and 15h(2)*	1744	1779
Percent Paid and/or Requested Circulation *(15c / 15g x 100)*	99	99

16. This Statement of Ownership will be printed in the December issue of this publication. ☐ Check box if not required to publish.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Brenda L. Mooney, Publisher — Date: 9/25/98

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions *(including fines and imprisonment)* and/or civil sanctions *(including multiple damages and civil penalties)*.

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster on or before October 1, annually. Keep a copy of the completed form for your records.
2. Include in items 10 and 11, in cases where the stockholder or security holder is a trustee, the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check box. Use blank sheets if more space is required.
3. Be sure to furnish all information called for in item 15, regarding circulation. Fee circulation must be shown in items 15d, e, and f.
4. If the publication had second-class authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or the first printed issue after October, if the publication is not published during October.
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