AMERICAN HEALTH CONSULTANTS

HOSPITAL CASE MANAGEMENT™

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

IN THIS ISSUE

DECEMBER 2002

VOL. 10, NO. 12 (pages 177-192)

Integrated departments: Can CMs and social workers get along?

Dallas hospital uses team-building activities to reinforce collegiality

It's no secret that at some hospitals, relations between social workers and case managers are downright chilly — if there's any relationship at all. But turf battles and resentment are not inevitable, as long as roles are clearly defined and the right case management model is in place.

One case in point is Medical City Dallas Hospital, where **Beverly Cunningham**, RN, MS, director of case management, made a point of clearly delineating the roles and responsibilities of the case managers and social workers in her department.

"You really have to look at your facility, how your facility works, and what the staffing is when you're differentiating the roles," she says. "At many hospitals, the roles aren't differentiated, and it's tough to say what a social worker's responsibility is."

Monica Hale, LMSW, a social worker in Cunningham's department, says that before Cunningham's arrival, social workers and case managers "were performing the same roles in many ways. We were comfortable with that because as social workers, we felt that we could handle the clinical issues and complications."

Although change took some getting used to, it was worth it, Hale says. "It ended up with having RN case managers be true to their profession and allowing social workers to do what we do best — working with the families, providing supportive counseling, and looking at the big picture to find resources and things like that. It has been a challenge, but I've been glad that we've had the opportunity to explore our true professional roles."

In Cunningham's model, the nurse case manager often is the "triage person, who will let the social worker know that there is a need." Regardless of the model used, however, what's most important is that some sort of differentiation is made.

"Whether you say that the nurses are going to do discharge planning, the social workers are going to do counseling and handle complex placement issues, or whatever it is, it's important that you really do differentiate it and everybody knows what the roles are," Cunningham says. **(For more on integrating social work and clinical case management, see story, p. 179.)**

It's also important for those differences to be reflected in the job descriptions. At Medical City, Cunningham rewrote the job descriptions of RN case managers and social workers to specify their different responsibilities.

"In the job description, at our hospital, we identify what makes a solid performer and then what makes somebody exemplary," she says. **(For more on job descriptions, see story, p. 181.)**

Of course, changes can't just be made on paper; they must be reflected in the daily practice of the department. And that means securing the cooperation of the RN case managers and social workers.

Cunningham explains that because she was new as director, changing the model was a fairly easy process. "When I came here, I had individual meetings with all of my staff. I said, 'Tell me what it is you're doing. What are your roles and responsibilities?' That's where I picked up that people were doing a lot of the same things."

Hale acknowledges that when Cunningham first arrived, they were "a little nervous and not sure how this was going to work." The social workers, in particular, had concerns. "Working in a group where we're outnumbered significantly by RN case managers and getting a new director who is an RN, I think we would always have the concern, 'Is she going to get rid of us?'"

Those initial concerns were dispelled quickly, however. "She made it very clear from the beginning that it's a team that needs both professions, that we were both valued for different professional roles," Hale says. "She made us feel like we were all significant parts of this team and very much needed. We're just fortunate that our group here has been responsive to that and feels the same."

Hale says that without Cunningham's positive attitude and approach, "it could have been a very negative change. It could have been far more difficult. But the tone she set was that this was something that would help us grow in our profession."

Unfortunately, at some hospitals, change is more difficult, especially when RN case managers and social workers have a history of territorial disputes.

It's important to have social work and case management in the same department, Cunningham says. Having both groups under the same leadership can help foster a common sense of identity. Also, whether the director of the department is a social worker or an RN, "it's important that director be sensitive to the profession that they are not [a member of]." She adds that, if there is an RN director of case management and the department includes social work, there should be a social worker who directly supervises social workers.

Hospital Case Management™ (ISSN# 1087-0652), including **Critical Path Network**™, is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Case Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 Mon.-Thurs.; 8:30-4:30 Fri. EST. E-mail: customerservice@ahcpub.com. World Wide Web: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $429. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $343 per year; 10-20 additional copies, $257 per year. For more than 20 copies, contact customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $72 each. (GST registration number R128870672.)

Editorial Questions

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

American Health Consultants® is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, provider number CEP 10864, for approximately 18 contact hours. This program (#0704-2) has been approved by an American Association of Critical-Care Nurses (AACN) Certification Corp.-approved provider (#10852) under established AACN Certification Corp. guidelines for 18 contact hours, CERP Category O.

Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcpub.com).
Senior Production Editor: **Ann Duncan**.

One technique that has helped head off any territorialism has been the use of teams that include both social workers and RN case managers. These include a women's and children's team that is responsible for the children's hospital and women's services, a medical/surgical team, and an ortho/neuro rehabilitation team.

"When I have to do my business plan, they have to write their business plan of what their focus is," Cunningham says. "It's not the nurse case manager's business plan or the social worker's business plan. It is: Together, what are we going to accomplish?"

Related to that, Cunningham makes sure that nurses and social workers in the department share a feeling of responsibility for case management outcomes.

"We look at length of stay as everybody's responsibility," she says. "I look at avoidable days as everybody's responsibility. When we see that we have shared outcomes, that tends to move us out of that territorialism."

Another way to develop a sense of collegiality among nurse case managers and social workers within a department is to engage in some old-fashioned team-building exercises.

For example, at Medical City, at least once a quarter, members of the case management department have some type of outing. This summer, they went to the local farmers' market together. They've also gone as a group to the Texas State Fair. Staff who chose not to go were allowed to leave work a half-day early.

Cunningham acknowledges that some facilities might not have the flexibility to have such outings, but "you have to think of things you can do within your department that bring the group together. I feel like that's my responsibility," she explains.

One way to help bring nurse case managers and social workers together is to have shared continuing education (CE). At Medical City, the department has two sessions per month, "and we like it if they can be CEs for social workers and for nurses," Cunningham says. Often, however, nurses will attend even if the session is just for social workers.

Hale adds that while there is a clear difference in their professional roles, all are treated equally.

[For more information, contact:

*• **Beverly Cunningham**, RN, BSN, MS, Director of Case Management, Medical City Dallas Hospital. Telephone: (972) 566-7000.*

Cunningham and Hale will conduct a presentation, "The Best of Both Worlds: Nurse Case Manager and Social Worker Collaboration" at the 2003 Hospital Case Management *Conference, to be held April 27-29 in Atlanta. For more information about the conference or to register, call (800) 688-2421.]* ■

The three levels of case management integration

Levels include low, moderate, and complex

Some of the key questions facing directors of case management today are: 1) How much integration is appropriate for the department? 2) Should one person handle both clinical case management and social work responsibilities? 3) What about utilization management?

Hussein A. Tahan, MS, DNSc(C), RN, CNA, director of nursing for cardiac specialties at Columbia Presbyterian Medical Center, New York Presbyterian Hospital in New York City, categorizes case management integration into three levels: simple, moderate, and complex.

Each category has its advantages and disadvantages. The categories of integration, according to Tahan, are defined based on the level of integration of the three main case management functions in the role of the case manager. The three functions are:

1. **Clinical care management** as evidenced by the case manager's involvement in care activities such as facilitation and coordination of the patient's plan of care, tests and procedures, and patient/family education.
2. **Social work/services** as evidenced by the case manager's involvement in care-related activities such as psychosocial counseling, complex discharge planning, arranging for charity care, or health insurance coverage (e.g., Medicaid application).
3. **Utilization management** as evidenced by indirect care activities such as managed care reviews, obtaining authorization/certification for care services, and ensuring that care is being provided at the appropriate level and in the relevant setting.

At the simple level of integration, there are virtually no shared or integrated responsibilities. The case manager may assume any of the three functions. The department of case management

employs the services of a clinical case manager, a utilization manager, and a social worker. This type of integration is basically limited to the case management program housing the three departments (clinical case management, social services, and utilization management) as one — reporting to one director / administrator. Although they're all under one department, the social worker only does social work, the nurse case manager only has clinical care responsibilities, and the utilization manager only does managed care reviews.

"Even though you may have a single department, you really don't integrate the functions," Tahan says. "It's almost like you have three subdepartments in one major department and reporting to one person."

On the bright side, at this low level of integration, there are few turf issues. But it is an expensive way of doing case management, "because there will continue to exist a lot of duplication and redundancy in the responsibilities among the three departments," he contends.

At the moderate level of integration, two of the three case management functions are combined: clinical case management and utilization management or clinical case management and social work / services. For example, one individual (i.e., a clinical case manager) may assume responsibility for both clinical care and social work, while someone else has sole responsibility for utilization review. Or a nurse case manager may take on utilization management responsibilities but not social work. At this level of integration, Tahan says, "You begin to maximize the effectiveness and efficiency of the case manager. The case manager is going to review the patient's chart anyway, and the utilization reviewer / manager also is going to review the chart, so it's only natural and easier to combine these two functions into one role. This integration results in eliminating any duplication or redundancy in the roles of the clinical case manager and the utilization reviewer. And then you leave the social worker to continue to assume social services functions and base the social worker activities on referrals from the clinical case manager."

At the complex level of integration, all three case management functions are combined into one. "So, you have one person who assumes the responsibility for managed care / utilization management, clinical case management, and also social work-type case management activities," Tahan says. At this level, some turf issues are likely to arise. This type of integration is costly to implement, at least in the beginning; however, savings will be achievable in the long run as a result of maximizing the efficiency and effectiveness of the care delivery processes and the elimination of duplication, fragmentation, and redundancy of care activities and services.

As the level of integration increases and becomes more complex, the size of the case manager's caseload must decrease due to the complexity of the role and the increased number of activities / functions embedded in the case manager's role. "If you want the case managers to focus on the three aspects of case management, then they cannot case manage the same number of patients as those who function in a department with level-one or simple-type integration. [Even though] in the end, and long-term-wise, you'll be eliminating nonvalue-adding processes and saving a lot more unnecessary expenses," he adds.

At the complex level of integration, although a nurse case manager usually has primary responsibility for the three main aspects of case management, "you will continue to need the services of a social worker who may function in a consultative role to the case manager," Tahan says. "There are areas in case management where the social workers are the knowledge experts," particularly in cases involving complex discharge planning (e.g., homeless patients, those requiring placement in a skilled nursing facility, and the uninsured), and psychosocial counseling (e.g., patients who lack social support network, or are medically complex or financially compromised).

Delineating roles

Differentiating the roles of case managers and social workers in a highly integrated case management model is a key success factor of case management programs. Clarifying the roles is essential for eliminating or reducing duplication in services. However, differentiating the roles of the case manager and social worker is not enough. Defining who will assume primary responsibility for case management is equally important. A rule of thumb is making such decision based on the patient population being case managed and its carefully examined needs and care services. Deciding who should have primary case management responsibility and who should have secondary, consultative duties must be driven by who is best to assume which case management functions, Tahan says. For example, many patients in behavioral health benefit more

from social work interventions than from nursing interventions, "because social workers are better equipped to handle the counseling aspect of the care and can handle the patient's and family's psychosocial dynamics," he says. Because the primary issues in behavioral health are likely to be psychosocial in nature, the social worker should be the primary and the nurse the secondary case managers for this population.

In contrast, however, a geriatric population is likely to have complex medical issues (e.g., multiple medical conditions/comorbidities, chronic illnesses, and complex medical care regimen) and would more likely be better served with a nurse case manager than a social worker. Therefore, a nurse case manager should assume the primary case management responsibilities and the social worker the secondary or consultative role. "So you will know your population, you'll study it, and then you make the decision as to who's best to be working where," Tahan says.

There is no one rule as to who is best to assume the role of the case manager. Each organization must make its decision based on cost; clinical and administrative policies and procedures; system operations; patient population; preference of providers and their level of comfort with case management; and cost-saving and quality of care opportunities. One important issue to avoid is copying what another organization has done without carefully examining its relevance and benefit to your organization first.

[For more information, contact,

*• **Hussein A. Tahan**, MS, DNSc(C), RN, CNA, Director of Nursing, Cardiac Specialties, Columbia Presbyterian Medical Center, New York City. Telephone: (212) 305-3888. E-mail: hut9001@nyp.org.]* ■

CCMC announces changes to CCM credential

Could open the door for more hospital-based CMs

The Commission for Case Manager Certification (CCMC) in Rolling Meadows, IL, has announced changes to the eligibility criteria for the popular Certified Case Manager (CCM) credential. The changes could open the door for more hospital-based case managers to sit for the CCM exam.

According to **Susan Gilpin**, chief executive officer of the CCMC, the eligibility criteria changes are in effect for the applications submitted by the Nov. 15 deadline. The changes include a redefinition of "continuum of care" and elimination of the requirement that case managers apply the core components of case management in "multiple environments." Further, the new standards eliminate the requirement that case managers never provide direct patient care.

Gilpin says the eligibility criteria were adjusted based on research the CCMC conducted with regard to how case management has changed over the years.

"The available knowledge of the field of case management has grown so much, making the certification eligibility criteria that were appropriate and applicable 10 years ago no longer reflective of the field today," says **Hussein A. Tahan**, MS, DNSc(C), RN, CNA, director of nursing for cardiac specialties at Columbia Presbyterian Medical Center, New York Presbyterian Hospital in New York City. Tahan also is a commissioner with the CCMC. "The field is constantly changing. Therefore, as a commission, we had to revisit the eligibility criteria for the case management certification credential and revise them to meet the standards and the practices of case management as we know them today," he adds.

The changes were based in part on a CCMC-conducted pilot study of a random sample of 107 case manager job descriptions. "In reviewing the preliminary results, it did appear that case management had changed in a number of ways," Gilpin says. "Indications were that the definitions that the commission had been using with regard to continuum of care and the multiple environment issue did not necessarily work in the current environment." A more intensive job description study currently is under way and should be completed by summer 2003.

Previously, the CCMC required that a case manager function in "at least one environment beyond his/her work setting," a requirement that many hospital-based case managers found difficult to meet. The new standard, however, defines the continuum of care as matching "ongoing needs with the appropriate level and type of health, medical, financial, legal, and psychosocial care for services within a setting or across multiple environments."

According to Gilpin, "the biggest consideration was what this research was showing about the fact that people can practice case management without

the additional step of referring out and having constant interaction with the individual receiving services once he or she has left the facility."

Earlier this year, the commission revisited its certification eligibility criteria and examined whether they were still necessary and relevant for today's case management practice, Tahan says.

As a result and due to the changing case management knowledge, the commission made three main modifications in the criteria. First, it waived the criterion of "license in one's specialty or field provided on the basis of an examination," he explains. It was necessary to eliminate this criterion because not every state provides or requires a professional license based on an exam. For example, the social work licensure by exam requirement varies based on regional location; not every state mandates social workers to have a professional licensure to be able to practice social work.

The second eligibility criterion the commission re-examined was that of the "multiple environments." Case managers were required to apply the core components of case management as defined in the certification handbook into more than one environment or setting. This criterion presented a challenge for case managers to meet, especially for those who function in the hospital setting.

This criterion was redefined focusing more on the behaviors and interactions of case managers with other providers and health care professionals across the continuum of care. For example, case managers in the hospital setting would be able to meet this criterion by virtue of their communication and interactions with other providers along the continuum of care such as home care agencies, skilled nursing facilities, case managers in managed care organizations, and durable medical equipment agents. Case managers also would be able to meet this revised criterion based on their role responsibilities that include assessment, planning, implementing, monitoring, evaluating, and following up on the care they provide to their patients. These activities require case managers to work with a patient and his or her family over time and to interact with multiple care providers and community agencies along the way.

Tahan notes that, in the hospital setting, the case manager plans the care to be received during the patient's hospital stay and arranges for the community services necessary to meet the patient's after discharge care needs. As a case manager, "you're also making sure that you help transition the patient to the care setting where the most relevant level of care can be provided; that is, to ensure that the patient goes to the setting where his or her needs will be appropriately met. Even though case managers do not normally travel physically across care settings, they follow up on the patient's plan of care and ensure that the patient's transitional plan is appropriate and the care provided as needed."

The third criterion the commission eliminated is the "no direct care involvement." Since the practice of case management varies based on the organization and setting where case managers are employed and the patient population they care for, it sometimes is necessary for case managers to be involved in direct care providing.

For example, those in the hospital setting may be involved in care activities such as complex wound dressing changes (considering they are expert practitioners) or patient and family teachings regarding the plan of care and medical regimen. This change allows case managers whose job description includes both direct and indirect care responsibilities to be eligible for the certification exam compared to in the past, when eligibility was limited only to those who were not involved in direct care provision.

[For more information, contact:

• ***Commission for Case Manager Certification,*** *Rolling Meadows, IL. Telephone: (847) 818-0292. Web site: www.ccmcertification.org.]* ■

Clinical pathways program presents challenges

Software tends to be physician-driven

Advancing technology continues to reshape the way acute-care case management is practiced. One example of that is the growing trend toward automation. However, early experience shows that technology is no guarantee for physician buy-in at the front end, much less patient compliance at the back end.

Several large institutions such as New York University (NYU) Medical Center in New York City now are using automated systems. However, even for a large sophisticated system such as NYU, automation it is no easy task. It is not primarily the hospital information system that is the

(Continued on page 189)

CRITICAL PATH NETWORK™

Clinical pathway for colorectal procedures

Clinical pathways development in Singapore

By **Soh Mun Chin**, RN
Senior Case Manager
Tan Tock Seng Hospital
Singapore

Singapore is a small country in Southeast Asia with a land area of 682 square km and a population of 4.4 million.

Singapore is a multiracial society. The ethnic groups include 77% Chinese, 14% Malay, 8% Indian, and 1.5% other.

The health care financing in Singapore is a dual system:

- private;
- subsidized.

For the private system, patients pay out of pocket for their medical expenses. Patients in the subsidized system get 65% to 80% subsidy from the Ministry of Health, depending on the class status they choose: Paying A, B1, B2, or C class beds.

The health care mission in Singapore is:

- to promote good health and reduce illness;
- to ensure that Singaporeans have access to good and affordable health care that is appropriate to their needs;
- to pursue medical excellence.

Clinical pathways in Singapore

Clinical pathways were first developed and implemented in Tan Tock Seng Hospital (TTSH) in May 1996. TTSH is the second largest acute-care hospital in Singapore. It has 1,200 beds.

The first clinical pathways implemented are the following:

1. hip fracture [length of stay (LOS) 11 days / 10th postoperative day (POD)];
2. ischemic stroke (LOS 5 days);
3. hemorrhagic stroke (LOS 10 days).

The goals of the clinical pathways initiative were to accomplish the following:

- streamline variations on care;
- standardize care and ensure that minimal standard of care are provided to the patient;
- ensure patients are seen timely;
- ensure that interventions are carried out timely, with no delays;
- provide quality and cost-effective care to patients;
- ensure clinical outcomes and goals are met.

Currently, TTSH has 11 clinical pathways, which are actively running and used by the health care team. The pathways include:

1. asthma (LOS 3 days);
2. acute chronic obstructive pulmonary disease exacerbation (LOS 5 days);
3. acute myocardial infarction, uncomplicated (LOS 7 days);
4. congestive heart failure (LOS 5 days);
5. diabetic ketoacidosis in the emergency department (ED);
6. transurethral resection of prostate (LOS 4 days);
7. colorectal procedures (LOS 10 days / 8th POD);
8. total knee replacement (LOS 10 days / 8th POD);
9. acute lumbar spinal injury with paralysis (LOS 18 days);
10. diabetic / ischemic foot with or without minor procedures (LOS 8-10 days);
11. diabetic / ischemic foot with major procedure (LOS 10th POD).

The implementation of clinical pathways at TTSH certainly has had an impact on the ways that care is being delivered and has been a great pathway and difficult journey for health care providers to have a complete paradigm shift. It was not an easy journey for all of us who were involved with the design, development, and implementation.

In TTSH, clinical pathways are developed by the collaborative effort of the multidisciplinary team to provide the best sequence and timely interventions for selected homogenous groups of patients and to ensure clinical quality outcomes are met.

Developing the colorectal pathway

Here, I would like to share our experience of the development of the colorectal pathway. The colorectal surgeon, Denis Cheong, MD, first initiated this pathway. Its goals are to:

- standardize care for patients with colorectal surgeries;
- provide timely pre- and postoperative education to patients and families;
- prevent/reduce postoperative complications;
- improve patient, family, and staff satisfaction.

The project team was formed in October 1998. The team members include:

- colorectal surgeon — chairperson/"champion" for the team;
- stoma nurse clinician;
- case manager;
- registered nurse representative;
- medical social worker;
- dietitian;
- physiotherapist.

The case managers collated the pathway content from the team members and formatted them onto the TTSH clinical pathway template. Cheong, the project leader, was not happy with the hospital format and wanted his own format, which the clinical pathway steering committee did not approve.

The pathway was put on hold because the surgeon refused to get it implemented. The final version of the pathway was put in "cold storage" for about a year.

In early 1999, with the changing health care policy and implementation of case-mix funding and diagnosis-related groups (DRGs), many hospital administrators had to review their care delivery system. Then came the initiative by the Ministry of Health to divide the health care system into two clusters: National Healthcare Group (NHG) and SingHealth Group.

The CEOs for both the clusters are given the autonomy to run the care delivery services. They are monitored by their performance in managing the resources and care delivery services.

TTSH is under the umbrella of NHG. The CEOs of NHG and TTSH strongly support clinical pathway development and implementation as a tool to use for delivering a minimal standard of care to the patients. Because of that support, the colorectal pathway surfaced again for implementation. The pathway was piloted in October 1999 and was reviewed and remodified in February 2000.

The latest revision was done in August 2002. It has greatly improved features, and the latest version was tailored for standardization across the cluster hospitals in NHG.

The purpose of standardizing the clinical pathway format was to provide a standard way of using the clinical pathways by nurses, physicians, and other allied health care providers across the cluster hospitals.

The latest format was approved by the clinical pathway steering committee and NHG clinical management committee.

Benefits/impact of clinical pathways

Some of the benefits and effects of the pathways include:

- There is standardization of care.
- Minimal standard of care is provided to patients.
- There is improved quality of care.
- There are reduced length of stays.
- There are reduced post-op complications.
- There is improved patient/family satisfaction with care.
- There is improved staff satisfaction.
- There is improved communication with patient/family and health care professionals.
- Patient/family are well informed of the plan of care.
- Clinical outcomes are met.
- Patient/family receive education and caregiver training on time.
- Discharge planning initiated on admission and patients are discharged timely.
- Clinical pathway data collected serve as a tool for clinical service improvement and future

research projects and paper presentations in conferences.
- Colorectal surgeons review the clinical pathway data report and benchmark against themselves and against the other clusters in terms of their care management.
- Clinical pathways serve as an education / orientation tool for new nurses, house officers, and medical officers.
- Nurses like to use the pathways because they don't have to write care plans for patients, as the pathway is the plan of care.
- Junior physicians like the pathway because it serves as a guide for them in ordering treatment and tests for the patient.

Format design features

The format of the clinical pathway for colorectal procedures consists of the following features:
- The cover page lists the DRG codes, principal diagnosis, comorbid conditions, principal procedures, and complications during the patient's stay. **(See sample, p. 186.)**
- Guidelines for health care professionals on the use of the pathway are printed on the back of the front cover page.
- Pre-op day to discharge days are listed next.
- Physician's orders are on the left-hand corner of the pathway.
- Nursing and other allied health care team interventions are on the right-hand corner.
- Multidisciplinary team notes and documentation are on the back of the daily pathway.
- The health care team members tick on the interventions that have been done and do charting by exception. They only need to chart on the outcomes of the interventions or anything that is unusual and variances from the standard.
- The variance form is placed at the end of the pathway and removed and submitted to the case manager upon patient discharge.
- The pathway is a legal document and is kept in the patient's medical record.

{For more information on Singapore's clinical pathways, contact:

• **Soh Mun Chin**, *RN, Senior Case Manager, Tan Tock Seng Hospital, 11 Jalan Tan Tock Seng, Singapore 308433. E-mail: chin_soh_mun@ttsh.com.sg. Telephone: (65) 3578526. Fax: (65) 3578530.]* ■

CE questions

This concludes the current semester. Please return the enclosed survey form.

21. Which of the following approaches were used as team-building exercises in the case management department at Medical City Dallas Hospital?
    A. Members of the department took part in a weekly bowling league.
    B. The entire department took part in an Outward Bound retreat.
    C. Members of the department went as a group to the Texas State Fair.
    D. all of the above

22. At the lowest level of integration in a case management department, virtually no responsibilities are shared, according to Hussein A. Tahan, MS, DNSc(C), RN, CNA, director of nursing in cardiac specialties at Columbia Presbyterian Medical Center in New York City.
    A. true
    B. false

23. The Commission for Case Manager Certification changed its eligibility requirements for the Certified Case Manager credential based in part on a pilot study examining what type of document?
    A. clinical pathways
    B. job descriptions
    C. practice guidelines
    D. case management algorithms

24. What automated pathway system is currently in use on Atlanta-based Emory University Hospitals' intensive care units?
    A. CareMinder
    B. Midas
    C. VoiCert
    D. Emtek

Answers: 21. C; 22. A; 23. B; 24. D

Source: Tan Tock Seng Hospital, Singapore.

AMBULATORY CARE
QUARTERLY

Cutting-edge strategies go beyond staffing ratios

Don't be shortsighted when it comes to staffing

Do you staff your emergency department (ED) based solely on ratios? Do you use staffing productivity measures that only address paid nursing hours per patient visit? These methods are not effective in the ED and actually can endanger patients, warn staffing experts, who point to a growing trend toward state-mandated ratios for nursing staff.

"They do not look at variables unique to emergency nursing, such as acuity, length of stay, and staff skill mix," says **Carl E. Ray**, BSN, RN, senior clinical analyst for Sentara Healthcare in Virginia Beach, VA, and a member of the Des Plaines, IL-based Emergency Nurses Association's (ENA) Staffing Best Practice Workgroup.

Ray gives this example: Some ratios have set a one-nurse-to-one-patient ratio for trauma and critical care patients, yet it takes at least two nurses to care for that patient during the first hour they are in the ED. "Length of stay is also crucial because as long as patients remain in the ED, they require nursing care," he adds. "This is especially true in today's hospital environments where patients are held for long periods in the ED while waiting for inpatient beds."

The dollars saved in keeping a low ratio in the face of increased patient volume, admissions, and ED inpatient holds will be spent later on contract labor, the costs of ED nurse attrition, and potential risk management expenses, warns **Camilla L. Jones**, RN, director of emergency and transfer services at Lewis-Gale Medical Center in Salem, VA. "In a nutshell, shortsightedness regarding appropriate staffing can destroy your competitive advantage," she says.

Here are ways to effectively staff your ED:

- **Use the new ENA staffing tool.**

  New staffing guidelines developed by ENA give you the nursing full-time equivalents (FTEs) needed to staff an ED based on patient volume, patient acuity, and length of stay, Ray says. *(For more on the staffing guidelines and tool, go to the ENA web site, www.ena.org.)* The workgroup has developed an ENA Staffing Tool in an automated Excel Workbook format based on the guidelines. By inputting data into the tool, you will be given the number of FTEs needed to staff your ED, Ray explains.

  The tool takes census changes specific to the ED into account; the census usually peaks about noon, with a second, larger peak in the early evening and a dramatic drop late at night, he says.

- **Obtain extra staffing for high-acuity patients or inpatient holds.**

  Jones developed a staffing formula to use in the ED with high-acuity patients who require extended care and/or for inpatients held in the ED. "I created the formula to communicate the extra man-hours needed to cover effective patient care and justify them mathematically," she says.

  When justifying your staffing needs, a general statement such as "we were swamped" is not as effective as a formula that objectively converts the extra length of stay into a productivity value, Jones emphasizes.

  Your ED's admission rates are another indicator that can be used to adjust man-hours to an appropriate level, Jones says. "If an ED typically runs at two man-hours and has typically experienced admission rates of 10%, it is only logical to assume that it will take more staffing resources to manage admission rates of 20% or greater," she says. The location of the patient's admission also is relevant, Jones says. "For example, if the ED is holding critical care patients, this will drive staffing requirements up," she says.

- **Determine what man-hour per-stat ratios to use.**

  The ratios you use will depend on the services your ED offers, such as forensics, a chest pain center, and interfacility transfer services, Jones

says. "The fact that EDs can't be compared as apples to apples has further complicated the standardization of ED staffing," she says. "There continue to be many methods out there that are used, even within local communities and market divisions." Jones advises against using a nurse-to-bed ratio to calculate staffing in the ED setting.

"Patients can continue to enter beyond the room capacity," she notes.

Jones monitors man-hour per-stat ratio trends that occur monthly, weekly, daily, and hourly; and staffing patterns are staggered, based on trend averages. Incentives are offered to staff willing to work extra hours if patient load goes beyond average capacity or if patients are held, Jones reports. "In addition, leadership staff maintain an on-call status so that extra resources can be made available on the spur of the moment if needed," she says. "We all share this responsibility."

- **Use different ratios for various patient groups.**

Consider staffing differently for three groups: acute emergent patients who usually are admitted; urgent and nonurgent patients who usually go home; and admission holds who can't get an inpatient bed, suggests **Jerry Keyes**, RN, director of emergency services for Florida Hospital Celebration Health in Orlando. "Each one of these patient types needs a different staffing ratio," he explains.

Keyes suggests looking outside the ED to the surgery area; the best performers separate outpatient and inpatient surgical patients into two categories because processing and staffing are different. He says that the same approach should be used in the ED, and he points to the success of fast tracks for minor care patients. "Thus, this group gets faster treatment than they would mixed in with the acute group," he says.

- **Track changes in acuity to justify additional staff.**

Cindy Wage, RN, BSN, nurse educator of the ED at Trinity Medical Center in Rock Island, IL, has demonstrated increased acuity levels linked to tasks routinely performed by nurses. She says that doing this has supported the need for additional nursing staff. "I just kept some of my own stats on things that we do every day that no one seemed to take into consideration," she says.

Wage gives the example of nurses doing an average of 600 electrocardiograms each month. She used this statistic to show administrators that acuity levels had changed since the hospital started its open-heart program.

"We have an average of [less than] 40 minutes from the door to the cath lab for acute myocardial infarctions," she reports. However, Wage says that the extra time nurses spent on electrocardiograms, which contributed to this impressive statistic, was overlooked until she pointed it out.

Wage also tracked the time nurses spent in answering radio calls from ambulance services and transferring ED medical/surgical admissions to the units. The ED manager and director took Wage's findings to the vice president of nursing to discuss the budget plans for the year. "I was able to have our nursing care hours increased," she reports. "We are now budgeted for one additional nurse for both days and second shift."

- **Provide the same level of care to admission holds as inpatient units.**

Keyes says that the most pressing staffing issue in his ED is measuring the workload for admission holds. "We need an inpatient acuity system to ensure equal patient care standards are met," he stresses. Keyes says that his ED is negotiating with the inpatient units to supply nurses to care for admission holds. Either revenue will be transferred from the inpatient units to the ED, or the cost of the ED's labor will be transferred to the inpatient units, he explains. "Too often, we hear of ED staff caring for these patients with fewer care hours per day than the inpatient setting," he says. "That is foolish and opens you up to criticism by [the Joint Commission on Accreditation of Healthcare Organizations] for having different care standards in different settings."

[For more information about staffing ratios, contact:

- ***Camilla L. Jones**, RN, Director of Emergency and Transfer Services, Lewis-Gale Medical Center, 1900 Electric Road, Salem, VA 24153. Telephone: (540) 776-4850. Fax: (540) 776-4849. E-mail: cami.jones@hcahealthcare.com.*
- ***Jerry Keyes**, RN, Director, Emergency Services, Florida Hospital Celebration Health, 400 Celebration Place, Celebration, FL 34747. Telephone: (407) 303-4034. Fax: (407) 303-4334. E-mail: jerry.keyes@flhosp.org.*
- ***Carl E. Ray**, BSN, RN, Senior Clinical Analyst, Sentara Healthcare, P.O. Box 6442, Virginia Beach, VA 23456. Telephone: (757) 668-5169. Fax: (757) 668-4126. E-mail: CERAY@sentara.com.*
- ***Cindy Wage**, RN, BSN, Nurse Educator, Emergency Department, Trinity Medical Center, West Campus, 2701 17th St., Rock Island, IL 61201. Telephone: (309) 779-3232. Fax: (309) 779-2105. E-mail: rcwage@cs.com.]* ■

(Continued from page 182)

problem, according to **Barbara Delmore**, RN, a nurse case manager on the NYU surgery unit. She says the biggest challenge is getting certain physician groups to use it.

"Right now, there are only two surgical groups using it faithfully," she says. "The others prefer not to use the care plan that gets loaded each day." Instead, she says they tend to use the order sets, which also are components of the pathway.

NYU began automating in its surgery department using a system called CareMinder, which takes the user through a series of order sets. Based on the written pathways that the hospital had used for years, and set up with the help of nurse specialists working in information systems, the automated pathway takes physicians or case managers through patient care, step by step, using different screens on the computer.

When the patient comes out of surgery, physicians execute all the orders at once instead of on a daily basis, Delmore explains. The CareMinder version is put into suspense by the nurse who sends the patient to the operating room (OR), she says. Once the patient comes out of the OR, the resident starts to execute the orders for the OR day, which is referred to as Day Zero.

The process is very interactive, Delmore adds. One step triggers the next. There also is an option to go outside the pathway's guidelines if someone deviates from the pathway.

Caregivers can order lab tests or antibiotics directly on the computer, she points out. "The clinical pathway is supposed to be looked at every single day. That is the whole purpose."

However, the system has some difficulties, Delmore says.

"Unfortunately, if someone goes into the OR and they were not put on the clinical pathway when they left and nobody put them on between the time the patient went to the OR and came to the recovery room, then you have lost the whole pathway," she says.

The software is all physician-driven, Delmore says. "Some groups use it and have no problem with it, and some do not." In short, it has become more of a practice issue than a technology issue. "The bottom line is that the clinical pathways are still there. They are still present, just in a different form," she says. NYU continues to push the system. Eventually, Delmore wants nurses to be able to chart the outcomes, she says. NYU also would like the system to be Windows-based, which it is not. "That, to me, would be cutting-edge."

Emory University Hospitals in Atlanta also has begun the automation of care pathways, says **Rosalie Przykucki**, RN, MSN, coordinator of clinical performance improvement. One benefit of the Emtek system, currently in place only on Emory's intensive care units (ICUs), is that it has some graphing capabilities. "Some of the physicians want to see trends, [such as] 'What has his temperature been for the last 24 hours?' and it actually builds a graph for you," she adds.

"I wish our systems were completely automated, but they are not," she adds. Instead, Emory has been structuring its paper pathways to be the same at both Emory University Hospital and Crawford Long Hospital — the result of the merger of the two Atlanta facilities. Currently, when a patient leaves the Emory ICU, all the pathway information is downloaded and printed onto a readable chart copy, which then follows the patient, Przykucki says.

Not just 'cookbook medicine'

The automatic aspect of the new technology gives physicians even more reason to call it "cookbook medicine." In fact, Przykucki argues the opposite is true. Having pathways on the computer makes it much easier to change and modify them to fit individual patients' needs.

In addition, more physicians are buying into the pathway process through this technology. "I think as more and more physicians go through their medical training, they are going to find that this is a tool that really helps them," she explains.

Przykucki agrees with Delmore that the real state of the art will be when the automated pathways and order sets become electronically linked to outcomes. "Everybody would love that."

Emory still is committed to the pathways but does not have a traditional case management system, she says. "It is a hybrid program more than strict case management, and my role is an interface to clinical performance improvement."

Przykucki says she looks at the overall flow of various pathways in the system — how well patients are doing in terms of the lengths of stay and any complications. "I also work with the physicians in the pathway teams on implementing changes for any new technology and new protocols that have come along," she adds.

When a patient is ready to leave the hospital, caregivers know where the patient should be and what he or she can do at home, Przykucki says. "This will give the caregiver and patient an idea

of what he should be able to do or what he may need help with," she explains. Patient pathways have been around for a long time, but there is now a lot more emphasis on the aspect of patient training, she explains.

For example, caregivers now can tell patients the kinds of procedures taking place for specific diagnoses such as diabetes or coronary artery disease, she says. "Then we move the patient through the hospital process to the point where he or she is ready to go home and we have given them patient education to take beyond the hospital walls."

Przykucki says that because a patient's stay in a hospital typically is short, it often is difficult to cram everything into that short period of time. That is why it is important to give patients something to take home that is easy to read and that has a link to the Internet or a 24-hour hotline at the hospital or the physician's office to help get their questions answered, she adds.

"Unfortunately, in the period of time in the hospital, their mind is not concentrating on everything," she explains. "It is racing ahead or thinking about what the doctor just said." The patient pathway can help translate the message into something the patients can take home.

Certain services such as surgical services also have clinical coordinators who call patients at regular intervals after discharge, Przykucki reports. "Our nurses routinely call the patients to follow their progress." Emory also has a 24-hour hotline in case there is an emergency and patients need to contact a physician, she says. A lot of this information is automated in the links that are available on the Internet sites. Some of the clinical programs for developing pathways and many of the major software companies now have programs that can be tailored to both clinical pathways for the hospital and the clinical pathway for patients based on evidence-based pathways.

"In general, any pathway that is worth its salt, needs to have a basis in evidence-based medicine," she says. "Basically, that is nothing more than looking at the body of clinical trials that are out there and trying to utilize them in a way that will bring about the best results for your patients."

[For more information, contact:

*• **Barbara Delmore**, RN, Nurse Case Manager, New York University Medical Center. Telephone: (212) 263-7946.*

*• **Rosalie Przykucki**, RN, MSN, Coordinator of Clinical Performance Improvement, Emory University Hospitals, Atlanta. Telephone: (404) 712-4665.]* ■

JCAHO unveils major changes to survey process

Changes include midterm self-assessments

The Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is significantly revamping its accreditation process to answer its critics and sharpen the focus of its accreditation process.

The new initiative, "Shared Visions — New Pathways," will allow hospitals to conduct self-assessments and let surveyors focus on actual patient care experiences.

According to the organization, "Shared Visions" represents agreements among JCAHO and health care organizations about what a modern accreditation process should be able to achieve, while "New Pathways" represents a new set of approaches or "pathways" to the accreditation process that will support fulfillment of the shared visions. The initiative will be implemented January 2004 for all accreditation programs.

Russ Massaro, MD, JCAHO's executive vice president for accreditation operations, says "Shared Visions — New Pathways" represents the next step in the evolution of accreditation. "It shifts the paradigm from a focus on survey preparation to one of continuous operational improvement," he explains. "In so doing, it enables the accreditation process to become more of a service than a commodity."

The new initiatives include the following:

- streamlined standards and a reduced documentation burden to focus more on critical patient-care issues;
- self-assessment process to support organizations' continuous standards compliance while freeing up survey time to focus on the most critical patient-care issues;
- priority-focus process that integrates organization-specific data and recommends areas for the surveyor to focus on during the survey;
- new survey agenda with six basic components: an opening conference, a leadership interview, validation of the self-assessment results, a focus on actual patients as the framework for assessing compliance with selected standards, discussion and education on key issues, and a closing conference;
- enhanced role for surveyors in the new process facilitated by extensive surveyor training;

- revised decision and performance reports providing more meaningful and relevant information;
- use of ORYX core measure data to identify critical processes and help organizations improve throughout the accreditation cycle;
- better engagement of physicians in the new accreditation process;
- new approach to surveying complex organizations.

Specifically, the new accreditation process is designed to focus the evaluation to a greater extent on the actual delivery of clinical care; increase the value of and satisfaction with accreditation among accredited organizations and their professional staffs; and decrease costs related to survey "ramp-up" and resource allocation.

It also is designed to shift the accreditation-related focus from survey preparation and scores to continuous operational improvement in support of safe, high-quality care; make the accreditation process more continuous; and increase the public's confidence that health care organizations continuously comply with standards that emphasize patient safety and health care quality.

In addition, the new survey process will be more continuous and will eliminate much of the "ramp-up" that often takes place before a scheduled survey, says **Dennis O'Leary**, MD, president of the Joint Commission. "We're consolidating, saying things in a lot fewer words, and moving standards to the most appropriate sections," he explains. "We have reduced the number of scorable elements, and that has a significant impact in terms of the burden on accredited organizations."

According to the Joint Commission, a new self-assessment process will be rolled out for ambulatory care, behavioral health care, home care, hospitals, and long-term care in 2004. This process aims to support continuous standards compliance and free up surveyor time during the on-site survey to concentrate on the organization's critical focus areas and provide practical, educational support.

Accredited organizations will complete the self-assessment at the 18-month point in their three-year accreditation cycle, rating the level of compliance with all standards applicable to that organization. There will be no on-site surveyor visit at the 18-month point.

In the self-assessment, if an organization finds itself not compliant in any standards area, it must detail the corrective actions that it has taken or will take to comply. These actions will be entered into the self-assessment and submitted to JCAHO for review. This activity will not result in any change in accreditation status for the organization.

A JCAHO staff member will follow up with the organization to review its findings, approve the corrective actions, and provide advice or assistance on those actions. At the 36-month point, or the triennial survey, surveyors will go on-site to verify that the organization has implemented the corrective actions as laid out in its self-assessment.

JCAHO reports that, during pilot testing, organizations strongly approved of the self-assessment process to help maintain continuous standards compliance. Organizations reportedly required no new resources to complete the assessment, and most already were completing self-assessments using other tools. All the organizations that took part in the pilot completed the self-assessment in the eight weeks allowed. The majority of the organizations indicated that they would prefer three to six months to complete the assessment.

JCAHO says it will contact organizations three to six months in advance of their accreditation midpoint with information on the self-assessment tool, so organizations have adequate time to complete the assessment.

As long as an organization plans appropriate corrective action, the 18-month self-assessment activity, including the report to JCAHO, will not change the organization's accreditation status. In addition, JCAHO says it will work with each organization, often suggesting appropriate corrective actions.

At the triennial survey, surveyors will validate an organization's compliance over a minimum 12-month track record with all standards involved in its corrective actions. The corrective actions will also drive appropriate on-site education with surveyors.

[A special 16-page edition of Perspectives*, the Joint Commission's official newsletter, takes an in-depth look at the new accreditation process and is*

COMING IN FUTURE MONTHS

- Denial management: The role of the case manager
- How to measure your case management effectiveness
- Emergency department case management
- Dealing with 'frequent-flyer' patients

available at Joint Commission Resources' web site at www.jcrinc.com/perspectives. Questions may be e-mailed to sharedvisions@jcaho.org.] ■

Revised CMSA standards reflect new CM issues

The 2002 version of the Little Rock, AR-based Case Management Society of America's (CMSA) standards of practice is designed to reflect the role of the case manager in the changing health care system.

"The development of the CMSA standards went from infancy in the first 1995 edition to adolescence in the 2002 updated edition. The new standards reflect a maturing of case management as we figure out who we are and what we can be," says **Kathleen Moreo**, RN, Cm, BPSHSA, CCM, CDMS, CEAC, who co-chaired the Standards of Practice Task Force with Gerri Lamb, PhD, RN, FAAN.

In revising the *Standards of Practice for Case Management*, the task force looked at the growth of managed care and demographic trends, along with other current issues, such as patient rights, quality initiatives, technology, and cultural competency and how they affect the practice of case management. "Instead of the case manager in the center, we put the patient in the center. We have changed our focus from identifying resource utilization to identifying resource management and stewardship," Moreo says.

Although there were many minor changes in the standards, major changes included:

- legal issues of consent for case management services and health care services and products;
- cultural competency for case managers;
- patient confidentiality issues for case managers;
- a shift in focus from resource utilization and cost of care to resource management and care management.

As they reviewed the standards, the task force looked at issues and trends in case management today. "We looked at emerging trends and maturing trends. We realized that the *Standards of Practice* couldn't embrace everything. We were trying to be as reflective of current practice as possible," Moreo says.

[Information on the Standards of Practice for Case Management *is available at the CMSA web site: www.cmsa.org. Telephone: (501) 225-2229.]* ■

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. ■