

Inside: 1999 Reader Survey

# HOSPITAL CASE MANAGEMENT™

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

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MAY  
1999

VOL. 7, NO. 5  
(pages 81-96)

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## Patients' increased severity of illness drives up LOS around the country

*Disturbing trend forces re-examination of QI and cost reduction*

The first concrete evidence that traditional utilization review has outlived its usefulness is here. According to data compiled by San Francisco-based HCIA and New York-based William M. Mercer as part of their 100 Best Hospitals study, average lengths of stay (LOS) have begun to creep up for the first time in 20 years — and increased costs are likely to follow.

For many hospitals, the time of quick fixes and easy answers is over, experts say. If quality improvement efforts are to continue to yield positive results, case managers will have to look at the concept of quality in a whole new way.

The bad news is that the rise in LOS, while small (from an all-time low in 1997 of about 3.8 days to 3.9 in 1998), almost certainly results from a slow but clear increase in the severity of illness of patients treated in hospitals, says **Jean Chenoweth**, who until recently served as senior vice president in the consulting division of HCIA. This trend — as well as the trend toward higher lengths of stay — is most apparent in Western states with higher managed care penetration. Concurrently, Chenoweth found, more patients were being shifted to the outpatient setting. "What's going on is that many patients who can be handled in lower-cost or alternative sites of care are no longer being admitted to the hospital, and the ones who are being admitted to the hospital are increasingly more severely ill," she says.

### *Severity shift: Only the very sick hospitalized*

Chenoweth's first indication that LOS was increasing came with HCIA's 1997 study, which detected increases in hospitals where 90% or more of the patients belonged to managed care plans. The 1998 data, however, released in mid-March 1999, shows that "it isn't just in those hospitals whose patients are in managed care programs anymore. It's spreading across the entire population," Chenoweth says. "What showed up in the 1997 data expanded and rippled in its effect in the 1998 data."

## KEY POINTS

- For the first time in two decades, lengths of stay at hospitals across the country are creeping upward, thanks to a corresponding increase in the severity of patients being treated in the acute care setting. Some experts say this trend is solid evidence that traditional utilization review has outlived its usefulness and must be replaced by more effective cost-containment efforts.
- While case management traditionally is oriented toward reducing overutilization, experts say underutilization of resources can hurt your bottom line, too, if it's having a negative effect on patient care.
- A second, largely untapped source of potential cost savings is identifying and addressing misutilization, namely medication errors and other mistakes that invariably lead to higher treatment costs — as well as possible litigation expenses — down the road.

Chenoweth adds that other information management firms have picked up on the trend as well.

“What’s stunning about this change is that probably for two decades, everybody has said that the ultimate effect of utilization review will be that everybody in the hospital will be very sick,” Chenoweth says. “But people said that over and over for 20 years and it never happened. Well, guess what? It finally happened. The severity of illness is higher, and as a consequence, the overall costs will probably increase because of a need for a higher-skilled population of caregivers in the hospital.”

### *‘The simple stuff is over’*

However, that doesn’t mean you should resign yourself to ever-worsening financial outcomes, Chenoweth says. It only means that for now, and particularly for West Coast hospitals, “the simple stuff is over, and their gains in cost reduction are going to come from taking a far more clinical approach to the management of these patients.”

**Steven Freedman**, MD, a national practice leader for quality at William M. Mercer in San Francisco, agrees that cost-containment efforts in acute care will necessarily shift away from simply managing utilization to improving the quality of

clinical care. Indeed, Freedman says most hospitals remain in only the most basic stages of quality improvement. For these hospitals, Freedman advises looking not only at the overutilization of resources — the most traditional focus of utilization review — but at underutilization and misutilization as well.

Concerning underutilization, Freedman contends that, ironically, some hospitals lose money because they don’t allocate *enough* resources in certain areas. For example, he cites data from the best hospitals study on why the nation’s elite facilities tend to achieve better clinical outcomes for their myocardial infarction patients. Surprisingly, it wasn’t because of any technological edge or a higher rate of bypass operations. Rather, it was because the best hospitals tended to prescribe beta blockers and aspirin more often and more effectively. “These drugs cost pennies,” Freedman says. “But their use resulted in a better outcome, associated with shorter hospitalization.”

### *Making medical errors a quality issue*

Meanwhile, misutilization — costs resulting from medical errors and other mistakes — represents a potentially huge opportunity for cost savings, but to date few hospitals have addressed it from a quality improvement perspective, Freedman says. The now-famous Harvard Medical Practice Study of 1985 found that 4% of hospital patients suffered injuries due to medication errors and 14% of those patients died. The study also found that 12% of patients suffered adverse drug events or near-misses. Several more recent studies have found serious or potentially serious medication errors among at least 7% of patients. And one study claimed that the cost of medication errors in terms of additional treatment and hospital days amounted to an average of \$4,000 per case.

“Think about 7% of admissions having an extra \$4,000 tacked onto them,” Freedman says. “And all of that’s preventable.”

**Daniel T. Risser**, PhD, a senior behavioral scientist at Dynamics Research Corp. in Andover, MA, says case managers can be instrumental in reducing errors. Indeed, Risser has been a key part of the innovative MedTeams program, which applies behavioral science techniques to the hospital emergency department setting to cut the rate of medication errors.

*(Continued on page 84)*

# MedTeams project saves \$16 million nationally

*Try these proven error-reducing ideas in your ED*

An innovative program to reduce medication errors by applying behavioral science techniques has resulted in savings of \$16 million so far for the 10 hospital emergency departments involved. Preliminary results for the MedTeams project show an 80% drop in errors and a 50% reduction in risk management cases.

Here are several MedTeams concepts that have been proved to reduce errors:

- **Checkbacks.** Pilots and flight crews use the “checkbacks” system to ensure effective communication and minimize errors, explains **Dallas Peak**, MD, FACEP, clinical assistant professor of emergency medicine at Methodist Hospital in Indianapolis and a physician investigator for MedTeams. “In MedTeams training, we stress that all verbal orders are to be acknowledged verbatim. This will minimize the possibility for errors,” he says. “The order-giver has a chance to hear what was said and correct a mis-statement, while the order-receiver ensures the accuracy of what he or she heard.”

## ***Repeat orders aloud to avert errors***

At the emergency department at Madigan Army Medical Center in Tacoma, WA, the nurse is required to repeat the order out loud so it's clear what the physician actually wanted, notes **Matthew Rice**, MD, FACEP, medical corps chief at the department of emergency medicine. “We have had several cases where bad or less-than-ideal outcomes or medication errors were avoided because of the checkbacks,” he reports.

- **The two-challenge rule.** “This is one of the most effective empowerment tools I've ever seen,” says Peak. “Whenever a team member questions a decision, that team member has a responsibility to seek resolution. In fact, they may seek two challenges, first with the person who is directing them, and then take it to a superior.”

The two-challenge rule encourages a permissive atmosphere, notes Rice. “If even the newest,

least empowered people see something wrong, they have permission and an actual responsibility to challenge that in a professional way,” he says. “At that point, they will either correct a potential error or be educated as to why they were mistaken, so they are a better provider.”

## ***Empowering those who perceive problems***

“The whole point is to move the welfare of the mission or the patient onto the whole team,” says **Robert Simon**, EdD, chief scientist for the crew performance group at Dynamics Research Corp. in Andover, MA.

The key to this concept is that the responsibility lies with the person who perceives the problem, says Peak. “They are empowered to supersede rank or traditional hierarchy in order to resolve the issue,” he explains.

- **Cross-monitoring.** This is a powerful mechanism to reduce the error rate, advises Simon. “A nurse in a busy ED asked a physician, can a patient with NSAID allergy take Aleve? The attending physician answered yes, but another nurse asserted that Aleve is NSAID. By doing that, a potential injurious dose was avoided,” he says.

As many as half the serious adverse events in EDs can be caught by someone who is in the area, says Simon.

- **Advocacy and assertion.** If a resident physician routinely orders IVs for intermediate patients, a nurse may question the practice, Simon explains. “The nurse may state that it increases the patient's length of stay, increases the cost, makes patients uncomfortable, and possibly also causes complications,” he says. “After a discussion, the physician modifies his practice of routinely ordering IVs.

“The idea, however, is not to berate or correct another provider in front of a patient,” Simon says. “If that occurs, the provider needs to explain, ‘When you reprimand me in front of patients, I lose credibility, and we are not performing effectively as a team.’”

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According to Risser, some basic principles of quality improvement and old-fashioned teamwork have helped MedTeams hospitals save an average of \$3.45 for every patient who visits the emergency department — a huge cost savings over time. These principles include:

- Use communication protocols that verify information.
- Make informal agreements with peer caregivers to check each other's actions.
- Whenever you think a fellow caregiver has lost situational awareness, offer information to re-establish it.
- Review the priorities set for a patient's care plan to be sure the priorities make sense.
- Track whether organizations you recommend and use have effective teamwork systems in place. (For more error-reducing approaches, see related story, p. 83.)

### Examine greatest cost drivers first

What's most important in looking for additional innovative ways to contain costs is to prioritize effectively, Freedman says. That means taking the basic steps of looking first at your greatest cost drivers, such as the operating room, intensive care, and pharmacy, before moving on to other areas. For each priority, compare basic data on lengths of stay and costs per case to national benchmarks and then work to assess why a gap exists.

Interestingly, Chenoweth has found in her research that in areas such as the use of antibiotics to prevent postoperative wound infections, the nation's best hospitals displayed a high level of similarity, whereas other hospitals did not. "Standardization will take place, and is beginning to take place," she says. "But it is my sincere hope that it is based on actual practice tied to outcomes, so that we assure good results for the patients."

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## Push past pathway limits to cut resource use

*Cutting LOS should be secondary goal, expert says*

With lengths of stay (LOS) apparently set to rebound despite the best efforts of case managers, some experts maintain that clinical pathways must be used more as tools to standardize patient care and foster a team approach and less as a way to shave hospital days.

"Reducing length of stay is not a high priority now for pathways, because financial incentives have already driven lengths of stay down," says **Patrice Spath**, ART, a health care quality and resource management specialist with Brown-Spath and Associates in Forest Grove, OR. "If we want to continue to use pathways as one of our tools, then they're going to have to meet the needs of tomorrow — and the needs of tomorrow involve reduced resource use."

Spath contends that LOS remains an important variable to measure, but that doesn't mean pathways have to be structured using the traditional day-by-day time line approach. More useful, she maintains, is a flowchart approach that lets all care providers know what's expected when a patient presents with a given clinical condition. "I don't care if it's day three, day seven, or day 30; the question is whether the patient needs that third chest X-ray," Spath says.

### KEY POINTS

- With lengths of stay now beginning to rebound, some experts claim that clinical pathways must be used primarily to standardize resource utilization and foster a team approach in coordinating patient care.
- While length of stay remains an important variable to measure, pathways don't have to be structured using a traditional time line. Other options include using a flowchart approach and supplementing traditional pathways with perioperative pathways and algorithms.
- To effectively identify and decrease unnecessary resource use, you must analyze what physicians and other clinicians are really using and attempt to standardize it, experts say.

## Automated pathways to require more CM oversight

While no one is using a fully automated and integrated clinical pathway system yet, most experts say it's only a matter of time before such systems become commonplace among case management departments. Some warn, however, that while automated pathways may ease some burdens, they're likely to require a high level of oversight to make sure things run smoothly.

There's no question that automated pathways will finally make data collection more efficient, says **Patrice Spath**, ART, a health care quality and resource management specialist with Brown-Spath and Associates in Forest Grove, OR. "Clinicians don't have time to manually gather data unless it's a component of their documentation system," she says. "Of course, if they're documenting in a computer, they don't have to manually gather it anymore."

She adds that while pathways can be useful in such discussions of resource use, pathways aren't always necessary. "It's the old story of putting the cart before the horse," she says. "Sometimes people want to develop a pathway and that becomes their end goal, when their goal should be instead to reduce unnecessary resource use, streamline processes, or eliminate hand-offs. People continue not to have a good understanding of the goals they're trying to achieve. They've taken the traditional pathway and thrown it at every problem, hoping that it will stick somewhere."

Spath notes that one recent study from researchers at Stanford University Medical Center demonstrated how small hospitals could save money with knee replacement pathways.<sup>1</sup> But, Spath points out, the researchers found that most of the cost savings came not from cutting length of stay but rather from standardizing the equipment used. "You can't just create a pathway that says 'scrub nurse cleans site and drapes it,'" Spath says. "You've got to talk about things like what drapes we are using and how many basins."

The fact is that traditional pathways sometimes have been geared so much toward reducing length of stay that they haven't really been effective tools when it comes to cutting unnecessary resource use. For example, a traditional hip

Even so, Spath worries that too many case managers are expecting too much of automated pathways. "My biggest concern is that they're hanging their hat on automation and saying that once we automate our pathways, everything will be fixed and everything will run smoothly," she says. "It almost seems that once something's on a computer screen, we all believe that it's accurate and we quit thinking."

The fact is, however, that human intervention and human oversight will become more important than ever. Spath notes, for example, that like clinical pathways themselves, automated systems tend to function best when everything's proceeding according to plan. When unexpected events occur, human judgment will always be necessary. "When machines make errors, we don't always notice their errors because we just assume they're accurate," Spath says. "But the truth is, computers can't think for us, and when pathway systems are automated, case managers will be needed more than ever before." ■

replacement pathway might list key nursing and physician activities for preadmission, the day of surgery, and postoperative days one and two. (See **sample hip pathway, p. 86.**) But the pathway doesn't address the surgical episode of care itself, where much of the resources are spent. "Consequently, a lot of the dollars that we were trying to save really didn't get saved because we didn't address the most resource-intensive piece of it," Spath notes.

A more effective approach would be to factor in a perioperative pathway that would actually be used to manage the surgical minutes, streamline the process of care, and ease hand-offs among providers in the operating room. (See **sample perioperative pathway, p. 91.**) But even the addition of a perioperative pathway won't automatically lead to cost reductions. To identify and decrease unnecessary resource use, you must analyze what's really being used in the operating room and what physicians really want and need. "In order to reduce costs, in addition to perioperative pathways, you need to dig into those preference lists and standardize them," Spath says.

Other examples of possible cost-saving measures in the operating room include:

*(Continued on page 92)*



## Decrease Unnecessary Resource Use

### Traditional Hip Replacement Pathway

	PRE-ADMISSION (3-4 days before surgery)	ADM/SURG DAY	POD1	POD 2 (Discharge)
Key Nursing/ Physician Activities	Anesthesia visit	Postop: VS per protocol, assess for pain relief, CMS checks to affected limb, assess dressing site, drain(s), I&O, sequential TEDS, foley care, call saver, reinforce/encourage IS, assess lungs, GI status. Orient to room, equipment, Nursing Admission assessment	Assess: VS, lungs, bowel status, skin condition, PCA pain relief, CMS to affected limb, dressing site, drain(s), foley care, I&O, monitor sequential TEDS. Assess for DVT. I.S. x 20 qh while awake. Ice to affected extremity.	Assess: lungs, bowel status, PO pain relief, CMS to affected limb, check dressing/ incision site, I&O, monitor sequential TEDS. Assess for DVT. I.S. q2h w.a. DC foley, DC IV · hepbloc, DC drain if in place. Ice removed from affected extremity.
Tests	CBC, Chem Panel, PT, PTT, Type & Screen, CXR, EKG	X-ray hip in PACU	CBC PT if on Coumadin	CBC PT if on Coumadin
Activity		Bedrest, turn per protocol with abduction pillows.	Turn per protocol with abduction pillows. PT: Stands, 25lbs weight bearing, transfer, reinforce hip precautions. OOB to chair TID.	Turn per protocol with pillows. BRP, transfer, functional ambulation, hip precautions.
Treatments	2 Units of autologous blood on hold	Eggcrate, trapeze. Postop: PACU, Discharge per scoring system < 2 hrs. Set-up PCA/start prn.		
Physical Therapy	Instruct and Review: - Transfer training - Stairs - Hip prosthesis precautions - Gait training - Grasper use - Exercises - PT goals	Encourage physical therapy exercises	Physical therapy assessment. Collaborate with nursing: transfer, ambulation, assistive devices. PT treatment, BID bed-chair/ commode with mod/min assistance. Review precautions.	Exercises. PT: Home exercise instructions and family training. Review car transfer handout. Written home instructions.
Meds	Multivitamin and Iron (1 mon. prior) Coumadin 10mg PO 9hr prior to OR Pain meds	IV, IV Ancef 1gm q8h x6 doses. PCA, Coumadin 5mg PO	PCA, IV, IV antibiotics, Coumadin 5mg PO	5 mg Coumadin
Teaching	Incentive spirometer DB&C Turning instructions Activity restrictions PCA LOS critical path review with pt/s-o	Reinforce IS Review pre-op teaching	Importance of participating in ADLs. Activity restrictions. Coumadin management.	Reinforce ADLs, activity restrictions, coumadin management, and signs and symptoms to call Dr. Coumadin video.

Source: Patrice Spath, ART, Brown-Spath and Associates, Forest Grove, OR.

# CRITICAL PATH NETWORK™

## Pilot acute ischemic stroke program saves \$9,756 per case

By **Kimberly Jungkind**, RN, MPH, CCM  
**Cheryl Corish**, RN, MSN  
Thomas Jefferson University Hospital  
Philadelphia

**T**homas Jefferson University Hospital (TJUH), a 717-bed tertiary care university teaching hospital in Philadelphia, implemented a three-month pilot case management program for acute ischemic stroke patients in June 1995 because of increased managed care penetration in the Philadelphia marketplace. The program was started with congestive heart failure (CHF) patients and expanded to include acute ischemic stroke patients in July 1998. A multidisciplinary team was used to revise the current pathway, which was not being utilized, and to assist in developing case management objectives.

The objectives of the hospital case management program were to:

- promote and provide a coordinated care experience for patients and families;
- promote optimal resource utilization for the select population;
- increase patient and family satisfaction;
- promote a decreased length of stay.

To meet the objectives, an acute ischemic stroke pathway and other supporting documents were developed by members of the pathway team. The seven-day pathway was designed to incorporate the vital first few hours during the preadmission phase of care (emergency department) through the discharge phase of care.

The case management patients had the following ICD-9 codes: 433.11-433.91, 434.11-434.91, and 436.0 under DRG 014. The stroke population was 59% female and 41% male. Ages ranged from 35 to 94, with a mean of 66 years. A majority of the

patients (88%) were admitted to the acute stroke unit (ASU), while 12% were admitted to the neuro intensive care unit (NICU). These stroke patients were discharged to home (55%), an acute rehabilitation facility (25%), a subacute rehabilitation facility (18%), or to a skilled nursing facility (2%). Length of stay (LOS) for these case-managed patients decreased from 9.4 days to 6.4 days during the pilot phase.

The path follows the patient from the emergency department to either the ASU, intermediate neuro intensive care unit, or the NICU. The stroke team physicians had the majority of the case-managed patients as part of a pilot. Volunteer faculty and off-service physicians also admitted patients and participated in the pilot program. The stroke patients were identified for case management services by numerous sources as well as by computer-generated admission lists. Patients identified for case management services were evaluated using intracerebral hemorrhage and procedure-related stroke as exclusion criteria.

Acute ischemic stroke patients admitted for case management were centralized to one location in the hospital. National Institutes of Health Stroke Scale information and a Barthel Index were collected on these patients upon admission. Highlighted areas on the pathway denoted a focus for variance collection and for case management intervention. Clinical and nonclinical outcomes and risk factors were included on the path and served to focus the teaching objectives. Selected variances were identified and placed on the last page in a column for easy tabulation. These variances were coded according to corresponding patient information.

*(Continued on page 89)*

Admission Date: / /  
 Pathway Start Date: / /  
 D/C Date: / /

Check Admission Day

- M     F  
 T     Sat  
 W     Sun  
 TH

## Acute Ischemic Stroke Critical Pathway

Case Management Use Only	
Age	
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
LOS	
Comorbidities	
HTN	<input type="checkbox"/> Yes <input type="checkbox"/> No
A fib	<input type="checkbox"/> Yes <input type="checkbox"/> No
CAD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prior PTCA/CABG	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prior TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prior Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No (    pack/yr.)
Diabetes Mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No
H/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hyperlipidemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Preexisting Skin Breakdown	<input type="checkbox"/> Yes <input type="checkbox"/> No

	<b>Admission Day</b> Day 0-1 (1st 24 hrs) ER to ASU/NICU (or direct to ASU)
<b>Goals/Outcomes</b>	Identify acute ischemic stroke patient Document time of symptom onset Evaluate for appropriate treatment options and/or clinical trial Avoid Aspiration  NIH Stroke Scale (NIHSS) _____ Barthel Index _____
<b>Laboratory/Diagnostic Tests</b>	STAT CT brain without contrast    CBC, PT/PTT EKG    SMA-7 CXR    SMA-12 Carotid Dopplers    ESR Echocardiogram    RPR UA (if febrile) <b>To Consider:</b> • MRI/MRA • CTA • TCD <b>To Consider:</b> • ACLA, LA • ANA, RF • Fibrinogen level • Protein C & S, AT III (if age <55; venous infarct)
<b>Assessments/RN Interventions</b>	V5 as per Unit/t-PA protocol Neuro check as per Unit/t-PA protocol Cardiac monitoring Continuous Pulse Ox, and titrate O2 to keep SpO2 > 95% Bowel/Bladder/Skin assessment Avoid foley cath Compression boots (unless anticoagulated) HOB up 30°/Aspiration Precautions Institute Falls Risk Precautions Barthel Index completed and documented
<b>Medications/Treatments</b>	IV NSS Evaluate admission medications BP meds w/parameters as needed Acetaminophen 650 mg p.o./PR q 4 <sup>h</sup> prn temp >100° Sliding Scale Insulin as needed Bowel regimen prn  <b>To Consider:</b> • Antiplatelet treatment • IV heparin • t-PA (No ASA, Heparin or Warfarin for 24 hrs.—Refer to t-PA protocol) • Investigational drug (refer to Protocol)
<b>Consults</b>	<b>Notify Case Manager on Admission</b> <b>Notify Social Work on Admission</b> Consult as Needed: • Physical Medicine & Rehabilitation (PM&R) • Speech Therapy • Primary MD • Cardiology
<b>Activity</b>	Bed rest (HOB up 30°) <del>or</del> Increase activity as tolerated <b>To Consider:</b> • Pt may come off monitor for testing or traveling to Rehab Dept.
<b>Nutrition</b>	Nutrition Screen NPO/Aspiration Precautions <del>or</del> Diet as recommended by Speech
<b>Patient/Family Education/D/C Planning</b>	Orient to unit routine Educate about disease process Educate about diagnostic tests and meds Discharge Planning Assessment Initiated
<b>Comments</b>	

Source: Thomas Jefferson University Hospital, Philadelphia.

Supplementary tools were developed to enhance the case management process. These included a comprehensive discharge instruction form, post t-PA orders, first-day admission orders, patient pathway, and an education brochure. The hospital discharge instructions, which are compiled on a multipage form, are shared with the physicians and other health care providers. The hospital education channel provides a stroke video that focuses on signs and symptoms and on life after stroke.

An extensive educational effort was undertaken prior to start-up to inform all disciplines about the case management program for this population. The case managers administered many educational presentations or communicated informally with appropriate health care providers.

Detailed resource utilization information still is under analysis. However, results of the first three months were summarized and shared with the multidisciplinary team. Results included: a savings of \$9,756 in charges per case, better communication among hospital services regarding the need to expedite diagnostic tests, identification of increased need for social work intervention, and identification of peak days of admission for stroke patients.

The pilot program was successful due to administrative support, multidisciplinary collaboration, and key physician leadership. ■

Home Health
Maintain compliance with meds, diet and risk factor reduction Follow-up with Primary MD/Neurology Absence of recurrent symptoms Return to baseline activity level Recognize Signs & Symptoms and when to call Physician Advance diet accordingly
Labs per MD order -PT/INR if on warfarin -CBC q2 weeks x 3 months if on Ticlopidine
Vital Signs Assess for and educate about recurrent signs and symptoms of TIA/Stroke Complete Oasis Tool Assess PT/OT/Speech and swallow needs Assess feeding tube functioning Evaluate support system Bowel/Bladder Training
Review medications Set up med schedule via mediplan or calendar
Home Health Aid as needed Home PT/OT/Speech as needed Social Work/Registered Dietician if needed Case Management telephone follow-up
Encourage increase in activity as tolerated Exercise/Therapy protocols as per PT/OT
Reinforce prescribed diet. Refer as necessary to Out-Patient Dietitian X5077 Consider Swallow re-eval for removal of feeding tube
Reinforce signs/symptoms of stroke and need for urgent intervention Reinforce importance of risk factor reduction and med compliance Reinforce need to stay on meds Encourage pt/family that rehab process continues long after hospital stay and to continue to work towards improvement Advise on the availability of community/ financial/transportation resources Warfarin teaching as needed

Source: Thomas Jefferson University Hospital, Philadelphia.

### Variance Collection

Please document the reason for the variance by placing on the line the corresponding letter/number from the Key.

Day	Variance	Reason	Key
Admission	<b>A. Diagnostic Tests</b> 1. CT Scan 2. Carotid Doppler 3. Echocardiogram	_____	a. Test not ordered b. Pt. unstable c. Transport delay d. Radiology Issues d1. Machine in use d2. Machine malfunction d3. Tech unavailable e. Other: Specify f. Test completed elsewhere
2	<b>B. MRI/MRA</b>	_____	a. Not ordered b. Consult not called c. Notified, but unavailable e. Other: Specify
2	<b>C. Consults Completed</b> 1. Case Manager 2. Social Worker 3. PM&R 4. Speech/Swallow Evaluation 5. Cardiology	_____ _____ _____ _____ _____	a. Not ordered b. Consult not called c. Notified, but unavailable e. Other: Specify
2	<b>D. Transfer from NICU → ASU</b>	_____	1. Bed not available 2. Prolonged monitoring a. Cardiac a1. Pt. condition a2. No identified reason b. Continuous Pulse Ox b1. Pt. condition b2. No identified reason 3. Deterioration in Status
3	<b>E. Transfer from ASU → floor</b>	_____	a. Cardiac a1. Pt. condition a2. No identified reason b. Continuous Pulse Ox b1. Pt. condition b2. No identified reason 3. Deterioration in Status
3	<b>F. Pt. seen by PT/OT</b>	_____	a. Not necessary per PM&R b. Therapist not available c. Pt. unavailable d. Pt. condition e. Other: Specify
3	<b>G. Consults Completed</b> 1. Rehab Coordinator 2. Home Health 3. Neurosurgery 4. Vascular Surgery	_____ _____ _____ _____	a. Not ordered b. Consult not called c. Notified, but unavailable e. Other: Specify
3	<b>Delay in Disposition/Placement/D'C</b>	_____	1. Insurance 1a. Awaiting approved bed 1b. Equipment coverage 1c. No insurance 2. Anticoagulation Issues 3. Placement Issues 3a. Family Issues 3b. No bed available 4. Deterioration in Status
4	<b>Delay in Disposition/Placement/D'C</b>	_____	
5	<b>Delay in Disposition/Placement/D'C</b>	_____	
6	<b>Delay in Disposition/Placement/D'C</b>	_____	
7	<b>Delay in Disposition/Placement/D'C</b>	_____	
Discharge	<b>Pt./Family Education Documented</b> 1. Anticoagulation Therapy 2. Signs & Symptoms of Stroke/TIA	<input type="checkbox"/> N <input type="checkbox"/> N	

Source: Thomas Jefferson University Hospital, Philadelphia.

## Total Joint Perioperative Pathway

Medical Center East, Birmingham, AL

	Preop Holding Area/Setup Time = 15 min.	Intraop Preinduction Time = 5 min.	Intraop Postinduction Time = 15 min.		Cut to Close	Close to Out Time = 7 min.	Room Cleaned Time = 5 min.
<b>ANESTHESIA ACTIVITIES</b>	CRNA reviews chart, assesses patient, starts IV and sedates prn, hangs antibiotic. If A-line needed, send 15" early.	CRNA applies monitoring devices. Intubation/ induction. MDA to room with patient.	CRNA assists in positioning patient.			Warm, turn patient. Reverse (if late dose of relaxant, move to PACU with ETT and vent). Extubate.	Anesthesia Tech replaces used supplies, removes dirty items, cleans prn. CRNA transports patient to PACU and gives report.
<b>NURSING ACTIVITIES</b>	Circulator checks room for readiness and proceeds to preop assessment of patient. Verifies x-rays available. Scrub checks case cart for completeness and adds supplies prn; scrubs. Float creates sterile field and assists scrub as needed.	Circulator assists anesthesia (5"). Scrub sets up case. Float assists scrub. PCA assists other team members prn.	<b>HIP</b> Circulator inserts foley, assists MD to position/pad patient, apply grounding pad. Preps (5"). Float assists team members. PCA assists with positioning, holds extremity for prep.	<b>KNEE</b> Circulator inserts foley, assists MD to position/pad patient, apply grounding pad. Assist MD in placement of tourniquet. Preps (5"). Float assists team members. PCA assists with positioning, holds extremity for prep.	Circulator supports op team, completes documentation and counting. Float gets next case cart, and at end of case, disassembles back tables. PCA makes bed and assists circulator, and at closure, gets next patient.	Circulator assists with undraping and application of dressing, checks bovie pad and turns patient. PCA assists circulator. Float assists scrub and carries case cart to dirty room, brings case cart for next case to room.	Circulator assists in transport of patient to PACU. PCA wipes off used equipment and returns to proper place, reassembles equipment for next case. Scrub (previous float) assembles case cart supplies and proceeds to scrub. Float (previous scrub) creates sterile field and assists scrub prn.
<b>SURGEON ACTIVITIES</b>	Checks in with front desk. Greets patient. Dress out.		Position patient.		Completes closure.	Speak with patient's family (5-10").	
<b>SUPPLIES/ EQUIPMENT PCA</b>	<b>HIP</b> PCA sets up positioning devices and equipment: beanbag, 2-5lb sandbags, 2 kidney rest pillows, bovie, pulsavac.	<b>KNEE</b> PCA sets up positioning devices and equipment: tourniquet, pulsavac, bovie, tourniquet cuffs 24", 34", knee boot plate.	Helps position patient.		Gets patient bed. Picks up next patient when wound closure begins.	Brings patient bed into room. Helps turn and transfer patient to bed. Begins cleaning room.	Removes trash from room and wipes down equipment not needed for following case. Mops floor. Makes bed.

Source: Spath P. *Clinical Pathways for Perioperative Practice*. Santa Fe, NM: OR Manager; 1998.

(Continued from page 85)

- Suggest/require use of lower-cost pharmaceutical alternatives.
- Restrict albumin use.
- Reduce waste (e.g., medications, supplies, etc.).
- Increase use of low-flow anesthesia.
- Improve control of accessibility to expensive pharmaceuticals.
- Reduce inventory.

For more information, contact Patrice Spath, ART, health care quality and resource management specialist, Brown-Spath and Associates, P.O. Box 721, Forest Grove, OR 97116. Telephone: (503) 357-9185.

### Reference

1. Macario A, Horne M, Goodman S, et al. The effects of a perioperative clinical pathway for knee replacement surgery on hospital costs. *Anesth Analg* 1998; 86:978-984. ■

## Clinical Pathway Development Time Line

**1969:** Buchan and Luttrell describe clinical pathways in their article about open-heart surgery and emergency tracheostomy procedures.<sup>1</sup>

**1988:** New England Medical Center Hospitals write about their experience in developing comprehensive clinical paths that were used to describe the plan of care for a patient during the entire hospitalization.<sup>2</sup>

**1993:** Survey of 328 hospitals conducted by the American Hospital Association reveals that 42% had implemented clinical paths.<sup>3</sup>

**1995:** Survey of 187 hospitals conducted by Decision Support Systems in Charlotte, NC, reveals that 81% had implemented clinical paths.<sup>4</sup>

### References

1. Buchan JR, Luttrell WB. The critical path method of relocating departments. *Hospitals* 1969; 43:79-82.

2. Zander K. Nursing case management: Strategic management of cost and quality outcomes. *J Nurs Adm* 1988; 18:23-30.

3. Lumsdon K, Haglund M. Mapping care. *Hosp Health Netw* 1993; 67:34-40.

4. Anderson Consulting. *Clinical Path Survey: A Study of Clinical Path Trends in Healthcare*. Charlotte, NC: Decision Support Systems; 1995.

## How can you show your CM efforts' effectiveness?

*Use statistics for administrators, visuals for docs*

Your case management department has worked hard to improve the quality of patient care at your hospital while at the same time reducing unnecessary costs and boosting patient satisfaction. You've faced numerous obstacles and overcome them, but you and your colleagues never seem to get the credit — or the resources — you deserve. How can you demonstrate your effectiveness to the stakeholders at your facility in a way that will get results?

First, before anyone else can fully appreciate the contributions of your department, you must fully understand the extent of your own strengths and capabilities, says Larry Strassner, a health care consultant with Ernst and Young LLP in Washington, DC.

Strassner says case managers are particularly effective in three areas: financial outcomes, functional outcomes, and provider, patient, and family satisfaction. "Those are the three areas in which case managers either influence or have a direct correlation to improving outcomes," Strassner says. (See chart for a list of ways case managers can influence outcomes, p. 93.)

### KEY POINTS

- All your efforts to improve clinical and financial outcomes at your facility could go underappreciated — and underfunded — unless you can forcefully demonstrate the effectiveness of your program to the important stakeholders at your hospital.
- The first step is to fully understand the extent of your own strengths and capabilities, particularly in the areas of financial outcomes, functional outcomes, and provider, patient, and family satisfaction.
- In demonstrating effectiveness to administrators, experts recommend presenting a high-level picture of cost-containment efforts and achievements followed by a brief discussion of areas for potential improvement. For physicians, use visual displays of data that demonstrate effectiveness at the level of clinical practice.

Once you've taken stock of everything you and your colleagues bring to the table, you must identify the stakeholders to whom you must demonstrate your value. "Is it the nurses on the unit, the physicians, or is it the administrator who keeps saying that you need to demonstrate why you need to have a case manager for every 20 patients in the organization?" Strassner says.

Although stakeholders differ at various institutions, most case managers will be forced to demonstrate their value to administrators — both in terms of improving or maintaining the quality of care and being able to reduce the cost of care, Strassner says.

"When you're working with administration, you've got to be able to show them where the savings are," he notes. Strassner recommends starting by presenting a high-level picture of what's going on in terms of cost containment, and following up by identifying areas of potential improvement. Keep the presentation brief, explaining bottom-line statistics with a minimum of jargon.

In contrast, when you present to physicians, it's important to demonstrate not just where the savings are but how physicians can assist in the process. "For example, when you begin to benchmark yourself and you look at practice profiles, you might notice that there seems to be a lot of variation around a particular diagnosis, like CHF, in the areas of lab and radiology," Strassner says. While physicians will be interested in dollar figures, they'll also want to know what they can do differently in those areas. "So physicians are down to the test level," Strassner says. "They ask, 'What am I doing that's different from one of my colleagues, who seems to have the lowest cost per case?'"

Strassner says while hard data is important to physicians, it's just as important to engage physicians in understanding the data by bringing it down to the level of actual practice. "After all, they're the individuals who have to make the change," he says.

As with administrators, it's best to start with a presentation of the big picture, using a one- or two-page document. "Physicians tend to prefer a visual display of the data," Strassner says, "so they can quickly look at it and come up with an understanding about what the data are telling them rather than deal with a lot of narrative or a lot of numbers that they have to scroll through. When you're presenting data to physicians, you need to be right to the point, highlight areas that you want to focus your attention on, and use as many graphics and visual displays as possible."

## Areas of Optimal Case Manager Effectiveness

### Reducing costs

- Avoiding test/consult delays
- Avoiding prolonged use of IV antibiotics
- Decreasing inappropriate high-cost lab, radiology, pharmacy, and other medical orders
- Avoiding unauthorized treatments
- Expediting discharge process on admission to prevent increased LOS
- Negotiation with payers to maximize patient funds
- Suggesting alternative treatment plans/appropriate level of care
- Monitoring costs

### Enhancing quality clinical outcomes

- Synthesizing other disciplines' assessment findings and completing an expanded assessment of the patient's and family's needs on admission
- Teaching patients and families prior to, during, and post-discharge
- Coordinating the multidisciplinary team under the direction of the MD to promote achievement of desired patient outcomes
- Monitoring patients' progress toward expected outcomes
- Anticipating an emerging problem and acting quickly to manage an evolving clinical picture
- Preventing patient, practitioner, and system variances when possible
- Monitoring, tracking, and analyzing aggregate complex patient population quality data to improve process/outcomes of care

### Enhancing patient, family, and provider satisfaction

- Assist patient in understanding treatment choices, alternatives, benefits, and risks
- Orchestrate the "system" for the patient
- Work with health care team to ensure that patient and family are fully informed and in agreement with the plan of care
- Provide 24-hour on-call availability to MD, patient, and health care team
- Establish working relationships with referral sources
- Communicate to other health care providers as appropriate to coordinate patient care
- Discuss patient's and family's satisfaction with them, and respond to complaints appropriately
- Monitor, track, and analyze satisfaction data

*For more information, contact Larry Strassner, Ernst and Young LLP, 1225 Connecticut Ave. NW, Washington, DC 20036. Telephone: (202) 327-6000. ■*

# How to document patient education effectively

*Records prove teaching and communication*

Surveyors for the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations are looking for proof of patient education. While policies, procedures, teaching sheets, and programs all point to a patient education program, they don't provide enough evidence by themselves. To prove interdisciplinary teaching takes place, it must be documented.

"The No. 1 way the Joint Commission determines if you met the standards is to look at documentation in the patient record. The main evidence of patient teaching and assessment is in the patient record," says **Louise Villejo**, MPH, CHES, director of patient education at the University of Texas MD Anderson Cancer Center in Houston.

When preparing for an accreditation visit from the Joint Commission, MD Anderson Cancer Center hired a company to conduct a mock survey to see if the health care facility was meeting Joint Commission standards. The consulting firm noted that although teaching programs and process were in place, documentation of many components of education was inconsistent and there was no continuity among disciplines.

To remedy the problem, the patient education committee decided to revamp the documentation form and examine the barriers to documentation.

Documentation on an interdisciplinary patient/family education record at Shands Hospital at the University of Florida in Gainesville helped show a Joint Commission surveyor there was a collaborative effort toward patient/family education. The form was developed by an interdisciplinary team according to Joint Commission standards.

"Development and implementation of the form helped to demonstrate compliance," says

**Kathy Conner**, ARNP, MN, CPON, coordinated care manager of nursing and patient services at Shands.

While a good interdisciplinary documentation form is definitely a piece of the puzzle, the form in and of itself will not prompt disciplines to document, says **Sandra Cornett**, RN, PhD, program manager of consumer health education at The Ohio State University Medical Center in Columbus. There is no proof of interdisciplinary teaching and communication if the form is not used.

Therefore, Cornett recommends you make sure you have a form that streamlines and facilitates patient education. However, once the form is in place, there are other steps that must be taken to make sure the form is used. They include:

- **Provide adequate training.**

To implement the new form created at MD Anderson, all disciplines had to participate in a mandatory inservice. A poster session that showed the use of the form and required a self-test at the end was used to provide flexibility and accommodate the varied schedules of busy staff.

## KEY POINTS

- While policies, procedures, and teaching sheets help establish the credibility of your patient education program to the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations, they don't go far enough. To prove you really do provide effective patient education, you must document your efforts.
- The first step is to formulate an interdisciplinary documentation form according to Joint Commission standards.
- To make sure the form is used, provide adequate training for staff in all disciplines, and include documentation of patient education as part of each employee's performance appraisal.

## COMING IN FUTURE MONTHS

■ Special report: The ethics of hospital-based case management

■ What case managers can do to optimize hospital reimbursement

■ Information technology supports case management efforts at Staten Island, NY, health system

■ Building an infrastructure for a successful case management program

■ What case managers must know about their facility's corporate compliance plan

Inservices on units targeting various disciplines also were conducted. Chart audits coincided with staff education to determine which areas were not documenting patient education effectively.

"It is a continuous education process. We can't expect staff to go through one inservice and document on the form 100% of the time," says Villejo.

To educate staff about the patient teaching process, the patient education committee at York (PA) Health System created a self-learning packet, says **Donette Lasher, MAT**, patient education coordinator for the system. The packet included information on assessing the patient for readiness to learn, creating a plan for education, implementing the plan, evaluating the teaching, and documenting it. The form also was covered in the packet.

In addition to completing the self-learning packet, all nurses had to attend an inservice that included an explanation of why the form is important, how it is used, and a case study. "We taped the program to make sure that everyone could attend an inservice," says Lasher. Following the teaching, nurses were required to take a test.

- **Create a mindset for documentation.**

If you want staff to document patient education, managers must place a value on it, says Cornett. Teaching — and documentation of that teaching — should be part of a staff member's job description. Also, documentation of patient education must be part of an employee's performance appraisal.

While there should be consequences for poor documentation, staff should be rewarded if they do a good job, according to Cornett. She recently implemented an incentive program in which staff receive a button that reads, "I educated the write way," for documenting patient teaching. The rewards are distributed following chart audits that are conducted every three months.

- **Discover barriers to documentation.**

Interview staff to determine what barriers there are to documentation of patient education, advises Villejo. For example, one problem at MD Anderson was the form's location. The nursing staff wanted it at the patient's bedside for convenience, yet when the patient went to another area, those disciplines couldn't document because they didn't have the teaching record. "We made it a rule that it had to stay in the chart," says Villejo.

*For more information on documentation of patient education, contact:*

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**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. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Case Management™**, P.O. Box 740059, Atlanta, GA 30374.

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**Subscription rates:** U.S.A., one year (12 issues), \$369; approximately 18 nursing contact hours, \$419; Outside U.S., add \$30 per year, total prepaid in U.S. funds. One to nine additional copies, \$295 per year; 10-20 additional copies, \$221 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 1 month of the missing issue date. **Back issues**, when available, are \$62 each. (GST registration number R128870672.)

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This continuing education offering is sponsored by American Health Consultants®, which 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.

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#### Editorial Questions

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# NEWS BRIEFS

## More elderly die in the hospital than in the home

Half of elderly patients receiving long-term home care die in the hospital, according to a report in the January issue of the *Journal of the American Geriatrics Society*.

In fact, only one out of five elderly patients die at home, according to researchers. Researchers point out that they were “unable to obtain the patient and family preferences for site of death” in order to determine if dying at home was a planned event for the study participants.

Characteristics of those more likely to die at home included:

- being female;
- being severely dependent functionally;
- experiencing mental deterioration;
- having illnesses, such as cancer, chronic lung disease, or coronary artery disease.

Researchers studied 620 patients over age 65 who died within a year of being admitted to a community long-term care program during 1989 and 1990. Overall, 49% died in the hospital, 21% at home, 20% in a nursing home, and 7% in an inpatient hospice. ▼

## Medical errors likely to go unreported

Hospital-based registered nurses responding to a survey by *RN Magazine* said fewer patients are harmed by medical errors today than were harmed 10 years ago. Two of three respondents said they were unaware of patients harmed because of incompetence or errors by physicians or nurses in the month before the survey. Only 59% could say the same in 1988.

The survey also shows fewer nurses are reporting errors. In fact, 26% of respondents said they knew of at least one instance in which a patient was harmed because of physician incompetence

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or error and did not report the incident to their supervisor, up from 22% in 1988.

“There are many possible explanations for why more nurses today are not reporting medical errors,” says **Marianne D. Mattera**, editor of *RN*. “Fear of being disciplined or fired and lack of institutional support are just two of the reasons why nurses keep quiet.”

Also, existing laws provide relatively little protection for nurses who fear reprisal. Only Kentucky, Minnesota, and New Jersey have laws protecting nurses from retaliation by employers for reporting care that endangers patients. ■

## 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. ■