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HOSPITAL CASE MANAGEMENT™

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

INSIDE

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Erase the battle lines: How to cut out conflicts with MCO case managers

'The stronger the relationship, the easier it is to negotiate,' experts say

As managed care penetration increases in markets across the country, so do tensions between hospital-based case managers and their payer-based counterparts. The managed care representative may too often be merely a voice on the phone, seemingly reciting a litany of rules without reference to the specific needs of the patient. And as hospitals add more and more managed care contracts, it becomes increasingly difficult to maintain effective relationships with managed care case managers on behalf of the patient and the facility.

But experts who've worked both sides of the fence say there are ways to reduce the inevitable conflicts that arise between case managers in the hospital and those working for a managed care organization (MCO). And reducing conflicts — by opening up lines of communication and seeking to align incentives — is the only way to get more of what you want from your relationships with MCOs.

"The stronger the relationship is, the easier it is to negotiate," says **Deborah Smith**, MN, RN, Cm, CNAA, executive vice president of American Medical Systems in Los Angeles. Smith, a former hospital case manager, also is lead author of the Little Rock, AR-based Case Management Society of America's standards of practice. "When people know each other and understand each other's motives, as well as the mission of each role, then they have a platform from which to work that's far more effective than if they don't that strength of relationship."

Smith adds that most people on both sides are motivated to do what they think is right. The problem is reaching a consensus on what the right thing is. "It's easy to criticize somebody you don't know and have never seen and who's across the country on the telephone," she says. "What's more difficult is understanding the various perspectives and the knowledge base that each [person] brings to the situation."

Toni G. Cesta, PhD, RN, director of case management at Saint Vincent's Hospital and Medical Center in New York City, agrees that any successful negotiation with managed care companies depends first on

finding some kind of common ground. "We've been successful many times in negotiating benefit changes because of our relationships [with payers]. Organizations that create an antagonistic relationship are not really going to get where they want to go," Cesta says. **(For more on how Cesta has built positive relationships with managed care representatives, see related story, p. 23.)**

But aligning incentives and finding common ground can be more difficult than it sounds, given the many and sometimes complicated points of contention between hospital case managers and their managed care-based counterparts. These include:

• **Authorization.**

"Hospital case managers often claim that with HMO X, their patients never get a certain test or a certain intervention," Smith says. "That's probably overstated, but often their feeling of conflict comes because the patient needs something and the managed care case manager doesn't see it the same way. So there becomes a conflict over authorization and medical necessity."

• **Vendor selection.**

"Sometimes the acute care case manager will want to use a particular vendor for quality purposes," Smith says. "Or something they know about the local terrain will lead them to select a certain long-term care facility. The MCO may have a different idea, either because it has a contractual relationship or because it's not knowledgeable about the local community. Or they may just have a different opinion. So we see some struggle about what the patient needs for discharge and where they are going upon discharge."

• **Lack of contact.**

Joanna Kaufman, RN, MS, a managed care specialist and president of Pyxis Consultants in Annapolis, MD, says differing perspectives among managed care and hospital-based case managers often are a cause for conflict. And those conflicts are only exacerbated when case managers are forced to communicate by long distance.

"The acute care case manager is trying to do her best for the patient, and may develop a plan that is not consistent with what the MCO case manager's plan might be," Smith says. "There's a sense [from hospital case managers] that 'I'm here, I'm seeing the patient frequently, if not every day, and here's this person on the telephone telling me what I've got to do.' The problem is that the person with the leverage is the MCO case manager, while the person with perhaps more of a sense of rightfulness is the acute care case manager, because she's right there on the scene."

• **Access to patients.**

Another issue, Smith says, is the question of who has "ownership" of the patient. Some hospitals insist on barring managed care case managers from having physical access to the patient as a way to decrease confusion on the part of the patient.

Kaufman, who has served both as a hospital nurse and as vice president for case management at a managed care company, says such an approach can be divisive and can undermine the quality of the hospital/managed care relationship. "I think that most managed case managers understand that hospitals have policies and procedures about access to patients," she says. "And it's probably incumbent upon the managed care case manager to call the case manager at the hospital and have a discussion about what those policies and procedures are."

Smith says such negotiations regarding policy disagreements are more easily resolved if the managed care representative spends significant time at the facility. "When you have lunch or coffee with somebody and you see her day in and day out and you work together on a number of patients, you develop a sense of trust

KEY POINTS

- With managed care penetration increasing, it's more important than ever for hospital case managers to find ways to resolve the inevitable conflicts that arise with their managed care-based counterparts. Typical conflicts include struggles over authorization, vendor selection, lack of contact, and access to the patient.
- Some conflicts can be resolved simply by increasing the level of communication — usually by having managed care case managers stationed in the hospital itself. But even when contact is only by telephone, there are steps you can take to ease the tension.
- One way is simply to keep managed care case managers informed regarding such things as return admissions by problem patients. Effective discharge planning practices also can strengthen bonds, especially when it comes to patients with complex care needs.

CMs facilitate managed care cooperation

But they draw the line at direct patient access

Although her facility's in an area with only about 35% managed care penetration, **Toni G. Cesta**, PhD, RN, director of case management at Saint Vincents Hospital and Medical Center in New York City, already has laid the groundwork for developing cooperative working relationships with managed care organizations.

Cesta's first step was to provide office space at the hospital for the managed care representatives. "That was a big issue for us — what were the costs and benefits associated with making space and resources like telephones and computers available to them?"

Ultimately, Cesta concluded that having the managed care reps located together near her own case managers would create a more positive atmosphere and contribute to better working relationships between the two groups. "We looked at our contracts to see if we had agreed to provide space, and there wasn't anything there," she says. "But it seemed like a smart business decision."

Another move designed to foster closer cooperation was inviting the managed care representatives to monthly staff meetings. Cesta notes that she has 30 case managers, "so it's a large group for them to get to know. We bring them in to the staff meetings so they can put names and faces together. I really make an effort to have a collegial relationship with them, because that gets you a lot further than an antagonistic one."

Even so, there are some things Cesta won't allow. Chief among those is letting managed care representatives talk directly to patients. "I really felt that would cause a lot of stress for the patient," she says. "Having all these different people coming in and saying 'I'm the case manager' would be very confusing and intimidating. It's really not appropriate." Managed care case managers are allowed to look in the patient's medical record.

Overall, Cesta's been pleased with having managed care case managers located on-site in her hospital. Because their primary function is utilization review, having them at St. Vincents saves her case managers from making time-draining phone calls. On the other hand, there's always a potential danger in having managed care personnel be physically present at a facility. "It could potentially result in more denials," she says. "I can't say for a fact that that's happened, though. There's always a risk when you have people on site looking in your medical records."

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about what that person knows, what she's trying to achieve, and how she's going to achieve it," she says.

That kind of trust is particularly apparent in cases where health plans delegate discharge planning and utilization review duties for their high-risk patients to hospital case managers, says **Sandra L. Lowery**, BSN, CRRN, CCM, president of Consultants in Case Management Intervention in Francestown, NH. "Talk about trust," she says. "They've found a way to communicate at the same level. And I see that naturally occurring when everyone is trying to work together. Especially in hospital environments that have already accepted capitation, case managers should be providing the same level of service and the same model of service, whether they're responding to a managed care organization or to their own organization. It's only when there's a disconnect between the two that problems occur."

Lowery adds that trust is possible only when case managers share common goals and principles of practice. But finding that sort of common ground is difficult, particularly because the roles and responsibilities of individual case managers can vary widely. "That's where we find tremendous difficulty, because many case managers have the title but are not adhering to the national standards of practice," Lowery says.

And even if roles and responsibilities match up, viewpoints may differ widely. For example, while hospital case managers may be accountable for financial outcomes, they also must be accountable

for clinical and functional outcomes, as well as patient satisfaction. Meanwhile, a managed care case manager may not consider her responsibilities that comprehensive.

One way hospital-based case managers can help to win over their MCO-based counterparts is to actively involve them in the case from the beginning, Kaufman notes. "More and more members have case management in their plan, but they don't always come to the attention of the managed care case manager at first blush," Kaufman says. "One way for the hospital case manager to enhance communication and establish a positive relationship is to inquire whether the patient is known to the system or should be known to it."

Update MCO on problem patients

Another relationship builder is to give managed care case managers an occasional "heads up" on the status of problem patients. For example, Kaufman says, a patient familiar to both the hospital case manager and the MCO case manager is admitted again. "A simple follow-up phone call to the managed care case manager saying 'we're going to put together a new plan, and we'll keep you updated' lets the managed are company understand that we're working on this together," she says.

Good discharge planning practices also can help strengthen bonds with managed care case managers, Kaufman notes — especially when it comes to patients who may have complex ongoing care needs. "It's very helpful if we know a good discharge plan has been put together, and there's been input from all the appropriate sources and proper documentation," she says. "It strengthens whatever requests people have for equipment, nursing, and ongoing funding."

Smith says she believes case managers ultimately will have to work together not just to develop discharge plans but also master plans that cross the continuum and are agreed upon by both payers and providers. "That might be one way we could begin to fix the problem rather than just complain about the problem," she says. "We have to stop competing over whose patient it is and try to develop a sense of consistency for the patient and perhaps broaden our horizons. The issue of compartmentalization is still very real, and I look forward to being able to cross those bridges."

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CMs fight for acceptance of premature infant path

Standardization a key selling point for staff buy-in

The idea seemed simple enough. Case managers at University Hospital-University of Colorado Health Sciences Center in Denver identified factors they believed were boosting length of stay among premature infants and decided to tackle the problem with a clinical pathway. They did their homework, convened a pathway team, and spent a year hammering out a finished draft.

The response? "Everyone was against it," says **Ginger Okada**, RN, a case manager at the hospital who championed the pathway. "The nurses didn't think it was a good idea; the physicians didn't think it was a good idea. We needed to win people over."

The idea to create the pathway originated with the hospital's office of clinical practice, which saw that costs per case and length of stay were higher there than at similar facilities. One possible reason was Denver's mile-high altitude, which might have made breathing more difficult for fragile infants. Because of the altitude, the hospital requires that babies be able to breathe freely without supplemental oxygen for 40 minutes before they're eligible for discharge. "That way, we know that if the parents are asleep and the baby pulls the nasal cannula off in the middle of the night, it's going to be safe for a while," Okada says. "I don't think many other hospitals around the country require that." University Hospital also requires

KEY POINTS

- Responding to benchmarking data indicating that their length of stay for premature infants was above the national average, case managers at University Hospital-University of Colorado Health Sciences Center in Denver formed a multidisciplinary team to develop a pathway designed to address the problem. But they encountered stiff initial resistance from both staff nurses and physicians, many of whom regarded the pathway as "cookbook medicine."
- The main appeal to nurses was that the pathway's preprinted orders would help standardize care — a key selling point at this teaching hospital, where attending physicians and interns rotate in and out on a monthly basis. Case managers also changed the pathway's documentation requirements at the suggestion of the nurses, adopting a charting-by-exception approach.
- Physicians have been slower to come around, but the case managers are optimistic that outcomes data on the revised pathway, due within six months, will demonstrate the pathway's benefits.

that infants be free of life-threatening apnea bradycardia (pauses in breathing combined with a slow heart rate) for five days before discharge.

But while the case managers and office of clinical practice viewed the proposed pathway as an opportunity to improve and standardize care, they encountered stiff resistance from physicians and staff nurses, who claimed it wasn't necessary. Many cited the old bromide about pathways being "cookbook medicine." The challenge quickly became how to win sufficient support for the pathway to have a chance at success.

The main appeal to the nurses was that standardization would help simplify and add consistency to the care of premature infants. Nurses had long had problems with physicians writing different or incomplete orders upon admission. Those problems were complicated by the fact that the facility is a teaching hospital, with different attending physicians each month. "And of course the interns also go through very rapidly," Okada says. "Things would change from month to month, and we wouldn't know what to expect. We used that to say, 'If we have the pathway [with its preprinted orders], then you'll know what to expect when you're getting an admission of this type." **(See sample page from the pathway, p. 26.)**

Okada used a similar argument regarding discharge: "Everybody gets frustrated when it's the day of discharge and things haven't been done that needed to be done. We used that as a selling point for the pathway," noting that the path broke down responsibilities by time period.

> "Everybody gets frustrated when it's the day of discharge and things haven't been done that needed to be done. We used that as a selling point for the pathway."

Okada and her colleagues also spent time listening to nurses' questions and suggestions about the pathway. For example, the initial pathway, piloted a year ago, required nurses to initial and sign off in several places. Now the pathway will be charted by exception, which should speed up the documentation process.

Because of such efforts, the staff nurses have largely come around to support the pathway, Okada reports. Physicians, however, have been tougher to convince. Their initial opposition to the pathway stemmed from their contention that environmental factors — and not their own practice patterns — were to blame for the higher length of stay at University Hospital.

Okada and her colleagues are using nurse practitioners as their liaisons to the physicians. "I don't know that we'll ever quite win the attendings over," she says. "What we're going to have to do is show them the benefits that we've seen from using [the pathway]." That means providing hard data on outcomes, which should be available within six months.

In the meantime, Okada's trying to win converts by dispelling myths about pathways being mere "cookbook medicine." For example, one attending who had been particularly vocal in

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University Hospital
4200 E. Ninth Ave.
Denver, CO 80262

UNIVERSITY HOSPITAL CLINICAL PATH

Diagnosis: 28-29 week Premature Infant, no complications Diagnosis/DRG Code: 386

This protocol is a general outline and does not represent a professional care standard governing provider's obligations. Care is revised to meet the individual patient's needs.

Allergies _____ _____ _____	Phase: 2 Length of Phase: 10-14 days
	Circle and initial box if item is unmet
Tests	Crit, ABGs Lytes at 24 hr of age CXR as ordered
Treatments Interventions	Continuous pulse ox, till stable To isolette when stable TPR and BP q 2 hr from monitor, q 4 hr hands on Length and OFC q week Weight q day
Pulmonary	Ventilator Support as needed CPT as ordered Suction as needed
Medications	Ampicillin q 12 hr Gentamicin q 24 hr, D/C anti-infectives when no longer indicated Continue dopamine if needed Surfactanct q 12 hr as indicated
Diet	Begin feeds when stable UAC as needed, D/C when ventilatorily stable UVC/PIV Pacifier if tolerated ELIMINATION: Accurate I and O Caluclate output q 8 hrs
Activity	Supportive positioning Minimal stimulation, increase stimulation when stable and can tolerate
Teaching	Visiting policy completed and returned
Consults	Social Services Lactation Physical Therapy for observation

Source: University Hospital-University of Colorado Health Sciences Center, Denver.

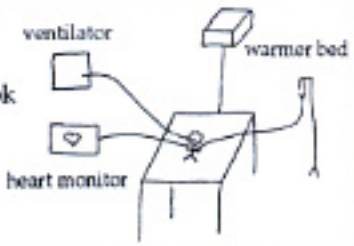
UNIVERSITY HOSPITAL

We practice what we teach®

PATIENT & FAMILY CLINICAL PATH
28 TO 29 WEEK PREMATURE INFANT

This is a general plan of how the staff will work with your baby. It will help you know what to expect. Each baby is different and goes at their own speed. Some babies may not need some of the things listed and others might need extra things done. Your nurse will go over this with you and answer any questions you may have.

Baby's Name: _____

	PHASE 1: FIRST 8 HOURS
Blood Tests	Your baby will have blood work drawn to test for sugar levels, infection, oxygen levels, and anemia. A blood sample is also sent to the blood bank in case your baby needs a transfusion. 
X-rays	Your baby's body will be x-rayed from the chin to the hips. This helps us make sure the breathing tube and IV lines are in the right place. The doctor will also look at the lungs and the intestines.
Medicines	• All babies in Colorado receive an antibiotic eye ointment and an injection of vitamin K when they are born. (Vitamin K helps blood clot in case there is a bleeding problem.) • If needed, your baby may receive antibiotics or a medicine given directly to the lungs to help with breathing.
Diet	 Your baby will not be eating during the first 8 hours. Instead your baby will receive sugar water through a vein using an IV (intravenous). If you wish to breast feed, please talk to your nurse, so you can pump your breasts. (The nurse will tell you how to save the milk so we can later feed that to your baby.)
Activity	• Your baby will be going through a big change – from being inside a warm womb to being in a bright nursery. We try to keep things quiet and comfortable for your baby, but many things need to be done in the first 8 hours. • Most babies are quiet and sleep a lot at first. • You are welcome to visit your baby. He or she will be glad to hear a familiar voice.
Team Care	• The nurse will weigh your baby. The nurse will take your baby's vital signs (heart rate, blood pressure, breathing rate) frequently. • The nurses and doctors put in the necessary IV's and hook your baby up to all the machines they may need: ⇒ Warming bed. This keeps your baby at the right temperature. ⇒ Heart monitor. Patches are placed on the chest to connect to this. ⇒ Breathing machine (ventilator). This attaches to a breathing tube that goes into your baby's lungs. (If your baby cries there will not be any sound while the breathing tube is in place.) ⇒ Monitors for blood pressure and oxygen. 
Education	• You will have lots of feelings and questions. Please feel free to ask us about anything. • We will show you where your baby is, what all the equipment is, and explain our visiting policy. (You will need to fill out a visiting form and return it to your nurse.) • You will receive an information folder explaining some of the special things about having a baby in the Neonatal Intensive Care Unit (NICU).
Preparing to Leave	A case manager or social worker will meet with your family. You may discuss financial and insurance matters and begin planning for your baby's discharge from the hospital.
Goals You Have	

Source: University Hospital-University of Colorado Health Sciences Center, Denver.

(Continued from page 25)

opposition to the pathway came to Okada recently to ask if there was any way to make sure all infants got head ultrasounds. "I used that as an opportunity to show him that head ultrasounds are on the pathway, and if infants were on the pathway, the ultrasounds wouldn't get missed." Okada notes that, like the nurses, the physicians have generally responded well to the inclusion of preprinted orders on the pathway.

Another positive development was the creation of a family education pathway that is provided to parents. **(See sample page from the family pathway, p. 27.)** Okada wrote the family pathway herself, then ran it by a support person who adjusted it to the proper reading level and added graphic design elements. "We can tell them what to expect, but if it's written down and we can show them, then they're able to understand it better," Okada says.

Despite the success of the preprinted orders and family pathway, some elements of the clinical pathway itself still needed work following the pilot test in early 1998. One problem was that, initially, the pathway had to be documented only once per phase — with a phase lasting anywhere from eight hours to several weeks. As a result, some people would forget the pathway altogether.

"Our approach this time is to replace the Kardex documentation they already do with a notebook at the bedside that they need to chart on every shift," Okada says. If they did everything required for that shift, they only have to sign at the bottom of the form. If something was omitted, they circle it on the form, fill in a brief explanation, and reschedule if necessary. "So it serves as a kind of reminder sheet for them," Okada adds.

With a second trial due to start soon, Okada remains patient and optimistic that the pathway will take hold and achieve positive outcomes for premature infants and the facility. "When we started this process, I had done the research on clinical paths and their benefits, and I knew where I was coming from," she says. "But I had to be patient in dealing with the rest of the team. You can't force people to do things just because you see the situation a certain way. You have to help them come around to seeing the benefits."

For more information, contact Ginger Okada, RN, University Hospital-University of Colorado Health Sciences Center, 4200 East Ninth Ave., Denver, CO 80262. Telephone: (303) 372-6470. ■

HCFA's new rules on newborn LOS take effect

Rules may shield providers from liability

With little fanfare, new rules from the Baltimore-based Health Care Financing Administration (HCFA) that set guidelines for hospital lengths of stay in connection with childbirth have just taken effect. The rules govern implementation of Newborns' and Mothers' Health Protection Act (NMHPA), which was passed in September 1996.

NMHPA adds to existing protections under the Health Insurance Portability and Accountability Act, which significantly expanded the federal government's ability to aggressively pursue alleged health care fraud and abuse.

Basically, the new rules state that a group health plan or other insurance carrier is not allowed to restrict mothers' and newborns' benefits for a hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The rules also assert that the only the attending provider — not the insurance company — is allowed to determine whether an admission is in connection with childbirth.

According to the rules, length of stay should be calculated from the time of delivery, if the delivery occurs in the hospital. If delivery occurs outside the hospital, length of stay begins upon admission. There is one exception to the 48-hour rule: The attending provider is allowed to discharge the mother or newborn earlier if the mother agrees to the discharge.

The rules also seek to protect providers from the pressure of payers to discharge mother or newborns early. Specifically, they state that "a plan or issuer may not penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider furnished care to a mother or newborn in accordance with NMHPA."

For a copy of the Department of Labor's booklet "Questions and Answers: Recent Changes in Health Care Law," which includes information about the Newborns' and Mothers' Health Protection Act, call (800) 998-7542. Information on the Act is also available on-line at both the Department of Labor's Web site (www.dol.gov/dol/pwba) and at HCFA's site (www.hcfa.gov). ■

Continuum improves CHF patient education

Packet and checklist provide standardization

Education is an important component of the congestive heart failure (CHF) program implemented at Johnson Memorial Hospital in Franklin, IN, both for patients and health care professionals all along the continuum of care.

Program planners realized that an education program could not be successful if implemented in an inpatient vacuum. Patients did not have enough time to learn how to manage their disease while in the hospital. To make the educational process effective, teaching would have to be continued at the next level of care. Therefore, the CHF project team mailed the CHF teaching packet to physicians' offices, long-term care facilities, and home health agencies to familiarize staff at the next level of care with the teaching.

Inservices also were conducted at connection meetings, which are gatherings designed for the hospital staff to connect with physician office staff. These meetings are held quarterly at the hospital for representatives from physician offices. Staff from home health agencies, extended care facilities, and long-term care / acute care facilities were invited to attend Teach the Teacher classes that provided information about the CHF patient education teaching pathway.

"We are still in the process of continually going back and re-educating physician offices, long-term care facilities, home health care, and our own acute care staff about the program goals and also the teaching topics so they can be reinforced," says **Jeanne Ernst**, RN, BSN, CPHQ, performance improvement and quality utilization case management coordinator and CHF project team co-chair.

The CHF project was launched in December 1997 after a team had assembled an educational packet and created a teaching checklist. The team consisted of representatives across the continuum of care, including representatives from home health and long-term care.

To determine what to include in the packet, the team conducted site visits and literature searches, and talked to peers. At meetings, the team would review patient education materials and decide as a group what would be the most beneficial.

The educational packet includes the following: a booklet on CHF, handouts on sodium, ways to simplify work to conserve energy, guidelines on symptoms that prompt a phone call to the physician, a treatment plan to hang on the refrigerator or in the bathroom, a medication schedule, and a chart to track daily weight. Patients who do not have a bathroom scale are given one to take home. According to Ernst, the $10 for the scale is money well spent because a readmission to the hospital could cost between $5,000 and $12,000.

A CHF video was selected to show patients upon admission, and a teaching checklist was created to track teaching. This checklist is copied and sent with the patient to home health care, extended care, or assisted living following discharge. If the patient is sent home, a copy of the checklist is faxed to his or her physician's office. **(See copy of the teaching checklist, pp. 30-32.)**

When a patient is admitted to the hospital with CHF, a case manager or floor nurse gives him or her the packet and briefly reviews the information with the patient and family members. The video is shown, and the patient and family are encouraged to read the CHF booklet.

Using the checklist, nurses continue to teach the patient throughout the hospital stay. For example,

(Continued on page 32)

Johnson Memorial Hospital

1125 West Jefferson St.
P.O. Box 549
Franklin, IN 46131
(317) 736-3300

Learner:
1. Patient
2. Family
3. Other (specify) _____

Readiness to Learn:
1. Appears eager to learn-asks questions, expresses interest
2. Sedated
3. Cognitively unable
4. Emotional barriers
5. Appears disinterested, eager to terminate session

Teaching Method:
P = Printed Material
V = Videotape
E = Explanation
D = Demonstration

Evaluation:
1. States concepts without assistance
2. Demonstrates task without assistance
3. States concepts with assistance/ coaching
4. Demonstrates task with assistance
5. No indication of learning (unable to verbalize or demonstrate basic concepts)

Congestive Heart Failure-Teaching Plan

Teaching Topic	Date Initials	Learner	Readiness to Learn	Teaching Method	Eval.	Comments
1. Receive CHF Teaching Packet						
2. View CHF Video (Milner/Fenwick #_____)						
3. Patient/Significant Other Able To: **A. State simple explanation of CHF:** *Congestive heart failure is a condition in which the heart does not pump blood efficiently, causing fluids to collect in the lungs and other tissues (Refer to Booklet-Pg. 2)*						
B. State Three (3) Signs/ Symptoms That Need To Be Reported To Your Physician (✓ those stated) Answers May Include: • Sudden weight gain (2-5 lbs. in 1-4 Days) • Swelling in ankles, legs, or abdomen • Shortness of breath • Frequent dry cough or frothy sputum • Fatigue • Changes in urination • Dizziness *Verbally restate signs/symptoms not included by (Refer to Booklet, Pg. 2) PT/SO*						
C. State Medication Schedule, Names, Dose, and Indications *(Refer to Booklet-Pgs 10-11 and Medication Schedule in Packet)*						
D. State Sodium Level of Diet and Three (3) High Sodium Foods to Limit. *(Refer to Sodium Sheets)*						
E. Demonstrate Use of Weight Record. Working scale at Home ☐ **Yes** ☐ **No (If No Refer to Case Management)** *Refer to Calendar in folder*						
F. Activity Recommendations *(Refer to Energy Conservation Tips in Packet).*						
G. Emphasize Need for Physician Follow-Up Appointment.						
H. Other						
I. Teaching sheet faxed/sent to _____ at discharge on _____ by _____ (If going home send to physician office. If referred HHC/ECF sent to HHC agency and/or ECF, residential area.)						

SIGNATURE/INITIAL SIGNATURE/INITIAL SIGNATURE/INITIAL SIGNATURE/INITIAL

CHF PATIENT/FAMILY EDUCATION RECORD

Form No.: 3440639

12/01/97 11:28 AM/C:/data/WINWORD/FORMS/CHF Checklist and Treatment Plan -R1.doc/LS
Rev 08/14/98

Johnson Memorial Hospital
1125 West Jefferson St.
P.O. Box 549
Franklin, IN 46131
(317) 736-3300

INSTRUCTIONS

Focus column refers to the categories on the Interdisciplinary Patient/Family Education Record; i.e., Safety, Activity, Pain Management, etc.

Date	Time	Focus	Discipline	Interdisciplinary Patient/Family Education Notes	Signature/Title

Discipline Key				
1. Nutrition	2. PT	3. OT	4. SLP	5. Nursing
6. Case Manager	7. Respiratory	8. Physician		

CHF PATIENT/FAMILY EDUCATION RECORD

Form No.: 3448630

12/01/97 11:28 AM C:\data\WINWORD\FORMS\CHF Checklist and Treatment Plan -R1.doc/LS
Rev 08/14/98

(Continued from page 29)

when a patient learns when and how to monitor weight gain, that section is checked. If more education is required, the nurse makes a written note.

Use of the checklist and learning packet was initiated at Johnson Memorial Hospital because the CHF patient population had a higher readmission rate than other chronically ill patient groups, says Ernst. In spite of the statistics, there was no organized teaching plan or follow-up for CHF patients. Also, the Health Care Financing Administration, the agency that monitors the quality of Medicare coverage, asked hospitals to look at quality of care issues to improve the care of their beneficiaries. "One of the ways they identified to improve care was through patient education," says Ernst. The project was initially financed with a $3,500 grant from the Partnership for a Healthier Johnson County.

Is education across the continuum of care improving outcomes for CHF patients? Hospital readmissions for the year to date are at 14%. The average rate of readmission for 1995, '96, and '97 was 22%.

Recently, the team implemented follow-up calls to CHF patients to determine how much of the education they remembered. Most could identify at least one symptom that would trigger a call to their physician. Also, they were weighing themselves each morning, which indicated they were attempting to make lifestyle changes.

"We're trying to get CHF patients to take responsibility for their own health. The reason for education is to help people be responsible for the things they can manage," says Ernst. ■

Congestive Heart Failure-Treatment Plan

1. **Daily Weight:** Weigh yourself on the same scale every morning. Keep a record of your daily weights. Call your physician if your weight increases by 5 pounds in a week or 2 pounds in one day.

2. **Medications:** Know what your medications do, their side effects, your prescribed dosage and the best schedule to take them. Plan ahead to avoid "running out" of medications.

   Four type of medications most frequently used are:

   - Digitalis: Makes pumping action stronger and decreases heart rate
   - Diuretics: Reduces the amount of blood volume to be pumped
   - Potassium: Replaces a vital mineral in blood that may be lost through the kidneys with diuretics.
   - Vasodilators: Relaxes the blood vessels

3. **Rest:** Planning rest periods throughout the day allows your heart muscle to regain its strength.

4. **Diet:** Sodium limitations frequently are part of the treatment plan because large amounts of it make the body hold fluids. When the body holds excess fluid, it increases the workload of the heart. It may be easier to eat several small meals per day rather than 3 large meals.

5. **Don't Smoke:** Smoking narrows blood vessels and makes breathing difficult.

6. **Avoid Temperature Extremes:** The heart works harder to keep the body temperature normal when you are too hot or too cold.

7. **Exercise:** Gradual increase in exercise to improve endurance is recommended. Avoid vigorous exercise that put sudden demands on the heart.

8. **Call Your Doctor If:**

   - Your weight increases by 5 pounds in a week or 2 pounds in one day.
   - Your experience change or increase in any of the following: Swelling of lower limbs, trouble sleeping, shortness of breath, frequent dry cough, fatigue.

9. **Follow-Up Doctor's Visits:**

   - Take your "weight diary" and "medication schedule diary" with you to your doctor appointments.

Source: Johnson Memorial Hospital, Franklin, IN.

Hospital brings social work into case management fold

Disciplines keep distinct focuses in one department

When 240-bed Jefferson Memorial Hospital in Crystal City, MO, decided to integrate utilization review and social work into a single case management department in 1994, administrators knew they were in for a challenge. But it was clear something had to give. Managed care was just beginning to hit the local health care market, and the hospital already was struggling to keep down its lengths of stay for Medicare patients.

"We had good-quality care, but it was too expensive and took too long," says **Chris Johansen**, RN, manager of case management services at Jefferson. Recognizing this, the hospital's chief financial officer made the decision to restructure the social work department and combine it with utilization review under a single department head.

Resistance from the social workers came immediately. "There were some people in social work who were not interested in that type of department structure and didn't want to be involved," Johansen says. Their main concern was that the focus on shorter lengths of stay would necessarily limit the amount of time they had to build relationships with patients.

The new combined system features seven case coordinators and three full-time social workers.

KEY POINTS

- To prepare for a wave of managed care penetration and to reduce duplication of work, 240-bed Jefferson Memorial Hospital in Crystal City, MO, integrated its social work and utilization review departments.
- The resulting case management services department features seven case coordinators and three social workers who often work out individual responsibilities for a given case among themselves.
- The newly hired case coordinators received extensive training in utilization review and discharge planning. The training curriculum involved trips to home health, hospice, a rehabilitation hospital, and a larger case management department.

The case coordinators perform screening for social work and home health and then refer cases to a social worker if necessary. Because of the department's structure, it's not unusual to have both a case coordinator and a social worker working on the same case at the same time.

One benefit of the combined system has been the elimination of duplicate telephone calls to insurance companies regarding patient benefits, Johansen says. "It seemed silly to have a case manager trying to get the hospitalization covered and then have a discharge planner come in right after her, look at the chart again, call the insurance company again, and have to do the whole thing over again to get the home care set up," she says. "By combining those responsibilities, we've become much more efficient."

Johansen notes that although they work in the same department, case coordinators and social workers still maintain some separation of responsibilities. "A nurse doesn't ever want to be a social worker and a social worker doesn't ever want to be a nurse," she says. "But sometimes you have a fuzzy area regarding who would be the most appropriate to help take care of a particular case." For such cases, the social worker and case coordinator are given the latitude to work out what their individual responsibilities will be.

"Nurses are very comfortable with complex medical issues, but when it comes to family dynamics, relationships, adjustment problems, and complicated community referrals, they'll usually call a social worker, because that's just something they're not trained for," Johansen says.

When they began the integration process, they started with a single case coordinator and built a job description from scratch that expanded greatly on the job description used by the old utilization review department. **(See draft of Jefferson's new job description for case coordinators, p. 34.)** Based on the new job description, Johansen hired four more case coordinators. All came from in-house and were therefore already familiar with the facility and its physicians. And all had considerable experience in nursing.

New social workers also were brought in. "They were mostly younger ones who hadn't had a lot of prior experience," Johansen explains. "It seemed that the people with a lot of experience were used to a different way of functioning. It was a barrier for them, and they weren't comfortable with [our system]." Another barrier was that

(Continued on page 39)

Jefferson Memorial Hospital

DRAFT JOB DESCRIPTION
Case Coordinator-Case Management Services

Statement of Purpose
To facilitate organized and integrated patient activities across the continuum of care available to patients of Jefferson Memorial Hospital. To provide ongoing support and expertise through comprehensive assessment, planning, implementation, and evaluation of individual patient needs. The overall goal of the position is to enhance the quality of patient management and patient satisfaction, and to promote continuity of care and cost effectiveness. Has accountability for the care coordination, discharge planning, and utilization review functions of the Case Management Services Department.

MAJOR RESPONSIBILITIES
• Provides primary resource for other professionals in problem solving on a day-to-day basis.
• Manages a variable case load of approximately 20-30 patients.
• Collaborates actively and functions in a multidisciplinary department with Social Workers to provide comprehensive full spectrum care coordination and discharge planning for each patient without regard to their personal beliefs or circumstances.
• Communicates daily with physicians, hospital staff, family, community care providers, and patients to facilitate coordination of clinical activities, and to enhance the effect of a seamless transition from one level of care to another.
• Assumes responsibility for coordination of discharge plan through discharge planning meetings on assigned units, and follows up with patients, physician, and hospital staff from admission through discharge.
• Facilitates discharge planning through active organization and monitoring of the process. Documents through discharge planning activities in the medical record appropriately and thoroughly at all times.
• Assesses for, coordinates, and pre-authorizes, and documents follow-up medical care including home health, hospice, home IV therapy, durable medical equipment or other technical needs.
• Maintains and documents insurance company authorizations, contacts, and records of transactions for each individual inpatient. Advocates for the patient, physician, and the facility to obtain needed benefits from insurance carriers and others that provide financial assistance for patients.
• Documents all patient review records according to regulatory, legal, and case coordination requirements and acts proactively to see that hospital resources are used appropriately.
• Seeks out information and resources and uses creative problem solving for complex discharge planning, quality of care, and utilization issues.
• Studies information available to remain abreast of reimbursement modalities, community resources, nursing techniques, review systems, hospital clinical systems, and legal issues that affect patients and providers of care.
• Participates actively in the development, implementation, evaluation, and ongoing revision of clinical initiatives to improve quality, continuity, and cost effectiveness.
• Provides educational support to patients, physicians, and professional staff on collaborative practice, levels of care, quality of care issues, and regulatory concerns.
• Works collaboratively with other departments to define and study areas of hospital inefficiency and participates in improvement projects.
• Orients and supports new department staff and assists in providing ongoing inservicing and updates to other hospital staff with regard to discharge planning, community resources, collaborative management, and regulatory requirements.
• Demonstrates a commitment to provide compassionate customer oriented services, on a continuous and consistent basis.
• Responds ethically in conduct and practice throughout all phases of interaction.

The above statement reflects the major responsibilities considered necessary to describe the principal functions of the job as identified and shall not be considered a detailed description of all the work requirements that may be inherent in the position. This job description will be revised by the supervisor as necessary.

EDUCATION
RN, holds a current Missouri registration.

EXPERIENCE
Minimum of three years experience in an acute hospital setting, skilled home health agency, or Medicare certified skilled nursing facility. Experience in multiple settings preferred, utilization review, discharge planning, or case management experience preferred. Computer experience highly desirable.

SPECIAL SKILLS
Excellent verbal and written skills, well rounded critical thinking skills, proficient in organizational techniques. Ability to facilitate groups, organize, and supervise other professionals in a team environment. Self-motivated, flexible, and goal oriented. Ability to tolerate frequent interruptions and demanding work load.

Source: Jefferson Memorial Hospital, Crystal City, MO.

JCAHO's proposed rules on clinical practice guidelines

By **Judy Homa-Lowry**, RN, MS, CPHQ
President, Homa-Lowry Healthcare Consulting
Canton, MI

Recognizing that data and information are being used more extensively than ever in health care, the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has made significant changes in its standards — changes that affect not only data and information but also the role of the case manager.

In particular, the recent distribution of proposed JCAHO standards for the use of clinical practice guidelines will likely have a significant impact on case managers. These JCAHO-proposed standards do not require that organizations use guidelines. Rather, they emphasize that the organization should develop a mechanism to "consider and review" guidelines that are available for the services that they provide.

The new standards appear to require that, at a minimum, organizations review and consider whether available guidelines are applicable to the patient populations that are served in their organization. These proposed standards would help to enhance the importance of other JCAHO standards, such as the information management standards that have been in place for some time. Specifically, the information management standards have required the use of medical record data, aggregate data, knowledge-specific information, and comparative information to evaluate and improve patient care.

Among the components of the information management standards that should be emphasized when discussing clinical practice guidelines are the standards related to knowledge-specific information. The term "knowledge-specific" has required hospitals to monitor and consider the use of patient care-related information in the literature to evaluate and improve patient care in health care organizations.

The development, implementation, and monitoring of clinical practice guidelines by other sources and institutions and the consideration of their potential use in your organization could be interpreted as compliance with specific information management standards. At the same time, there is compliance with some of the requirements in the proposed standards. The management of information standards were once referred to as the library standards. The library standards encouraged the same objectives that the current knowledge-based standards require. They required the use of research and other positive patient care outcome studies discussed in the literature to be evaluated for use in your health care organization.

If the proposed standards for clinical practice guidelines are accepted, they will require that health care organizations describe and implement a process to provide a link between the health care literature and literature specific to practice guidelines to evaluate and improve patient care. This is not to suggest that this is not currently happening in the field; rather, it appears that these proposed standards would become part of the accreditation process. They would represent the minimum standards for compliance.

If these standards are adopted, it may be helpful for you to have a list of the sources your organization uses to evaluate and develop guidelines. This should be done in the form of a policy. It could be a simple policy that states something like: "The following sources of information [list] are utilized on a regular basis when developing and/or revising our clinical practice guidelines." The JCAHO-proposed standards for practice guidelines reference the Agency for Health Care Policy and Research, professional organizations,

etc. This is a simple policy that may already be in place in your organization.

The Joint Commission is aware of the different terminology used to describe the practice of developing and using clinical practice guidelines. As a result, it developed its own definition of clinical practice guidelines. It states: "Guidelines are evidence-based, authoritative and shown to be efficacious and effective within defined patient populations and services." This would support the linkage between these proposed standards, information management, and performance improvement. It also illustrates the importance of the linkage of these standards as well as the leadership standards for future accreditation of health care organizations.

As mentioned, the proposed standards do not require that organizations use clinical practice guidelines, but rather that organizations develop a mechanism to consider them for use. This is especially true for those clinical guidelines that have similar populations to the organization. Recent changes in the JCAHO standards have required the implementation of sentinel event policy and procedures, the development of ORYX, and revised performance improvement standards. All of these standard additions and revisions have forced organizations to develop systems and processes.

They also require that organizations consider the relationship of these standards to one another. For example, the ORYX data may illustrate that an organization has significant complications within a diagnosis-related group (DRG) or that the organization is statistically different from the organizations it is being compared to with regard to certain DRGs. During the survey process, a question could be raised about whether the organization decided to develop clinical practice guidelines for these DRGs.

Statistical tools prove systems work

To establish and maintain compliance with these standards, the systems and processes developed by the organization have to work. One of the ways in which an organization can demonstrate its ability to show the effectiveness of systems and processes is by the use of statistical tools. The use of statistical tools is necessary for data analysis. When examining all of the JCAHO standards related to patient care, the ability of the Joint Commission to raise specific patient care questions relating to patient care and treatment by a specific diagnosis is emerging. This is why it's so important to have the case managers involved in the development of systems and processes relating to case management. This involvement also can greatly assist the organization in addressing JCAHO standards relating to case management and other related requirements for accreditation.

According to the Joint Commission, the proposed standards provide the organization with the opportunity to develop a system for selecting, implementing, and monitoring the effectiveness of guidelines in treating patients. Compliance with these proposed standards requires participation by the organization's leadership, as well as by the interdisciplinary health care team.

In order to accomplish compliance with the guidelines' requirements, the Joint Commission has identified four standards. They are currently proposed as follows:

• Clinical practice guidelines are considered for use in designing and improving processes.

• When clinical practice guidelines are used, the organization's leaders identify criteria for their selection and implementation.

• Appropriate leaders, practitioners, and health care professionals review and approve clinical practice guidelines for implementation.

• The leaders evaluate the outcomes related to use of clinical practice guidelines and determine indicated refinements to improve pertinent processes.

The second standard, which addresses the implementation criteria for clinical practice guidelines, would appear to be the most challenging for organizations. The implementation criteria consist of six points, according to the 1999 Joint Commission Hospital Executive Briefing:

— modification(s) necessary to support specific level or locus of guideline implementation;

— mechanisms for anticipating and evaluating variance in guideline(s) compliance;

— recommended or selected measures pertinent to decision points, outcomes and variations relating to compliance;

— whether the guidelines can assist the practitioner in making decisions about appropriate health care for special clinical circumstances;

— whether the guidelines are based on current professional knowledge and are reviewed and revised periodically;

— mechanisms for disseminating information about implementation of selected guidelines.

For each of the six points listed above, JCAHO-accredited institutions have the responsibility for developing policies and procedures to address

each of these main points if the proposed standards are approved for use. It is not adequate to rehash the verbiage of the standards. It is necessary that each standard and intent statement be addressed in a policy and/or procedure. The purpose is to illustrate how the organization is going to design systems and processes to address the standards and intent statements. The effectiveness of the clinical practice guidelines also needs to be evaluated.

The Joint Commission's proposal of these standards for clinical practice guidelines illustrates how the performance improvement standards are being used to develop a strong relationship among other JCAHO standards. The proposed standards for clinical practice guidelines would require the development of systems and processes to design, measures, assess, and improve patient care outcomes. It is possible to use these proposed standards as an opportunity to develop a performance improvement project for your organization.

In some organizations, the development of many of the systems and processes to address clinical services and regulatory compliance may not be clearly visible. This is particularly true when one examines the relationship between policies and procedures for patient care and actual clinical practice. As most professionals would agree, there is a fair degree of variation between what is in writing and what is actually practiced. Another example of this may be in organizations making the transition from a traditional hospital model to product or service lines. If the patient care is not consistent due the design of the infrastructure, poor patient care outcomes may result.

Policies may support or oppose guidelines

This raises another issue for case managers. What if the supporting policies and procedures do not adequately reflect what is expected in terms of standards of practice or standards of care? To be blunt, do the policies and procedures of the organization support the content of the practice guidelines, or are they in conflict with one another? This may not only be a potential legal issue, but it also may place clinicians attempting to comply with the guidelines at odds with one another.

One of the first steps would be to compare new or proposed guidelines with existing standards of practice available in the organization by all health care practitioners. Bylaws, rules, and regulations also should be reviewed. All care providers should be included in the process. This includes any potential issues that may arise out of contracts. The rationale for this approach is to diminish or greatly the decrease potential for having any patient care systems and processes that may be conflict with one another. This process also may identify systems and processes that need to be developed or redesigned.

Case managers need to evaluate whether the organization's systems and processes support the criteria in the pathway. For example, if the pathway requires tight time lines for medication administration and the medication systems of the organization are not effective, there may be difficulty in meeting the guidelines' time line for compliance. The potential linkage is to examine not only the criteria in the guidelines, but also the effectiveness of the supporting systems and processes to ensure the organizational operations support the success of the guideline. This also would be an example of the linkage of the JCAHO standards described above.

In terms of understanding whether or not a guideline is effective, it is important that the patient outcome is not the only measure. If there are numerous approaches to treating patients because the practice guidelines are changed so frequently, it becomes difficult to determine what is the "best" or what changed in order to ensure a good outcome. Statistical methods can be used to answer these types of questions. The proposed standards also suggest that a process be developed for anticipating and evaluating variation in guideline compliance.

In order to determine if the process is in control and consistent, the data from the guidelines should be incorporated into a statistical tool for analysis. Using the appropriate control chart can greatly assist the organization in analyzing the consistency and effectiveness of the practice guidelines. Clinical practice guidelines should foster interdisciplinary meetings of clinicians to define processes that outline how patients will receive clinical services for various diagnoses. They outline the interventions, medications, procedures, etc. for a certain disease or clinical condition. It is during this process that case managers and/or performance improvement professionals should determine what types of control charts can be used — and how — to measure the effectiveness of the clinical outcomes and the systems and processes that support these outcomes.

By designing the measurement tools during the development of the practice guidelines, it may

make the review, analysis, and potential changes in the pathways easier to examine. It also will provide quantitative and qualitative data for decision making in terms of the effectiveness of the guidelines.

As one develops practice guidelines, they can be designed as flowcharts that may provide a "picture," or as a form of an algorithm for patient care services. The potentially meaningful part of this process is that it allows for an organization to examine how it is currently providing patient care in certain diagnosis through a flowchart. A second flowchart should then be developed to describe how the organization would like to deliver care for a diagnosis. This allows for a visual comparison of what is and what should be. This approach could be used to evaluate whether practice guidelines obtained from the literature would be acceptable for the organization. If a process is not currently in place, this could be the part of the mechanism to evaluate whether or not a guideline should be accepted by the organization according to the proposed JCAHO standards.

By using this method, the practice guidelines can be developed including a statistical method of measurement built into the process. This will help identify variations in practice. It also may provide insight into the effectiveness of existing systems and processes. It also may reduce the need for developing or maintaining separate systems and processes in the organization to measure regulatory aspects of the guidelines through another mechanism such as a committee, i.e. blood use. This could be done through the pathway and the information addressed in the product line meeting, or it could be forwarded to the appropriate committee.

Combining the clinical practice guidelines with the issues that managed care companies are focusing on helps to provide additional information that may be considered when developing a pathway for review. At times, the clinical practice guidelines are developed in response to conditions that require high utilization of resources. The managed care company targets a diagnosis / procedure. The health care organization tends to also target the same diagnosis / procedure.

There are situations when the aggregate utilization data are not shared with the case manager in the hospital. Managed care companies have their own mechanisms for collecting data. In some companies, case management staff do not receive aggregate data. The result would be case-by-case reviews without an examination of trends and patterns by the very staff that can effectively intervene to assist with compliance with the guidelines. They also are the ones who can examine the need for a revision to the guideline. It is important these people be included in the process of pathway development, review, and evaluation.

Examination of the trends and patterns can assist in the refinement of clinical guidelines as well as communicating the "expectations" with staff. This also may confirm whether the issue was related to the specific intervention by a single practitioner or was part of a contributing trend or pattern.

Personnel participation encourages buy-in

The proposed standards for clinical practice guidelines require all of the appropriate personnel to be invited to participate in the process. The obvious reason is to have buy-in and input into the process. Some organizations invite the "resident expert" to discuss the standards of practice or care in a service or a unit at a meeting where the pathway is being developed. The individual should have baseline data to support how care is actually being delivered on the unit. It is important that current practice is measured prior to developing new guidelines.

As mentioned previously, leaders need to be involved in the process. This supports the JCAHO leadership standards holding that state leaders also should be involved in the development of new systems and processes. They also can provide necessary resources and support to get the system implemented. New systems and processes should be pilot-tested. The leaders also need to approve and evaluate the outcomes resulting from the use of clinical practice guidelines. They need to refine the practice guidelines if the assessment of the outcomes indicates opportunities for improvement.

Finally, in terms of getting ready for the JCAHO-proposed standards for the use of clinical practice guidelines, it is important to determine whether or not your organization is a JCAHO-accredited facility. If it is, it is important that someone in the organization is assigned to monitor the progress of the standards for approval and the time line for becoming part of the accreditation process. This can be done through the JCAHO Web site or the JCAHO publication *Perspectives*.

A copy of the proposed standards discussed in this article already may be available in your facility. If not, you can contact the Joint Commission and obtain a copy. ■

(Continued from page 33)

the combined department was headed by Johansen — a registered nurse — a fact that put off some social workers.

"When we hired people, we just laid it out to them," Johansen says. "Because the new department was built from scratch, we didn't have a lot of people left over from the previous departments. I told the new people right up front, 'This is the way we're going to function. It's a dynamic department, it's multidisciplinary, and it's very busy. If you don't mind high-intensity, fast-paced work, then this is the place for you.'"

To train the new hires, Johansen developed an intensive six-week orientation program. The curriculum was divided into several categories, including review and referral to home care, nursing homes, and hospice. During this process, the trainees visited the hospital's affiliated home care company and performed some home visits. They also made nursing home visits and toured a rehabilitation hospital in St. Louis. At each location, they were required to fill out a questionnaire to test what they had learned. "It gave them an opportunity to touch base with people, see the facilities, and get answers to some of their technical questions about referring," Johansen says.

The trainees also visited colleagues in the case management department at Barnes Jewish Hospital in St. Louis. "They were a little bit ahead of us in their case management program, and they allowed some of us to come up and round with them and see how they functioned. That was very beneficial," she says.

In addition, Johansen saw that the new hires were trained on reimbursement structures, Medicare and Medicaid, what private payers offer, and how to access it.

Now that the program is established and the case coordinators are more comfortable in their new roles, training has become easier, Johansen says. "Now, we have people that we can buddy [new hires] up with. It took a while to build this, and in the beginning, I would end up doing a lot of the training myself, because there just wasn't anything out there," she says.

For more information, contact Chris Johansen, RN, manager of case management services, Jefferson Memorial Hospital, P.O. Box 350, Crystal City, MO 63019-0350. Telephone: (314) 933-1226. ■

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COMING IN FUTURE MONTHS

- Information technology supports case management efforts at Staten Island, NY, health system
- *Critical Path Network:* Innovative variance tracking systems aids analysis of TKA pathway
- What to do when hospital case management expands to the outpatient setting
- Pathways for ischemic stroke and lung volume reduction
- Building an infrastructure for a successful case management program

NEWS BRIEFS

Dedicated teaching area can improve learning

Some health care facilities have dedicated learning centers where patients and family members go to learn medical skills. Yet most institutions don't have the extra space.

That was the case at the University of Utah Hospitals and Clinics in Salt Lake City. Therefore, staff in the bone marrow transplant program use the conference room as a teaching area. In this room, they demonstrate use of medical equipment and have the family caregiver demonstrate back.

"The home care nurse spends a lot of time with the caregiver. We have practice equipment set up in the conference room so they work there, and then we have them work the equipment with the patient. We want to make sure they are maintaining sterile techniques and understand how to work the pump and different lines," says **Robin Phillips**, MSN, RNC, nurse manager for the bone marrow transplant program at the health care facility.

For more information contact: Robin Phillips, MSN, RNC, Nurse Manager, Bone Marrow Transplant Program, University of Utah Hospitals and Clinics, 50 North Medical Drive, Salt Lake City, UT 84132. Telephone: (801) 581-2780. Fax: (801) 585-2098. E-mail: robin.phillips@hsc.utah.edu. ▼

Coordinate education across continuum

To coordinate patient education across the continuum of care, representatives from patient education and cardiac departments at Grant/Riverside Methodist Hospitals in Columbus, OH, have begun to meet with representatives from cardiology practices that do surgery at the hospitals.

During the first round of meetings, the hospital's patient education manager, cardiac rehab staff, outcome managers, and cardiac educators meet with one physician and nurse from each practice individually, says **B.J. Hansen**, BSN, patient education coordinator at Grant/Riverside.

"We meet to see how we can improve; for example, what teaching needs to be reinforced or how we can streamline the process by making only one phone call rather than have the physician office and cardiac rehab call the patient after discharge," explains Hansen.

Once meetings with individual practices are complete, hospital staff and representatives from each practice will meet biannually in a large group.

For more information, contact: B.J. Hansen, BSN, Patient Education Coordinator, Grant/ Riverside Methodist Hospitals, 111 South Grant Ave., Columbus, OH 43215. Telephone: (614) 566-5613. Fax: (614) 566-8067. E-mail: bhansen@ohiohealth.com. ■

CE objectives

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

- identify particular clinical, administrative, or regulatory issues related to the profession of case management;
- describe how those issues affect patients, case managers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■