HOSPITAL CASE MANAGEMENT™

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

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Program coordinates care, resources for medically complex children

Special needs case managers are liaison between providers

A typical day for **Deb Jablonski,** RN, CCM, may include going to visit a specialist with the family of a medically complex child; working with the inpatient case managers and treatment team at the hospital to coordinate the care of a hospitalized child; talking with a school therapist about the care a child needs; or communicating with the child's pediatrician.

Jablonski is a special needs case manager at Children's Hospital of Wisconsin (CHW), a 222-bed tertiary care facility with multiple specialty clinics. The hospital is a teaching hospital affiliated with Medical College of Wisconsin in Milwaukee.

The hospital began a case management program several years ago to help families coordinate the care of medically complex, chronically ill children and act as a liaison between the multiple specialists who treat the children, the school, the child's pediatrician, the hospital treatment team, and any community agencies that serve the family.

Dealing with lifelong problems

"We feel this program is really important because this is a population of children with potential lifelong problems. Historically, there haven't been a lot of resources to help parents, and this is not a population that's going to go away. We try to help them through the first years," she says.

The special needs patients range in age from 0 to 21 years and may have genetic conditions or acquired birth injuries. Many have neurodegenerative disorders that have left them with multiple disabilities.

They typically have feeding and nutritional issues, as well as neurology and pulmonary issues. Often, they see rehabilitation and orthopedic specialists.

"We don't manage a lot of kids with specific diseases. For instance,

children with cystic fibrosis are medically complex and have multiple problems, but the pulmonary clinic can adequately address all their needs," she says.

The case management program began in 1998 when the hospital hired a case manager to handle a small population of special needs patients covered by a contract, says **Jeanne Musolf**, MS, RN, CCM, manager of case management for CHW.

When the program began, the children were managed by many different people with expertise in their areas. For instance, the rheumatology patients were handled by a rheumatology advance practice nurse.

"We had 17 staff members providing case management services, each handling a few cases. In 2001, we hired Deb Jablonski as the first dedicated case manager for this population," Musolf says.

"The program has evolved to include three full-time special needs case managers, an advance practice nurse, and a special needs program medical director — John Gordon, [MD, FAAP]," she explains. "We are becoming the experts on kids who cross multiple disciplines."

The case managers have an average caseload of between 25 and 30 patients. **(For details on how the hospital keeps its special needs caseloads manageable, see related article, p. 147.)**

Coordination of care

The special needs case managers coordinate care among providers, help the family get the services they need, and provide the communications link between the pediatricians, the hospital, and the schools, so everybody is aware of what is going on with the child.

"More than anything, we provide a single point of contact at the hospital for families and doctors, so they have to call only one person to get an answer," Jablonski says.

Many of the families who come into the program have been struggling on their own for some time, trying to negotiate the health care maze.

"The issue for our families is that they have very clinically ill children; and they're not only trying to be the parent, they need to be to be the caregiver, financial person, home health nurse — all those roles. It can be incredibly overwhelming," Jablonski says.

When a special needs patient is admitted to the hospital, his or her special needs case manager acts as a liaison between community providers and inpatient care.

Special needs case managers make sure the health care team has information about issues at home, challenges with transportation, psychosocial issues, as well as medical concerns.

The information is helpful to the inpatient case managers who are handling discharge planning and arranging for home care for the young patients.

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Editorial Questions

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"These children have multiple medications, health care providers, and ongoing issues. The special needs case managers make sure the inpatient staff and physician have that information," she says. The case managers write a clinical summary, updating it periodically for the family, hospital staff, and community providers.

"The summary is really helpful for the doctors and other health care providers because the children have complex medical histories and frequent hospitalization. It keeps the parents from having to repeat the child's information over and over," Musolf says.

In the past year, the special needs case managers have partnered with Gordon, the medical director, to coordinate care for the extremely medically complex children.

"Dr. Gordon also provides clinical summaries for the children and families he works with and is integral to bringing the health care team together to formulate medical plans of care," Musolf says.

One of the goals of the special needs program is to partner with community pediatricians in the care of their medically complex patients. They

Team assists families in getting help they need

Goal is to find care coordination for every child

When a child is referred to the special needs program at the Children's Hospital of Wisconsin, a multidisciplinary team assesses the case and decides where the family can get the help it needs. Children's Hospital is a 222-bed tertiary care facility with multiple specialty clinics — and a teaching hospital affiliated with Medical College of Wisconsin in Milwaukee.

"One of our goals is to find appropriate care coordination experts for every child who is referred to the program, but we do look carefully at which children we can manage with our current resources," says **Jeanne Musolf**, MS, RN, CCM, manager of case management at the hospital.

Formalized referral system

The hospital has set up a formalized referral system and a dedicated telephone line for call-in referrals for the special needs patients. Referrals come from physicians in the hospital's specialty clinics, pediatricians, inpatient case managers, parents, and community agencies.

"When we get a referral, we gather as much information as we can about the child, his or her diagnoses, how many and what physicians he or she sees, and what the issues are for the family, whether it's coordination of care, financial issues, problems helping the school understand the needs of the child, or community resource needs," says **Deb Jablonski,** RN, CCM, special needs case manager.

The multidisciplinary team for special needs children includes the nurse-case managers, an advanced practice nurse, a representative from the hospital's Special Needs Family Center, a social worker, a rehabilitation physician, and the hospital's special needs physician, who is a pediatric specialist and the medical director for the program.

The team meets weekly, discusses the referred cases, and decides who in the community can best serve the family.

"Sometimes, they don't need a lot. They may just need to be connected to a community agency that can help with their concerns," Jablonski says.

Because of the program's limited resources, the team determines when it is appropriate to refer families to other organizations that can help coordinate their child's care.

For instance, if a child lives in a county with a public health nurse who has expertise in managing medically complex children, the team may refer the family to him or her.

Families may be referred to agencies such as United Cerebral Palsy, which provide care coordination in the community.

If a family is referred because most of the problems are psychosocial**,** the team refers them to a hospital social worker who is most appropriate to assist the family in their child's care.

Those who are medically complex with multiple physicians and health care coordination issues are assigned to a case manager.

"First and foremost, we want to be sure that each family referred has a contact for care coordination. Additionally, maintaining reasonable caseloads for each case manager assures that they will be able to fully assist the families with their multiple needs," Musolf says.

Some children and families only need short-term help, such as helping the child through a chronic illness or surgery.

"Children with complex, chronic illnesses often have periods of relative stability which may be interrupted by an acute illness or transition issues. The case manager's involvement varies according to the needs of the child and family. Ultimately, case managers work to empower parents to navigate the health care system and advocate for their child," Jablonski says. ■

provide the pediatricians with clinical summaries and information on treatment decisions following a child's visit to a specialist. Depending on the situation, they communicate with the pediatricians by telephone or e-mail.

The case managers often go with the family to CHW specialists or the pediatrician, or will accompany the family if the child is referred to a health care provider outside the hospital system.

"The families find it very helpful to have a communications link and a facilitator to assist them with assuring coordination between multiple specialists," Jablonski says.

Case managers work with the schools to make sure the children are getting what they need and to keep the school therapists apprised of what is going on with the child.

"Once a child enters the school system, outside therapy may stop and the issue becomes determining what is an educational need and what is a medical need. By attending the educational planning meeting, we are able to advocate for needed services," Jablonski says. ■

Follow-up system aims to improve patient safety

80% called unclear about follow-up appointment

A study by Irvine, CA-based Cogent Healthcare Inc. has confirmed what many case managers know instinctively: Following discharge from the hospital, many patients are confused about their medication, their discharge instructions, and when to follow up with their primary care physicians.

Among the patients who were contacted by the company's "homecoming callers," 80% were unclear about their follow-up appointment, and 20% had issues such as questions about their medication or durable medical equipment that had not been delivered, according to **Navneet Kathuria**, MD, MPH, national medical director for Cogent, an inpatient care management company.

About 7% reported having symptoms that staff at Cogent's call center determined should be discussed with a physician or nurse.

"The continuum of care doesn't end when a patient walks out of the hospital. Patients are often still sick when they leave the hospital. They are confused and need to talk to someone but are reluctant to call their physician," Kathuria says.

The patient discharge follow-up program is part of Cogent's program to provide a comprehensive hospitalist program on a contract basis to hospitals.

"We needed a program to make sure patients upon discharge from the hospital were getting appropriate follow-up," he says.

Just faxing information to the patient's primary care physician was not enough, he adds.

"We felt that we needed to follow up with the patients to make sure that once they got home, they had what they needed so they didn't end up back in the emergency room or visiting their primary care physician within a few days after discharge," he says.

Their solution was to set up a homecoming calling system that would follow patients after discharge.

The discharging physician dictates patient information, which is transcribed into a database. The information includes the admissions diagnosis, the discharge diagnosis, discharge instructions, medication and dosage, any critical labs, recommended follow-up visits, and any kind of home care ordered for the patient.

At Cogent's call center, trained callers, supervised by registered nurses, call patients within 48 hours of discharge. Only patients discharged to independent living situations receive phone calls.

The "homecoming callers," as Cogent calls them, have a set of questions to ask the patients. Among them: How are your feeling? Do you have any symptoms? Do you have medication? Do you know when your next appointment is with your primary care physicians?

Preventing returns to the hospital

In some instances, durable medical equipment or home oxygen was ordered for the patient but the company didn't deliver it.

"We can follow up and make sure it's delivered, as opposed to having the patient end up in the emergency room," he says.

Every patient who is seen in the hospital by a Cogent hospitalist is put into the system to receive the follow-up telephone calls. The callers are able to connect with about 65% of them after two attempts.

"We believe that the follow-up calls prevent unnecessary visits to the emergency room, readmissions to the hospital, and have an impact on the overall health of the patient," Kathuria says.

Often, the patients have information about how often to take their medicine or what time of day they should take it.

If there are issues such as not getting a prescription, side effects from the medicine, or symptoms that could signify a problem, the homecoming callers get in touch with the hospitalist or the clinical care coordinator and ask them to make sure the problem is addressed.

Cogent's hospitalist program is staffed by physicians specializing in hospital care and clinical care coordinators who are registered nurses or nurse practitioners to work with the physicians.

The clinical care coordinators work with the physicians in the hospital, handling paperwork and making sure patients gets what they need and that tests and treatments are done in a timely manner. "They work with the staff in the hospital. They don't take on the task of the hospital case managers, and they make sure they don't step on the hospital staff's toes," he says.

When Cogent established its hospitalist program, it did a time analysis of the physician's day.

"They were doing a lot of paperwork, including filling out forms and getting information from the specialists or primary care physician. We hired the clinical care coordinators to assist in the process," he says.

The program will help the company determine what actually goes on with patients after discharge.

"Until they visit their primary care physician, no one actually knows what is going on. We now have a process in place to track this information and address any concerns the patient may have," he says. ■

Make sure that you are culturally competent

CMs should prepare to treat a diverse population

Case managers shouldn't wait for their hospitals to institute cultural competency initiatives. They should try to become more aware of their patients' culture and beliefs on their own and make it a continuing process, asserts **Joyce E. Vaughn**, RN, CCM, a Louisville, KY-based case management consultant and former hospital case manager.

"A lot of people's beliefs have a big effect on how they perceive their illness and how compliant they will be. It affects what treatments they will undergo and what they won't undergo. Case managers should understand their patients' values and difference and incorporate them into the diagnostic and treatment process," Vaughn says.

By 2010, the U.S. Census Bureau predicts that 45% of the population in the United States will be minorities, Vaughn points out.

"There are going to be a lot of people who will require quality health care, and we have to prepare for it," she says.

Don't think that immigrants are going to adjust quickly to American culture and Western medicine. History says otherwise, she says.

"When our ancestors were coming into this country through Ellis Island, social workers and doctors theorized that they would assimilate into the American way of life and become just like us. But it didn't happen that way. They brought their own ideas and culture with them. You can see that in big cities with areas like Little Italy or Chinatown. Those of ethnicity or culture often stay within their dominant culture demographics," Vaughn says.

Any facility receiving any kind of federal funds is mandated by law to become culturally competent.

The U.S. Department of Health and Human Services, the Health Resources Services Administration, and the Centers for Medicare & Medicaid Services advocate that people who deliver services to the culturally diverse be culturally competent, Vaughn says.

The Case Management Society of America, the Joint Commission on Accreditation of Healthcare Organization (JCAHO), the National Committee for Quality Assurance, and many other health care organizations also promote standards that require cultural and linguistical competency among the health care team, she adds.

"It's not just one of those trendy things, and it's not just something else for case managers to do. It's here to stay, and it's one of those things that everyone in health care should be involved in," she adds.

Cultural competency isn't something that can be covered only in a one-day seminar. It's an evolving process, sort of a continuing quality improvement initiative, and one case managers should focus on, Vaughn says.

"Cultural competency is not just knowing that Jehovah's Witnesses will refuse blood transfusions

or having someone on your staff who speaks a little Spanish. It's more in-depth than that. Cultural competency is a skill that requires that a person be educated to deliver services to all segments of the population," Vaughn says.

Not understanding a patient's cultural practices and values can make it much more difficult for a case manager to establish rapport, she says.

"When a patient meets a case manager for the first time, this sets up how the relationship is likely to go. If the patient doesn't feel comfortable with the case manager, he or she may feel like the case manager won't help them and may not trust them. To be effective, case managers have to get off to the right start, and that means understanding the culture of the person you are treating," she says.

Understanding cultural differences

Understanding how various cultures approach human relationships can be useful, she adds. For instance, many people in health care call patients by their first name in an effort to be friendly, but in some cultures, this is a sign of disrespect.

Americans often feel that someone who avoids eye contact is trying to hide something or doesn't like them; but in some cultures, people are taught that looking people in the eye is disrespectful, she adds.

In a number of cultures, chubby babies are looked at as healthy babies. The case manager needs to understand this in order to convince the parents of the future health problems the child could face if he or she continues to overeat.

Having interpreters who understand medical terms rather than relying on family members of patients also is important, Vaughn points out.

"While JCAHO doesn't approve or allow children as interpreters, case managers know that it is quite common for people to show up with their children as interpreters," she says. Many times, elderly people who don't speak English may come to the hospital with a grandchild to use as an interpreter. "The problems arise when an older person is embarrassed to tell a child about their complaint or it's something the child doesn't understand and may not be able to translate," Vaughn adds.

The staff at the hospital where she previously worked developed signs in between eight and 12 of the most commonly spoken languages in the United States and posted them throughout the hospital.

When someone who did not speak English came in, the staff got him or her to point to the language on the sign. If there was not a staff member who spoke the language, the hospital knew which interpreter to call.

She suggests that hospitals develop posters showing a variety of nationalities and booklets in other languages for their waiting room.

"Not every patient is a blonde, blue-eyed person. Hospitals should put up pictures that represent the people they serve," she says.

Here are some other suggestions from Vaughn on how hospital care managers can better serve people from different cultures:

- Encourage your hospital's medical library to get videos in the languages your patients speak. For instance, pre-surgical videos or those explaining tests and procedures don't have much meaning if they're in English and the patient doesn't understand.
- Develop materials that your patients can read to let them know what is going on while you are waiting for the interpreter. For instance, print an explanation of common procedures written in the languages of your biggest populations.
- Develop a checkoff list in the language your patients can understand and use it to gather patient information.
- If you belong to a nursing organization, a church group, or another organization, invite a person who belongs to a different ethnic or cultural population to speak to your organization about his or her views on health and wellness.
- Volunteer at local community centers that serve a diverse population. It's a great way to learn firsthand about different cultures and races.
- Learn another language, one that you might use with the patients you manage.
- Hire more culturally diverse case managers.

"The more culturally diverse your staff are, the better you're going to do when you get a patient from another culture," she says.

[Editor's note: The Transcultural Nursing Society, with headquarters in Livonia, MI, offers information to nurses on caring for patients of different cultures, values, and beliefs as well as a transcultural nursing certification. For more information, visit their web site at www.tcns.org. Telephone: (888) 432-5470.

The U.S. Department of Health and Human Services Office of Minority Health has published a guide on 14 culturally and linguistically appropriate services. For more information, go to: www.OMHRC.gov/CLAS.] ■

CRITICAL PATH NETWORK™

Cancer rehab improves function, quality of life

Programs help patients cope with side effects

The National Cancer Act of 1971 set cancer rehabilitation as a goal and provided money to develop training programs and research projects. Soon after, the Bethesda, MD-based National Cancer Institute identified four objectives for rehabilitation of cancer patients: psychosocial support, optimization of physical functioning, vocational counseling, and optimization of social functioning.

Thirty years later, outpatient cancer rehab is an idea that has yet to take root in the day-to-day management of cancer across the country. Many of the nation's premier cancer centers offer some type of rehab or wellness programs; only a handful of programs exist in other locations. But some providers are beginning to blaze the cancer rehab trail, and their patients are seeing the benefits.

At Saint John's Health System in Anderson, IN, a three-year-old physical and occupational therapy-based program has improved patients' functional performance and satisfaction by an average of 37% in fewer than eight visits. The Saint John's staff used the Canadian Occupational Performance Measure to allow patients to rate their functional performance on a 100-point scale upon entering and completing the program.

"Can you imagine how patients feel if they are themselves rating their function and satisfaction to be that much better in usually only three to four weeks? It has been very rewarding," says **Julie McCormack**, PT, who led the collaborative effort to start the program between the Saint John's outpatient cancer treatment center and the Carl D. Erskine Rehabilitation and Sports Medicine Center.

A core group of two physical therapists, two PT assistants, and an occupational therapist works with patients to decrease fatigue, nausea, and pain as well as to improve strength, endurance, general mobility, and quality of life, McCormack says. In two to three visits per week for three to four weeks, patients work on low-level endurance training, general mobility training, activities of daily living, range-of-motion exercises and strengthening, she adds. The education component includes information on energy conservation, task simplification, relaxation, and stress management.

"We found that there was a great patient need for these types of services," McCormack says. "We work in the same outpatient building as several of the oncology doctors as well as the radiation therapy department and the chemotherapy department. We were able to see the functional limitations of patients coming and going for treatments and easily recognize their need for care."

A rehab staff member regularly visits oncology patients who don't get referrals to rehab to teach them how to help themselves through home exercise. "I can't say enough about the ways we have been able to improve the quality of life of those we have treated," she says.

McCormack set out to benchmark with similar programs when setting up the one at Saint John's.

"We tried for a long time to see if we could figure out what programs are out there, and we just really weren't finding programs like what we wanted to do," she says. "There are a lot of programs that include rehab on an inpatient side right after surgery, but for outpatients including physical and occupational therapy, we just really weren't finding those."

So McCormack attended a continuing education

course on cancer rehab and then jumped in. The program is individualized based on each patient's goals for improvement.

"On the performance measure, we are finding out what types of things the patient is having trouble doing. We gear treatment right toward those top five or so items," she says.

"It's nice to know you're affecting things that are very important to the patient. A lot of other things in physical therapy don't correlate so well straight through to what the patient wants to do," McCormack adds.

It takes an ongoing effort to communicate with the oncology department to encourage referrals and to break through patient resistance, she says.

"Part of it is the cancer diagnosis can be so dreadful. There are a lot of cases that are terminal, but there are a lot that aren't. People don't think of: 'What am I going to do to get better and get back to everyday life?' They're already thinking what's going to happen," McCormack says.

"But there's a lot of time in between. There's a lot of stuff going on for these patients, a lot of bad news. It almost gets to the point where they don't want to hear anything else, that they've had all the information they can take," she points out.

Every patient who has attended the cancer rehab program has said it was well worth the effort, McCormack says.

"It's such a common-sense thing that we need to help these people," she says. "This patient population is not being serviced like it could be."

Stanford University Medical Center in Palo Alto, CA, started a cancer supportive care program in 1999 that has a nice twist: All services are free to patients, even if they are not being treated for their cancer at Stanford.

"Our belief is that adequate support and informed guidance is essential to the success of cancer treatment," says **Holly Gautier**, RN, director of the cancer supportive care program, part of Stanford's Center for Integrative Medicine. "Cancer treatment is so expensive, even with insurance coverage. So many patients are not able to stay employed, and some of our patients wouldn't even be able to afford $10 more a month. I fight very hard for this to be a free program," she adds.

Donations support about half the program's cost; the rest is funded by Stanford. Between 600 and 700 patients per month participate in the menu of classes and workshops offered at the center.

Classes include gentle exercise, restorative yoga, stress management, coping with treatment side effects, healing imagery, nutrition, and medical qigong, which incorporates meditation, breathing, and gentle movements to promote healing. Chair massages are offered in the cancer treatment waiting rooms.

An oncology nurse offers fatigue consultations. "Fatigue is the No. 1 complaint of cancer patients. Cancer-related fatigue is not something that can be corrected by sleep, so it's somewhat of a Catch-22," Gautier says.

"We really encourage them to exercise, even if it's starting by walking to their mailbox. Many of these patients are too fatigued to take a shower, but they really need to move," she adds.

A patient evaluation found that 75% of those attending the yoga class had an increase in energy. Ninety-six percent saw some reduction in stress; 65% reported more restful sleep, and 59% had less pain.

"All of these classes are looking at improving the quality of life for individuals. Once they receive a cancer diagnosis, their lives are never the same," Gautier explains.

"Hopefully, we are exposing patients to new ways of coping with stress and anxiety and side effects and getting a great foundation to improve their quality of life," she says.

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Patient satisfaction depends on staff morale

ED manager who scores high shares tips

If you want to improve your patient satisfaction ratings, don't start by looking at how happy your patients are. Start by looking at satisfaction levels among your staff.

That's some advice from an emergency

department (ED) manager who can boast of patient satisfaction scores in the 99th percentile nationwide.

The ED at Hackettstown (NJ) Community Hospital has earned high patient satisfaction levels in recent years, which can be directly tied to improvements resulting in better employee morale and customer service, says **Loraine Skeahan**, RN, manager of the ED.

"The lesson may be that if you want to improve patient satisfaction, go deeper than that and address the fundamentals in the emergency department like how well you're staffed and how happy your staff are," she says. If you start off by going to patients and asking how to make them happy, you might be wasting your time.

"Chances are, they don't really know what could be improved in your department to make their visit better," Skeahan says.

In a recent patient satisfaction survey conducted by The Jackson Organization, a health care research organization based in Columbia, MD, Hackettstown's ED patients gave the hospital an overall satisfaction grade of 4.27 (on a 5-point scale, where 1 is poor and 5 is excellent). This compared to an overall 3.97 grade for competing hospitals serving the area and gave Hackettstown a 99th percentile ranking among hospital EDs nationwide.

Expanded ED helped patient satisfaction

In its research, The Jackson Organization identified several key predictors of Emergency Patient Satisfaction. Hackettstown's ED scored especially well in three areas:

1. Staff Availability to Provide Assistance at all Times.
2. How Well the Hospital Did at Meeting its Mission.
3. Total Amount of Time Spent in the Facility from Arrival to Discharge or Hospital Admission.

The Hackettstown ED also ranked exceptionally well in four other key areas:

1. How Quickly Nurses Responded to Requests.
2. Kindness Shown by the Nurses.
3. Kindness Shown by the Doctor.
4. How Well the Staff Kept Patient and Family Informed about Patient's Care and Condition.

Part of the high satisfaction ranking can be related to physical improvements in the ED, Skeahan says.

The hospital recently completely rebuilt its emergency area with 13 rooms, more than double the previous six rooms. The number of ED staff were doubled, and the number of secretarial support staff were increased to speed up paperwork and data entry.

"By streamlining waiting times and increasing space and staff, we reduced the average length of stay in the emergency department to less than an hour for those who were treated and released," Skeahan says.

Doubling its size was an absolute need, she says. "The population in Northwest Jersey is growing, and we went from 30 visits a day to 60 or 70 a day."

The ED staff now make a priority of getting the patient triaged, evaluated, and to a physician as quickly as possible. Physicians now provide double coverage on high-volume days.

Peg Carolan, RN, the hospital's director of nursing and its former ED administrator, says she worked hard to create a better working atmosphere for the ED nurses, which in turn helped them provide better care to patients.

Teaching staff about a caregiving spirit

Nearly everyone in the ED, including lab and X-ray technicians, support staff, and nurses, went through a program called Spirit of Caregiving, offered by Lant & Associates in Winter Park, FL, which helped them bond as teammates and learn to work toward a larger goal of improved patient care. That kind of effort paid off over time with better morale, she says.

"Now, when a nurse calls in sick, those who are here either volunteer to take that nurse's place or else find a substitute," she says.

"The keys to our success are the ability of our staff to create a warm and caring environment and patient-focused team, as we strive to achieve our mission of reflecting God's love in healing each patient's body, mind, and spirit," Carolan explains.

Though the effort worked wonders for Hackettstown, bigger EDs with more challenges may have more trouble creating such a family atmosphere for staff.

That doesn't mean you shouldn't try, says **Marilyn Swinford**, director of emergency services at Saint Joseph Hospital, a 446-bed hospital in Lexington, KY.

Her ED recently won the second place award for Overall Emergency Department Satisfaction

for Large Hospitals given by The Jackson Organization.

Swinford says her ED's high patient satisfaction ratings came from some of the same morale-building initiatives used in Hackettstown, such as a new "Star of the Month" program to recognize efforts that improve patient satisfaction. But the Kentucky ED's overcrowding meant it also had to implement some specific strategies aimed at getting patients through the ED faster.

First, Swinford organized a focus group with triage and registration that helped trim registration times to an average of fewer than five minutes. Saint Joseph also put much more effort into keeping patients informed about expected wait times.

While EDs focus so much on reducing wait times, they too often overlook the importance of keeping patients informed, she says.

Patients will be much more willing to wait, and ultimately express satisfaction with their visits, if they know how long they will wait and that there is a good reason for the delay.

"Customers want to know what to expect so proactive communicating is critical," Swinford says. "We are improving in informing patients reasons for wait times, focusing on keeping them informed of the overall expectation of what is happening related to their ED visit, and what to expect."

Point-of-care laboratory testing also has shortened door-to-diagnosis times. Testing processes to provide chemistry and cardiac screening were implemented in January 2003. Swinford says these devices have shortened the average test time from 90 minutes to 20 minutes — a huge change for anxious and impatient patients.

She also credits focused teamwork between the ED and cath lab, along with bedside treatment "AMI boxes" that have critical IV access and medications for cardiac emergencies, for providing smoother patient flow.

Listen to staff and give them what they need

When trying to improve staff morale as a way to improve patient satisfaction, Carolan and Swinford emphasize that you must listen to your frontline employees and remember that improvements don't happen overnight.

"Our success took several years to accomplish," Carolan says.

ED managers should pay particular attention to fully staffing the ED and providing support services to clinicians, Skeahan says.

She offers this advice for improvements that can lead to high patient satisfaction scores:

- **Provide ancillary support staff.**

Nurses and other staff can be frustrated by having to do everything, including tasks that don't require their expertise.

The Hackettstown ED operated for years without any ancillary or secretarial support, but Carolan added an ED tech position a few years ago.

Be prepared to make staffing changes

Now an ED tech works in the ED every night and every other weekend. The tech acts as an extra pair of hands wherever needed to assist with tasks such as performing a phlebotomy, transporting patients, and obtaining vital signs.

"This position works side by side with the nurse, rather than replacing a nurse," Skeahan says. "It's not the same as hiring another nurse, because that nurse would become busy with everything else and couldn't jump in wherever they're needed," she adds.

- **Provide secretarial support.**

Hackettstown now has two secretaries in the ED during the day and one in the evening. This removes a great deal of the paperwork burden from the nursing staff, Skeahan says.

- **Take educational opportunities to the ED.**

Staff usually are interested in learning, but ED staff can find it difficult to get out of the department for inservices. If they don't attend, they feel left out.

If you don't offer any inservices because you think they're too busy, they may miss the opportunity to learn more about the field. The solution is to take the inservices to the ED, Skeahan says.

"When you have some downtime, go to the unit and start a troubleshooting session or discuss the latest topics like pediatrics in the ED," she says.

"They really love it because they want to learn, but you have to be very flexible with inservices in this department," Skeahan adds. ■

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Independent CMs face greater HIPAA challenge

Don't debate; get authorization

Whether as employees of a covered health care entity or independent business associates, case managers must ensure that they are in compliance with the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA).

The burden of compliance may be greater, however, for the independent case manager, notes **Cathy Kauffman-Nearhoof**, RN, BSN, CCM, CMCN, CLNC, owner of Integrist Health Care Consulting, LLC, a Duncansville, PA-based firm that provides case management and legal nurse consulting services.

"[Independent case managers] must assume responsibility not only to comply, but also to conduct their own risk assessments and develop their own policies and documents," she adds.

Despite a provision of HIPAA that includes case management in the list of health care "providers" who do not need a signed authorization to use and disclose the protected health information (PHI) of their clients in the course of coordinating patient care, Kauffman-Nearhoof says, the most sensible course for independent case managers probably is not to fight the battles that claiming that right would entail.

45 CFR 164.502 (a) (1) *"A permitted entity is permitted to use or disclose protected health information as follows: (i) to the individual; (ii) for treatment, payment, or health care operations, as permitted by law and in compliance with 164.506.*

A parenthetical statement in HIPAA "throws case managers in" with the list of health care providers who do not need the authorization, she adds.

CFR45 164.502 (Health Care Operations) permits use and disclosure of PHI for certain activities, including *"population-based activities relating to improving health or reducing health care costs, protocol development, case management, and care coordination . . . and related functions that do not include treatment."*

HIPAA defines a health care provider **(45 CFR 164.501 (5) (1) & (2)** *as one who "delivers health care to the individual based on the orders of another health care provider; [and] typically provides services or products or reports the diagnosis or results associated with the health care directly to another health care provider who provides the services or products or reports to the individual."*

45 CFR 164.506 (c) *"A covered entity may use or disclose protected health information for its own treatment, payment or health care operations (2) for treatment activities of a health care provider; (4) for health care operations activities of the entity that receives the information, if each entity either has or had relationship with the individual who is the subject of the protected health information being requested (5).*

But Kauffman-Nearhoof says, "the health care world simply does not always see independent case managers in that bucket. My recommendation is just to get the authorization, get it signed and move on."

In this situation, it is critical to understand the difference between an independent case manager and one who is working for a covered entity such as a hospital, says **Jackie Birmingham**, RN, MS, CMAC, vice president for professional services for *e*Discharge with Curaspan Inc. in Newton, MA, and a veteran case management consultant.

"An independent case manager may be hired by a family to work with an at-risk patient, and this case manager may be working with hospital-based case managers on the discharge plan," she notes. "Since the independent case manager is not acting on behalf of the hospital, it is wise to have a signed authorization."

In the case of hospital or other facility case managers, Birmingham says, there is no need for this additional authorization before contacting

CM, DP communications covered in HIPAA FAQs

Here are a two frequently asked questions from the Department of Health and Human Services' HIPAA web site that specifically address the types of communication that case managers and discharge planners engage in:

Question: "Are health care providers restricted from consulting with other providers about a patient's condition without the patient's written authorization?"

Answer: "No. Consulting with another health care provider about a patient is within the HIPAA privacy rule's definition of 'treatment' and, therefore, is permissible. In addition, a health care provider (or other covered entity) is expressly permitted to disclose protected health information about an individual to a health care provider for that provider's treatment of the individual."

Question: "May covered entities use information regarding specific clinical conditions of individuals in order to communicate about products or services for such conditions without a prior authorization?"

Answer: "Yes, if the communication is for the individual's treatment or for case management, care coordination, or the recommendation of alternative therapies. The HIPAA privacy rule permits the use of clinical information to the extent it is reasonably necessary for these communications." ■

post-acute providers to determine if they can provide the services needed by a patient. "Case managers who are carrying out the function of discharge planning do not need authorization from the patient before contacting the post-acute provider. However, the discharge planner should always verify that the patient has signed the consent form that the hospital uses to provide care."

In the case of independent case managers, says Kauffman-Nearhoof, "there is a lack of agreement within the HIPAA consultation community. Under treatment, care coordination by providers is determined not to require an authorization. However, the issue is further muddled when we attempt to clarify the role of the case manager."

"Among the attorneys I've worked with," she continues, "there is indecision as to whether a case manager can be called a health care provider. For example, under 'treatment,' which is defined as 'coordination of health care,' the interpretation is left up in the air. [Case managers] are not really hands-on, but they do provide care coordination. It's a gray area but appears to be clarified under the statement from HIPAA in its definition of "health care operations," as noted above.

Rather than argue, she suggests, in the case of case managers not acting on behalf of a hospital or other health care facility, "just proceed with the appropriate authorization. It is the most conservative and safest approach, rather than attempting to garner consensus as to the 'case manager as care coordinator' role."

Further complicating the issue, she notes, there is another exception to the rule. "Workers compensation management and [management] of similar programs do not require an authorization when efforts are focused on coordination of care and payment of services."

Kauffman-Nearhoof adds that although the stipulation that patients sign a consent form before receiving treatment was removed in the final version of HIPAA — at the same time that notice of privacy and authorization regulations were enhanced — there is a strong possibility the consent requirement could be reinstated.

"HIPAA did away with it but left the door open" for its return, she adds. "There are a lot of legislators demanding that it be looked at again."

Another related point of concern, Birmingham says, is that states also have privacy rules that must be followed. "Some states have more restrictions than HIPAA and set out specific guidelines," she notes. "The burden of knowing all the privacy rules related to releasing PHI in the course of planning post-acute care is an important issue. And it is only one of the regulations directing how discharge planning is carried out."

Even among discharge planners working for health care facilities, there has been confusion concerning whether authorization is needed for them to use PHI when seeking appropriate post-acute care for a patient, Birmingham says.

"When I do seminars about HIPAA," she adds, "a question that comes up is, 'Can discharge planners contact a post-acute care provider to determine if a bed or service is available without specific authorization?'"

Her answer to that question is "yes," she says, citing a reference from the Department of Health and Human Services' web site (www.hhs.gov/ocr/privacysummary.pdf). "When you are contacting a post-acute provider for a specific patient who needs a rehabilitation facility that provides 'physical therapy, occupational therapy, and is located within five miles of where the patient lives,' you don't need specific authorization."

"When implementing the *e*Discharge work flow management tool for discharge planning," Birmingham adds, "we spend a lot of time going over the regulations, including HIPAA and the Conditions of Participation for Medicare, regarding patient choice issues that drive discharge planning work."

When that discussion starts, she says, case managers who are doing discharge planning as part of their workday sometimes are shocked at how many rules they must follow. Knowing the rules when doing discharge planning is critical, she emphasizes, since the very nature of the work is to send out patient information to other health care providers.

(Editor's note: Look for a discussion of the marketing issues addressed in HIPAA and how they affect case managers in the next Discharge Planning Advisor *in the January 2003 issue of* Hospital Case Management.) ■

Enhance care by making CM part of Medicare

Value of case managers 'yet to be recognized'

Even with their dependence on health maintenance organizations (HMOs), many of the nation's elderly suffer from a lack of coordinated care, are often confused about their treatment — including proper use of medications — and frequently end up in the hospital for lack of proper preventive measures.

At the same time, notes case management consultant **Cathy Kauffman-Nearhoof**, RN, BSN, CCM, CMCN, CLNC, many seniors don't have extra financial resources to put toward self-pay health initiatives.

With that in mind, Kauffman-Nearhoof, owner of Integrist Health Care Consulting in Duncansville, PA, says she has been focusing her efforts since spring 2003 on getting government programs such as Medicaid and Medicare to cover the cost of case management.

"My proposal is that, if the government would add case management as a component of Medicare and Medicaid — saying that if [recipients] get certain government health care benefits, they agree to case management as a mechanism to manage care and costs — everybody wins," she adds.

Case management, Kauffman-Nearhoof contends, is one answer to managing the skyrocketing costs of health care as baby boomers enter a system with insufficient nurses to care for them. "With a holistic approach to assessment, including team planning, collaboration, intervention, and provider communication, optimal outcomes become the primary focus."

Unlike physicians and dietitians, she notes, case managers cannot bill Medicare and Medicaid for their professional services.

In letters to legislators, Kauffman-Nearhoof argues that case managers should be permitted to practice their profession "proactively rather than reactively.

"We propose and request your support to introduce new legislation that would permit experienced and qualified licensed nurses and certified case managers to provide our professional services, independently if we choose and on the home front, and recognize our value by permitting us to be reimbursed for our professional services by Medicare, Medicaid, and other insurers," she writes. Complicating her efforts, Kauffman-Nearhoof notes wryly, is the fact that "organizing nurses is like herding cats.

"Case managers are mostly nurses, and nurses are impossible to organize," she adds. "They have no idea of the clout they would have politically if they organized and advocated as a professional entity to be reckoned with, and often perceive their work as a job and not a profession."

Adding to the challenge, Kauffman-Nearhoof says, many nurses — most of whom are women — are busy people raising families and taking care of aging parents. "When they go home from work, they don't want to do another [work-related] thing."

"And if they are working for a hospital," she adds, "most of their needs are met. The facility takes care of their benefits and their financial, educational, and social needs. [Lobbying efforts] are generally left to those of us working independently, and we're a small group compared to the entire population of nurses."

[For more information about the lobbying effort, including a template for the letter Kauffman-Nearhoof intends to send to legislators, contact:

- ***Cathy Kauffman-Nearhoof**, Owner, Integrist Health Care Consulting, Duncansville, PA. Telephone: (814) 696-7881. E-mail: cknearhoof@integristhealthcare.com. Web site: www.integristhealthcare.com.]* ■

How to determine 'What's a business associate?'

Case managers sometimes are confused as to what constitutes a "business associate" as referred to in the Health Insurance Portability and Accountability Act (HIPAA), notes **Cathy Kauffman-Nearhoof**, RN, BSN, CCM, *NMCC*, CLNC, owner of Integrist Healthcare Consulting in Duncansville, PA. When case managers are working for health care facilities and insurance companies, she notes, the issue is of lesser concern, since the details typically are managed by corporate attorneys and privacy officers. However, smaller case management entities and independents must identify their business associates and apply appropriate business agreements and policies, Kauffman-Nearhoof says. To determine who is a business associates, consider the following:

Step 1. Check each applicable statement.

☐ Does the outside organization perform services for or on your behalf?

☐ Does your business or organization disclose protected health information (PHI) to the outside entity?

If you did not check both boxes, the organization in question is not your business associate. If you checked both boxes, go to step 2, below.

Step 2. Check each applicable statement.

☐ Does the outside organization receive PHI to provide treatment?

☐ Is the outside organization a financial institution processing consumer-related transactions for the purpose of payment for health services?

☐ Is your contract with the organization one within which you both participate in an organized health care arrangement or where you're both in an affiliated arrangement?

If you checked any of the boxes above, the organization is not your business associate. If none of the boxes are checked, the organization is your business associate, and you should prepare a business associate agreement.

What's next? You've found relationships that qualify as business associates. In those situations, case managers need to prepare a business associate contract. Because the role of case managers is not yet defined clearly by the Department of Health and Human Services (HHS), we look to the agency for further guidance regarding this and other components of HIPAA regulations. For now, use these steps to prepare business associate contracts:

Step 1.

A. Prepare your list of current contracts.

B. Review your current contracts and agreements to identify and categorize each business associate relationship.

C. Identify contract renewal dates for current business associate relationships and update and revise in accordance with the most current guidance from HHS. (Go to: www.hhs.gov.)

Step 2.

A. Identify and list each organization you have identified as a business associate.

B. Create a business associate agreement.

C. If you developed new agreements prior to April 14, 2003, HIPAA language should have been inserted into the agreement as an addendum if a new agreement was not developed.

D. Create new and ongoing agreements when you assess new business relationships are business associates. ■

CE *questions*

13. Special needs case managers at Children's Hospital of Wisconsin typically do not manage the care of children with multiple disabilities.
    A. true
    B. false

14. Which is not a responsibility of special needs case managers at Children's Hospital of Wisconsin?
    A. coordinating care among providers
    B. helping families get the services they need
    C. discharge planning
    D. providing a communications link between pediatricians, the hospital, and schools

15. Which type of patients receive follow-up phone calls from Cogent Healthcare's call center within 48 hours of discharge?
    A. only patients discharged to independent living situations
    B. only patients discharged to skilled nursing facilities
    C. patients discharged to home or to assisted living facilities
    D. all discharged patients

16. The orientation program for new hires at SSM Rehab in St. Louis consists of what?
    A. a quick, one-day overview.
    B. a two-day intensive workshop
    C. a three-day weekend retreat
    D. five days of orientation over the employee's first month

Answer Key: 13. B; 14. C; 15. A; 16. D

Make diversity a part of daily operations

Orientation, mentors make difference

At SSM Rehab in St. Louis, diversity has become part of the institutional culture. Staff have successfully built diversity into its ongoing operations rather than instituting one program that would meet federal and industry guidelines, says **Kurt Delabar**, director of human resources.

SSM Health Care (SSMHC), the not-for-profit health system of which SSM Rehab is a part, last year became the first health care organization in the country to be named a Malcolm Baldrige National Quality Award winner. Successfully managing diversity among patients and employees is one of the elements involved in winning the award.

"Diversity is not a program," Delabar says. "It's part of what we do every day. Whether it's the diversity of focusing on marginalized patients or whether it's activities geared toward attracting and retaining employees with diverse backgrounds, it's just part of what we do. If it's part of what you do every day, that's how you will be successful."

One example of how SSM Rehab has incorporated diversity into its regular operations is its orientation program that gives new hires a comprehensive understanding of the organization. Instead of a quick, one-day event, the employees attend five days of orientation during their first month. Each new employee, from maintenance staff to office workers, from therapists to physicians, gets hands-on training from all disciplines.

Gina Garippo, communications manager, says the orientation helps staff members understand what patients are going through, how they feel, and what they encounter when working through recovery at the facility.

Employees try on special clothing that allows them to feel what it is like to be paralyzed on one side of their body or to try getting dressed after an amputation. They practice transferring from wheelchairs and tying shoes without the use of

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. ■

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their hands, she explains. "It really raises the sensitivity of our entire work force to who we're trying to treat. I hadn't thought in terms of what it might feel like to have lost a limb or to experience a stroke and not be able to use one side of my body. If the whole staff have been trained to have a heightened understanding, there's that sensitivity level that is different," Garippo adds.

Cultural diversity also is a topic in the staff's annual training, where issues such as differing customs are addressed. Staff members learn to be sensitive to Middle Eastern patients who may not embrace modern Western medicine and to Asian patients who may feel direct eye contact is a sign of disrespect, Delabar explains. Employees also have quick access to reference books on diversity issues at nurses' stations throughout the facility, he says.

SSM Rehab has begun a nurse recruitment program in the Philippines, which serves to alleviate the nursing shortage and bring diversity to the work force. Research has shown that some countries, including the Philippines, have an abundance of registered nurses who undergo training similar to what is offered in the United States, Delabar says.

SSM Rehab now has eight Filipino nurses on staff. "Some of these nurses have left their families to come halfway around the world, and our staff have embraced them," he says. "It has been interesting to work on a daily basis with people from another culture." SSM staff members have helped the nurses find housing and become more comfortable with their jobs and the community.

"One nurse even spent the holidays with one of our senior-level managers, who wanted him to feel at home during the holidays without family," says Garippo.

SSM Rehab also participates in a diversity mentor program that identifies employees — predominantly minorities — as future leaders. They are paired with a mentor from senior leadership who meets with them regularly for a year to teach them about such areas as budgeting and staffing that they would need to know in order to become a manager. "They work to develop those individuals professionally; and in a lot of cases, they are also developing personal relationships," Delabar says.

"One of the things that is built into our strategic plan is a goal to increase the numbers of minorities and women in professional and management positions. This initiative helps move toward that goal," he adds. Other activities include specific recruiting techniques to hire minorities and quarterly diversity forums for all employees. "It has been the mission of SSM for over 100 years to focus on the marginalized. We constantly find new ways to further that mission." ■

CCMC seeks feedback on revised code of conduct

The Commission for Case Manager Certification (CCMC) in Rolling Meadows, IL, is revising its Code of Professional Conduct for case managers and is seeking feedback on the draft revision from professionals in the case management field, including certified and noncertified individuals. Professional case managers are urged to go on-line at the CCMC web site at www.ccmcertification.org, review the draft, and submit comments by Oct. 31. "The new Code of Professional Conduct would further clarify the accountability of case managers to key stakeholders, regardless of where they practice. Given the potential impact, we urge all case manager to review the draft and submit comments," says **Diane Huber**, chair of the CCMC. ■