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HOSPITAL CASE MANAGEMENT™

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

IN THIS ISSUE

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Nurses vs. case managers? Deal with that turf battle before it becomes a war

Clarify your respective roles to create smoother working relationships

Unless you've handled things incredibly effectively, there probably is a turf battle going on right now in your hospital. It's being played out on the nursing floor, behind closed doors, and even during executive sessions. When the case manager walks on the floor, the nurses are probably saying, "OK, let her do it; since she's here, we don't have to." They may be dropping their professional responsibilities for a number of things related to coordination of care and discharge planning — apparently a common problem in facilities nationwide.

Bev Cunningham of Case Management Consultants in Tulsa, OK, hears about turf battles from every hospital that comes to her for help in setting up its case management program. "Everyone struggles with it," she says.

Evelyn Koenig, director of case management at Vanderbilt University Medical Center in Nashville, TN, says that to avoid potential problems, case management has to be introduced to a facility in a coordinated, well-planned manner.

Vanderbilt's case management system came into being rather suddenly when Tennessee Medicaid converted to a managed care system. Case management seemed to be a way to respond to managed care as a process of coordinating the care of the patient across the continuum.

"At first, there was no specific differentiation between what case management teams would do related to the coordination of care and what the nurse would do," Koenig tells *Hospital Case Management*. "One of the things that is incredibly important in the introduction of case management is to reiterate those responsibilities that remain in the role of the professional nurse."

Cunningham agrees that turf battles — one of the biggest problems facilities have right now — stem from not clarifying to the nursing staff just what it is a case manager does. One thing she has found to

be helpful is a responsibility list that identifies what the nurse manager, staff nurse, social worker, and case manager do. She has drawn one up for her clients, and they say it helps decrease turf battles by clarifying roles. **(See "Responsibility List," p. 171.)**

As Cunningham says, "It's our own fault that we are where we are today. When facilities put utilization management nurses on the floor years ago, the same thing happened. Nurses said, 'Who is this person sitting at the desk, breezing though the charts, while I'm working hard?' We haven't explained case management's role to the nursing staff. We haven't explained that nurses have just as vital a role in case management as case managers do."

Nurses are, in fact, acting as case managers for about half the patients on the floor, depending on clinical and discharge complexity. They manage the cases of patients who are predictable. They do not have utilization responsibilities, but both the staff nurse and the case manager move an individual patient through the system.

The case manager bases her decisions on what has happened to specific populations of patients. "For example," says Cunningham, "case managers know what to expect with pneumonia patients — which ones are most likely not to proceed predictably through the system. Case managers are outcomes-focused." In fact, in many facilities, the term "case manager" has given way to "outcomes manager."

She says it depends on the hospital, but case managers and nurses typically make about the same salary. "But one wears scrubs and one a business suit," says Cunningham, "because one does the bedside work and the other sits at a desk."

Koenig says there are two case management job descriptions at Vanderbilt, one at the BSN level and one at the MSN level, and both of those levels are on a different salary scale from that of the nurses. "That doesn't mean case managers are making more money than nurses," says Koenig. "Pay depends on the level of nursing experience."

She says a larger salary differential exists between nurse case managers and social workers. Nurses typically are better-paid because of the scarcity of nurses, and the tight nursing labor market has driven up nursing salaries. "Here we have a case of people working at a similar job with similar goals who are paid differently," Koenig says. Social workers are paid less than nurses or case managers not just at Vanderbilt but nationwide, due to the fact that there are more social workers than nurses on the market. "They are not a scarce commodity," she points out.

Get buy-in from your staff

You have to get the nurse manager on the floor to buy into your case management program, explains Cunningham. If the manager buys in and supports it, staff are more likely to welcome the program. How do you achieve that buy-in? "Include them in the decision-making process from the start," she advises, "and keep them educated on what's going on."

In 1995, Vanderbilt decided to address turf battles by implementing a triad of teams within case management. The teams are structured as follows:

- **social worker:** crisis intervention, psychosocial assessment, and brief therapeutic interventions;
- **utilization manager/DRG specialist:** precertification, recertification, concurrent chart review, DRG management, medical record completion, quality data collection;
- **nurse case manager:** clinical coordination, resource utilization, systems management, analysis / evaluation.

The three sections join as outcomes management, which includes high-risk screening and discharge planning. Within those teams, there is informal agreement on role differentiation. Vanderbilt's triad works well; the groups cooperate with and rely upon one another. "There are always personality issues, but the model works," says Koenig. "Team building is the key to overcoming turf battles. Give people the tools to work together as teams."

About a year ago, Vanderbilt leaders looked at the triad again to see if this was still the model they wanted to work with. They gave questionnaires to all the team members as well as medical directors and administrative directors of the patient care centers and asked respondents to give their opinion on what was good or could use improvement. The staff responses to the questionnaire validated the model. Everyone agreed that the triad is the key to accomplishing what needs to be accomplished. The facility today continues to work with the basic three teams.

"Everyone agreed that having a team partner with a different set of skills from yours allows

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RESPONSIBILITY LIST
ST. VINCENT MERCY MEDICAL CENTER

CATEGORY	CASE MANAGER	NURSE MANAGER	STAFF NURSE	SOCIAL WORK SERVICES	OTHER SERVICES
DISCHARGE PLANNING	Identifies discharge needs and refers discharge planning needs to Social Work Services	Assures initial discharge assessment	Initial assessment of discharge needs and refers to appropriate individual/team	Discharge planning	
EDUCATION	Evaluates educational strategies	Assures availability of educational materials	Provides patient education and evaluates patient understanding	Discharge planning education	
PATIENT CARE	Coordinates interdisciplinary patient care	24 hour accountability for patient care	Provides direct patient care		
CARE CONFERENCE	Coordinates patient care conferences	Facilitates staff attendance and participation	Participates in patient care conference	Participates in patient care conference	
DOCUMENTA-TION	Documents pertinent patient information in the physician progress notes	Assures appropriate documentation	Documents response to treatment each shift in DAR format (nursing notes)	Documents pertinent patient information in the physician progress notes	
PLAN OF CARE	Coordinates and evaluates interdisciplinary plan of care	Assure nursing plan of care completion	Develops, implements and evaluates nursing plan of care		
DATA	Collects and utilizes data regarding interdisciplinary outcomes, potentially avoidable days, and utilization review	Facilitates unit specific data collection	Completes unit specific data collection as assigned	Facilitates referral sources	
COMMUNITY REFERRAL FORM	Coordinates accurate completion	Accountable for nursing staff responsibilities	Obtains physician referral information Completes nursing section Evaluates data	Assures delivery	
CLINICAL PATH	Facilitates development of clinical pathways Follows complex patients who vary significantly from the pathway	Involved in development of clinical pathways Assures staff utilization of pathway	Involved in development of clinical pathways Initiates and utilizes the clinical pathway	Facilitates pathway process relative to discharge planning	

Source: Bev Cunningham, Case Management Consultants, Tulsa, OK.

the job to get done, and get done in a timely manner," says Koenig. "Initially, there was some concern about whether some people would take other people's jobs." That was at a time when pure nursing-case management models were being introduced, and there were some layoffs of utilization staff and social workers. There was some concern because nurses were being asked to assume all the roles. "But as it played out," she says, "all the staff became quite comfortable with it. They are dependent on their partners to get the work done."

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How St. Vincent Mercy handled its turf problems

Outcomes manager replaces three other jobs

Robin Bender, RN, director of the outcomes management program at St. Vincent Mercy Medical Center in Toledo, OH, says her facility's inpatient disease management department was restructured recently. Prior to January 1999, the department consisted of nurses working as quality management analysts who were responsible for quality aspects of utilization management, a few nurse discharge planners, case managers, and social workers. The case managers could be unit-based, service-based, or physician-specific.

"It was a fragmented system," says Bender. "You would frequently hear comments like, 'Well, we don't know what case managers do.'" There was little consistency from one case manager to another in terms of how they functioned, how they reported the achievements they made with certain populations, or what obstacles they were encountering. And there was no mechanism in place to feed back that information.

"We looked at the roles of those groups of people as well as of the social workers and ended up restructuring," she says. "We eliminated those original three roles — case manager, nurse discharge planner, and quality management analyst — and replaced them with a new role called outcomes manager." The displaced employees were given the opportunity to apply for the new position.

The outcomes manager is responsible for utilization management, case-managing the complex patient, and simple discharge planning, such as setting up home care and transporting patients home.

"In her role as utilization manager, the outcomes manager is in constant contact with the insurers, and that improves our ability to do discharge planning," says Bender. "We know up front if a patient has a preferred provider, who it is, and what kind of services are covered. Previously, we had to wait until we got a referral and then wait for someone else to find out that information."

When the reorganizers at St. Vincent folded existing positions into the new outcomes manager position, they weren't looking at decreasing the ranks of full-time employees, Bender says. "That was not our goal. We were looking at improving our program so that we could improve the outcomes relative to our patient population." They actually increased the number of people doing case management. It also freed up the social workers to do the things they are trained to do — investigating abuse and neglect cases, financial counseling with patients and families, guardianship issues, and complex discharges to rehab or subacute care.

"We focused energies on tasks that people were trained to do. Before our reorganization, staffers had been doing jobs they weren't trained for." Communication between the case managers, quality management analysts, and nurse discharge planners had been limited. Bender dealt with that by putting everyone through a comprehensive training program. There is also new resident orientation at St. Vincent on a monthly basis to let the rotating doctors know what social workers and outcomes managers do. "We give all residents a list of the individuals with their pager numbers so they can keep in touch," says Bender.

"Now we have outcomes managers and social workers who are team-based," she says. Teams are driven by clinical area. For example, critical care teams comprise the medical-surgical ICU, the step-down ICU, and the burn unit. There is a cardiovascular team, a med-surg team, a neuro-orthopedic team including trauma recovery, an obstetrics team, and a pediatrics team. A float team is cross-trained in all those areas to cover when others are on vacation or other leave.

"As we restructured," says Bender, "one of the issues that came up from the nursing staff was the comment, 'You're just trying to get the patient out of the hospital quickly.' Then we had a situation where the nursing staff would refuse to share information if they thought that information might mean that we were looking for an alternative setting for a patient." She explains that, of course, the outcomes staff were not trying to push patients out of the hospital but were looking for the most appropriate level of care for patients based on their needs.

Spending limited funds wisely

"Insurance supplies a finite number of dollars to cover a patient during his lifetime," Bender explains. "If we use a portion of those dollars unnecessarily, and something catastrophic happens, the patient will have fewer resources to pull from. We look at what is medically necessary for the patient and take everything into consideration."

Another perception of the nursing staff was, "We're very busy doing direct patient care. We don't know what you case or outcomes managers are doing, so why don't you help out and do direct patient care?" Bender echoes the other experts in saying this is a battle that still must be fought constantly. The situation is only overcome when the outcomes managers excel and accomplish interventions that work.

"Then they overcome those assumptions," says Bender. An example, she says, is that now patients are discharged directly from St. Vincent's ICU. "That never happened in the past," she notes. The outcomes manager facilitates patient care conferences with physicians, families, and staff. They discuss the chances for recovery and the plans of care. All the information is shared with the nursing staff.

"From that perspective, the nurse sees the outcomes manager's role as valuable," Bender says. "She might think, 'She has gathered valuable information that I have not had the time to get on my own.'" The nurse's perception of the outcomes manager depends on how the outcomes manager has integrated herself into the clinical areas and is working with the staff. It is then that the staff see what kinds of opportunities they have for additional information that they didn't have before. It's now a centralized process, where it wasn't before.

"We have to prove that we are a valuable member of the nursing staff's team," Bender says. "Our day is spent out on the nursing unit, not in a central office. We are accessible to the staff and physicians, trying to get everything coordinated." But, she says, the program is only as successful as the individual outcomes managers are.

"Overcoming barriers and turf battles is a day-to-day, person-to-person problem," she says, "but we're dealing with them. If one tactic doesn't work, there's always another way."

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New Hampshire CMs denied RN license renewal

Nurses must meet active practice requirement

Several New Hampshire nurse case managers were stunned recently when the state Board of Nursing denied their applications for renewal of their registered nurse (RN) licenses. The board says the move is a quality control issue designed to protect consumers in the state of New Hampshire.

Case management leaders warn that this policy, if it spreads, has far-reaching implications for all case managers, such as keeping nurses from acting as case managers.

"It came to our attention about a year ago that there were nurses in case management positions that did not require that the person holding the position be a registered nurse," says **Doris Nuttelman**, RN, EdD, executive director of the New Hampshire State Board of Nursing in Concord. "We have an active practice requirement. If an employer hires an RN as a case manager because the job requires the special skills and knowledge of a registered nurse, then the nurse case manager meets the practice requirement. If the employer also hires other professionals, such as social workers, to do the same case management position, then we feel that the job does not meet the active practice requirement for registered nurses in this state." She added that the board has challenged, and in some cases denied, license renewal for nurse case managers in payer, acute, and long-term care settings.

If the state board of nursing is simply practicing quality assurance, several industry leaders say, case managers should support the board in its efforts, but not before asking some hard questions. "We have to start some proactive discussions right now about the scope of professional practice as we move forward in new roles," says **Brenda-Jean Paradis**, RN, regional manager in medical management for Blue Cross and Blue Shield of New Hampshire in Manchester and project manager to accreditation organizations. "To meet standards set by credentialing bodies such as the National Commission for Quality Assurance [in Washington, DC], we only hire RNs to do case management. Yet, we've had two RNs here whose license renewal applications are currently under review by the board of nursing."

First, do no harm

"The health care system has required that health care professionals be more flexible and creative in their roles to meet new challenges in the delivery system," notes **Sandra L. Lowery**, BSN, CRRN, CCM, president of Consultants in Case Management Intervention in Francestown, NH, and president-elect of the Case Management Society of America (CMSA). "I'm concerned that this ruling has broad implications for nurses and other professionals who want to enter specialty areas. It could in essence prohibit nurses from taking case management positions, and my real concern is that consumers will be left without a valuable service."

If a nurse case manager can no longer be relicensed, that nurse is no longer of value to a health care organization, agrees **Kathleen Moreo**, RN, BSN, BPSHSA, CDMS, ABDA, RN,Cm, owner and president of PRIME, a case management consulting and education firm in Miramar, FL, and president of CMSA. "Organizations will turn to less-appropriately trained and credentialed individuals, and the consumer, the very person the board of nursing is trying to protect, will be harmed."

It's not just nurse case managers who are affected when their professional roles are challenged, but all case managers regardless of discipline. "As case managers, we must support each other regardless of our backgrounds. We spend so much time as professionals developing the skills we need to function as case managers; when one of us is challenged, we must all speak out," says **Karen Coish Mackey**, BSW, MBA, case manager with Regional Partners in Occupational Health, an occupational health practice in Manchester, NH. "In the past, I worked as director of an acute rehabilitation case management department which employed both nurses and social workers as case managers. I believe at times the skills of the different disciplines compliment each other. I also believe that there are times, and that there are cases, which require the strengths of either a nurse or a social worker."

If you practice outside New Hampshire, don't be lulled into a sense of false security. The New Hampshire State Board of Nursing has issued a wake-up call, and this is no time to be passive, caution industry leaders.

"I don't believe for a moment that this issue, and others like it that negatively impact case managers, will end in New Hampshire," says Moreo. "This situation is going to have a ripple effect. This is about health care economics. We are all going to be asked to be more accountable for who we are and what we do. It's not necessarily a bad thing, but one we must respond to and govern appropriately."

So, what is 'nursing'?

The American Nurses' Credentialing Center (ANCC) in Washington, DC, is grappling with similar issues for nurses who hold its nursing case management certification (RN,Cm), which became available in 1997, as well as certifications for other nursing specialties that don't clearly involve direct patient care. "Many of our recertification requirements have wording that refers to 'direct patient care.' Depending on what type of case management you practice, as a nurse case manager you may not even see your patient," notes **Mary Smolenski**, EdD, RN-CS, director of certification services for the ANCC.

ANCC has had inquiries from nurses concerned they may not be recertified because of the requirement that certified nurses perform "direct patient care," she notes. "We get a great many calls on this issue. Nurses are questioning themselves and the jobs they've taken or are considering accepting. They wonder, 'If I take this job, will it count towards recertification?' Over the past two years, this has become a huge issue. There are more and more jobs for nurses in the health care industry that don't involve direct patient care, and case management certainly falls into that category."

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CRITICAL PATH NETWORK™

Total hip replacement pathway aims at four-day LOS

In 1993, the average length of stay (LOS) for a total hip replacement at University of Colorado Health Sciences Center in Denver was eight days. The next year it was brought down to six. "We were discussing a path then, but not yet implementing it," says **Kathy Nold**, RN, manager of the office of clinical practice there. "We looked at comparative data locally as well as at other academic centers around the country and decided we needed to be addressing the situation."

The process of building the center's hip pathway helped staff identify a goal that some other facilities were achieving: four-day LOS. Now the center's total hip replacement LOS fluctuates between four and five days. Reimbursement issues are affecting the center's ability to discharge patients any earlier than that.

"We can't sacrifice clinical outcomes to payer issues," Nold states. "Part of our difficulty revolves around issues related to discharge planning, who's going to be home when the patient gets home and whether the family can get a home nurse."

One of the facility's major cost savings came about when it launched an initiative to get all the hip replacement surgeons to use one company's orthopedic appliance. "We were at about 50% at the time, and now we're well above 75% and trying to push it to 80%. One obstacle is that we know that sometimes a surgeon is not able to use a particular product when another company's [product] would be more suitable for a peculiar case."

Now the center is discussing issues such as changing patients from IV to PO meds quicker and managing their pain better so they can get up and out of bed sooner.

Kelly McDevitt, RN, MS, ONC (Orthopedic Nurse Certified), orthopedic clinical case manager at University Hospital (part of the Health Sciences Center), says the pathway **(see pathway, pp. 176-177)** is just for the primary hip procedure. "If the patient had a replacement 10 years ago and the physician now needs to revise it, for example, we might use a lot of the same information, but those patients are not on the [same] pathway as those with a primary joint replacement would be."

The age range for these patients is vast — from 30 into the 90s. McDevitt says age is not a factor on the pathway unless a patient needs to stay in the ICU because of his or her cardiac history. In that case, an extra day or two is added for the cardiac monitoring phase. If a patient is young with no comorbidity, he or she might be out a day or two earlier. But in each case, the goals or expected outcomes are the same.

"We started developing this path in 1996," she says. "Before then, there was no path for total hip. We find it valuable because now care is streamlined, and nursing and therapy staff know what is expected of everyone. They now have it on paper." Staff are not yet documenting on this path.

"We go over the form with the whole multidisciplinary team every month — nurses, physicians, case managers, and all residents because they rotate — to evaluate what we're changing and what we need to add and delete. Pathways are only a guide to care. The path is not static; it's always changing," she says.

"It's taken a long time to get everyone on board with thinking about critical plans," McDevitt says. "Our department of clinical outcomes helped tremendously because they look at trends. With its help, the staff can see how to make improvements overall instead of relying on individual physicians doing their own thing."

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

UNIVERSITY HOSPITAL CLINICAL PATH

Diagnosis: Hip Replacement

DRG Code: 209 ICD Code: 81.51
Admit Date:_____

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

Allergies:_____ _____ _____	**Phase: One** **Length of Phase : 2 days** **Day: Surgical Day**	**Phase: One** **Length of Phase: 2 days** **Day: Post-Op Day 1**	**Phase: Two** **Length of Phase: 3 days** **Day: Post-Op Day 2**
Tests	AP X-ray of OP site in PACU Spun Hgb in PACU	CBC AM Draw. Respond to results.	CBC AM Draw. Respond to results.
Treatments Interventions	TCDB, spirometer Q1° if awake Blood/IV fluids 02 @2 L/PM NC if 02 sat < 92% Foley cath care BID Thigh high stockings & thigh high compression device both lower extremities Hip abduction wedge while in bed TPR/BP Q4° CMS Check Q4° I & O including hemovac/drains Check dressing Q8° Pulse Ox Q8° until 0_2 sat > 92% x 48°	TCDB, spirometer Q1° if awake Buff cap IV if breakfast & lunch tolerated 02 @2 L/PM NC if 02 sat < 92% D/C Foley w/in 4° p epidural DC'd Remove stockings & compression device for 30 minutes, BID Hip abduction wedge while in bed and during turning TPR/BP Q4° CMS Check Q4° I & O including hemovac/drains Monitor BM & voiding Check dressing Q8° Pulse Ox Q8° until 0_2 sat > 92% x 48° Ice bag to hip PRN	TCDB, spirometer Q1° if awake Continue Buff cap D/C 0_2 if sat > 92% D/C foley Remove stockings & compression device for 30 minutes BID Physician to change dressing Hip abduction wedge while in bed and during turning TPR/BP Q4° CMS Check Q4° I & O including hemovac/drains Monitor BM and voiding Check dressing Q8° DC Pulse Ox if off 0_2 Ice to hip PRN
Medications	Epidural/PCA Cafazolin 1 GM IV Q8° x 3 doses Enoxaparin 30mg SC in PACU and then BID Pain/anti emetic meds as ordered by anesthesia No narcotics while on PCA/epidural	DC Epidural/PCA per pain service Cafazolin 1 GM IV Q8° x 3 doses Enoxaparin 30mg SC BID Start PO pain meds Start Ortho bowel protocol	Encourage pain medication prior to treatments & activity Enoxaparin 30mg SC BID Maintenance meds – resume as ordered

Legend for pathway:
AP=anterior and posterior
OP=operative
PACU=post anesthesia care unit
HgB=hemoglobin
CBC=complete blood count
TCDB=turn, cough, deep breathe
NC=nasal cannula
D/C=discontinue
CMS=color, motion, sensation
TPR/BP=temperature, pulse, respiration, blood pressure
PCA=patient controlled anesthesia
THA=total hip arthroplasty

Source: University of Colorado Health Sciences Center, Denver.

University Hospital Clinical Path
Diagnosis: Hip Replacement

Allergies:_____	Phase: One Length of Phase: 2 days Day: Surgical Day	Phase: One Length of Phase: 2 days Day: Post-Op Day 1	Phase: Two Length of Phase: 3 days Day: Post-Op Day 2
	Maintenance meds – resume as ordered	Maintenance meds – resume as ordered	
Diet	As tolerated	As tolerated	As tolerated
Activity	Bedrest/Dangle at bedside & OOB as tolerated Ankle pumps No hip adduction, no rotation. No hip flexion > 80° Encourage thigh/calf muscle contraction Q4° Quarter turn sideways per MD's orders	Up in chair as tolerated Ambulate as tolerated/WB w/assistive dev. Ankle pumps No hip adduction, no rotation. No hip flexion > 80° Encourage thigh/calf muscle contraction Q4° Quarter turn sideways per MD's orders	Up in chair as tolerated Ambulate as tolerated/WB w/assistive dev. Ankle pumps No hip adduction, no rotation. No hip flexion > 80° Encourage thigh/calf muscle contraction Q4° Begin active assistive ROM Quarter turn sideways per MD's orders Toilet / Tub Tx with OT
Teaching	Teach pt/family post-op routines (visiting hrs, etc.) Teaching re: TCDB, IS, PCA Teach THA precautions	Total hip protocol posted Teach PT/OT protocol Teach THA precautions Reinforce TCDB, IS, PCA	Begin teaching hip exercises OT/ADL's Reinforce THA precautions
Consults	Order PT/OT, Pain/Anesthesia (Rehab prn) Social Worker/Case Manager/VNA		
Discharge Planning	Update discharge plan	Re-evaluate equipment needs Rehab consult	Complete discharge plan

Legend for pathway:
AP=anterior and posterior
OP=operative
PACU=post anesthesia care unit
HgB=hemoglobin
CBC=complete blood count
TCDB=turn, cough, deep breathe
NC=nasal cannula
D/C=discontinue
CMS=color, motion, sensation
TPR/BP=temperature, pulse, respiration, blood pressure
PCA=patient controlled anesthesia
THA=total hip arthroplasty

Source: University of Colorado Health Sciences Center, Denver.

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There was some resistance to any critical plan at first. McDevitt says the physicians saw no value in it. "We got them to come around through the office of clinical practice. The physicians in the office tapped into the attending physicians of each service and charged them with creating the pathways. That's how we really got it going and how more and more pathways were created here."

The office of clinical practice developed an internal severity of illness scale. When they look at utilization for patients under 65 with no secondary diagnoses of pulmonary, cardiac, or bleeding disorders, Nold says, "it's flat — there's no variability. But when we look at patients over 65 and with secondary diagnoses, there's wide variation in their lengths of stay, charges, and costs." Those are the types of data the office continues to monitor.

"We recently went through a benchmark project with a university health systems consortium," she says, "and this facility was identified along with four others as being one of the top performers for excellence in primary hip replacement. Out of 15 categories of benchmarks, we met or exceeded 62%."

Part of what makes University Hospital successful, she says, is its multidisciplinary team that looks at data and talks about ways to improve practice.

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Information for your Patients

What are possible complications of hip replacement surgery?

According to the American Academy of Orthopaedic Surgeons in Rosemont, IL, approximately 120,000 hip replacement operations are performed each year, and less than 10% require further surgery. New technology and advances in surgical techniques have greatly reduced the risks involved with hip replacements. The most common problem that may happen soon after hip replacement surgery is hip dislocation. Because the artificial ball and socket are smaller than the normal ones, the ball can become dislodged from the socket if the hip is placed in certain positions. The most dangerous position usually is pulling the knees up to the chest.

The most common later complication of hip replacement surgery is an inflammatory reaction to tiny particles that gradually wear off of the artificial joint surfaces and are absorbed by the surrounding tissues. The inflammation may trigger the action of special cells that eat away some of the bone, causing the implant to loosen. To treat this complication, the doctor may use anti-inflammatory medications or recommend revision surgery (replacement of an artificial joint). Medical scientists are experimenting with new materials that last longer and cause less inflammation. Less common complications of hip replacement surgery include infection, blood clots, and heterotopic bone formation (bone growth beyond the normal edges of bone).

What types of exercise are most suitable for someone with a total hip replacement?

Proper exercise can reduce joint pain and stiffness and increase flexibility and muscle strength. People who have an artificial hip should talk to their doctor or physical therapist about developing an appropriate exercise program. Most exercise programs begin with safe range-of-motion activities and muscle-strengthening exercises. The doctor or therapist will decide when the patient can move on to more demanding activities. Many doctors recommend avoiding high-impact activities, such as basketball, jogging, and tennis. These activities can damage the new hip or cause loosening of its parts. Some recommended exercises are cross-country skiing, swimming, walking, and stationary bicycling. These exercises can increase muscle strength and cardiovascular fitness without injuring the new hip.

Source: The National Institute of Arthritis and Musculoskeletal and Skin Diseases, National Institutes of Health, Bldg. 31/Rm. 4C05, 31 Center Drive, MSC 2350, Bethesda, MD 20892-2350. Telephone: (301) 496-8188. Fax: (301) 480-2814. World Wide Web: www.nih.gov/niams.

Your patients can learn more from this source:

American Academy of Orthopaedic Surgeons, 6300 North River Road, Rosemont, IL 60018-4262. Telephone: (847) 823-7186; (800) 346-AAOS. Fax: (847) 823-8125. World Wide Web: www.aaos.org. ■

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ANCC's 11-member commission is reviewing its definition of "direct patient care," she adds. "One argument that has been discussed is that if a nursing intervention impacts a patient outcome, it could be considered direct patient care even if the nurse did not interface with the patient face to face," she says. "Under that definition, I think nurse case managers could argue that they meet the requirement."

One title, many disciplines

Of course, case management always has been a multidisciplinary field, and nurses are not alone in struggling to define new professional opportunities. The National Association of Social Workers (NASW) in Washington, DC, is the latest group to attempt to establish a quality control process for case managers. Its new specialty certification for social work case managers will be available in late fall.

"The title 'case manager' is used by many different disciplines. Each discipline approaches case management differently. We felt this was an appropriate time to set criteria for social work case managers," says **Susan Merrick**, ACSW, LCSW, senior staff associate with NASW.

The important thing for case managers to remember is that it's better to be proactive than to wait until it's time to renew their professional licenses or certifications to review the requirements and take corrective action, if necessary. "This is a wonderful wake-up call for case managers and their employers to review and update their case management job descriptions and consider education and outreach efforts," says Lowery.

Here are five actions industry leaders urge case managers to take to protect their professional status:

• **Review licensing and credentialing requirements.** Ask your state professional board for a copy of relicensing requirements. If you are unclear about any of the requirements or whether you meet a particular requirement, ask for a clarification before it's time to renew your license. Take corrective actions, if necessary.

• **Ask for a list of board members.** Ask to see a list of the board members, and if you feel that case management is not well-represented, work to make changes in the composition of the board.

• **Write an accurate case management job description.** Ask your employer for a copy of your job description. If it fails to accurately reflect your duties and responsibilities, make suggestions for revising it.

• **Keep your state and national professional associations informed about developments in your area that impact case managers.** One person can make a difference. Your professional associations have a strong voice and will use it to help resolve professional conflicts facing case managers.

• **Educate consumers and policy-makers.** If you feel that policy-makers or consumers are misinformed about the role and function of case managers, provide them with educational materials, such as case management standards of practice and codes of ethics.

[Editor's note: For more information or an application for the Washington, DC-based National Association of Social Workers' new specialty certification for social work case managers, call (800) 638-8799, ext. 447, or visit the association's Web site at www.socialworkers.org.] ■

Check patients' herb use before OKing surgery

Enhancing your immune system, getting a good night's sleep, and reducing your anxiety level are just three of the benefits promised to people who use herbs. But while consumers hear about the benefits of herbs, they usually haven't heard about the potential dangers if surgeons and anesthesiologists don't know about their use prior to surgery.

The American Society of Anesthesiologists (ASA) in Park Ridge, IL, has issued a warning for patients to tell physicians about the use of herbal medications before surgery. The ASA recommends that a patient stop taking herbal medications two to three weeks before surgery, and if there is not enough time to stop taking the medication, the patient should bring the product in its original container to the hospital or surgery center.

"Seeing the original container gives the pharmacist, surgeon, and anesthesiologist a better chance to identify other ingredients that might produce an interaction with drugs during or after surgery," explains **Jessie A. Leak**, MD, an associate professor in the department of anesthesia at

Popular botanicals may cause interactions

More than $5 billion will be spent on herbal products this year, and seven out of 10 people using these products will not tell their physicians, according to the American Society of Anesthesiologists (ASA) in Park Ridge, IL.

While many people may benefit from herbal medications, also called botanicals, the patient who is undergoing surgery must disclose the use of botanicals to his or her physicians prior to surgery, says **Jessie A. Leak**, MD, associate professor in the department of anesthesia at M.D. Anderson Cancer Center in Houston and a researcher who specializes in the study of herbal medication.

Potential interactions with drugs used for anesthesia as well as prescription medications the patient is already using can occur if the surgeon and anesthesiologist are unaware of the herbal medication's use, Leak advises.

"There have not been enough studies of botanicals in the United States for us to state that there definitely will or won't be a reaction during surgery, but most anesthesiologists and surgeons will err on the side of caution," she says. "We definitely need more botanical research, but based on anecdotal stories and the personal experiences of ASA members, we do recommend discontinuing some herbal medications at least two to three weeks prior to surgery."

Some of the more common herbal medications and their potential complications they could cause during surgery, according to Leak, are:

- **Ginseng.**
  Ginseng is used to enhance energy levels. If combined with stimulants used by anesthesiologists, it can cause tachycardia and high blood pressure. It can also decrease the effect of warfarin, causing the blood to thicken and develop clots.
- **Ephedra.**
  Ephedra is included in over-the-counter diet aids. It interacts with inhalants used for anesthesia to affect blood pressure. If used with monoamine oxidase inhibitors or oxytocin, the patient can experience high blood pressure and irregular heart rate during surgery.
- **Feverfew.**
  Feverfew is often used to treat migraines. It inhibits platelet activity that can increase bleeding during surgery.
- **Garlic.**
  Garlic is used to lower lipids and as an antioxidant. It inhibits platelet activity, especially if the patient is already taking warfarin.
- **Valerian.**
  Valerian has a mild sedative effect to help sleep. It causes a potential increase in the effect of barbiturates used in anesthesia, which causes a deeper effect of anesthesia.
- **Ginkgo biloba.**
  Ginkgo biloba is a circulatory stimulant. It decreases platelet activity and clotting ability.
- **St. John's Wort.**
  St. John's Wort is used to treat anxiety and depression. It may prolong the effects of some narcotics and anesthetics.
- **Licorice.**
  Licorice treats symptoms of gastritis and duodenal ulcers. It can cause edema and chronic liver problems and increase the risk of renal insufficiency.
- **Echinacea.**
  Echinacea is used to enhance the immune system. It may cause hepatoxicity and cause liver damage.
- **Ginger.**
  Ginger treats nausea. It can increase bleeding time.
- **Goldenseal.**
  Goldenseal is a diuretic and laxative. It can worsen edema and increase blood pressure. ■

M.D. Anderson Cancer Center in Houston and a researcher who specializes in the study of herbal medication.

One in three Americans use a botanical or herbal product, and 60% of these do not regularly disclose the use to their physicians, according to Leak. "We are very concerned about the possible effect of some herbal medications on a patient's outcome," she says. "Consumers don't realize that 'natural' does not equal safe for everyone in every situation."

Because herbal medications and vitamin supplements can be purchased over the counter, pharmacists don't have the opportunity to spot potential interaction with prescription medication. Some of those interactions can be dangerous if the patient undergoes surgery, Leak says. **(See potential interactions, above.)**

Some botanicals produce their effect by thinning the blood to increase circulation. If a patient taking one of these botanicals is also taking a drug such as warfarin, the result is excessive bleeding during surgery, says Leak.

Even without warfarin, the patient's blood may take longer to clot, she says. "If the surgeon knows about the use of the botanical, the patient

Your peers vent about their greatest challenges

Watch for future fax-back surveys from HCM

In the June issue of *Hospital Case Management*, we included a fax-back survey that asked readers to tell us the three biggest challenges in their job today. We are going to refer to your responses as we plan articles in upcoming issues. We want *HCM* to be as helpful as possible and jam-packed with articles relevant to those challenges.

Here are some of the challenges readers say are among their top three:

- working with managed care in a rural setting;
- how to maintain quality with fewer people to care for patients;
- automating concurrent outcomes in an outdated information system;
- keeping up with regulations and being creative in finding solutions for appropriate, effective care;
- getting physicians to buy into case/outcomes management;
- providing training to staff in order to "grow our own" case managers for both internal and external clients;
- getting Medicaid beds for ventilator patients (in Alabama);
- increasing physician utilization of clinical pathways;
- prioritizing time (should I be out on the floor seeing patients or in my office looking at data? doing research? improving processes?);
- getting the work done without constantly having to justify what I'm doing and why to different department heads and administration.

These responses came from hospitals of all sizes and types across the country.

HCM will be distributing more fax-back surveys in future issues. We hope you'll respond to them so the editors will know what's on your mind. Also, we are always interested in hearing about your case management projects and seeing your new critical pathways for possible inclusion in the newsletter.

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can discontinue its use several weeks prior to surgery to reduce the risk of bleeding."

Finding out if patients are using herbal medications or vitamin supplements is not a simple task because many are afraid to reveal the use to their physicians, says **Paulette Swanson**, RN, education coordinator at Lakeview Hospital in Stillwater, MN. "Patients tell us that they don't reveal their use of herbal medications because physicians don't ask or because they feel guilty," she says. Patients feel guilt because they don't want their physicians to think they don't trust their doctors' ability to care for them, she adds.

"To help patients feel comfortable discussing their use of alternative medicine, we have to initiate the conversation in a nonthreatening manner," says Swanson. The day-surgery program at her hospital uses a patient admission assessment form that specifically prompts the nurse to ask about alternative medicines as part of the question asking about prescription and over-the-counter medications. **(See assessment form, inserted in this issue.)**

"Because the nurse is already asking the patient for different types of information, the patient is comfortable giving information about herbal medications," explains Swanson. "If a nurse identifies a patient that is taking more than five medications [including prescription, over-the-counter, herbs, oxygen, or vitamin supplements], a pharmacy consult is requested," she says. "A pharmacy consult is also arranged if the nurse is not familiar with the herb identified by the patient or if the patient doesn't know why he or she is taking the herb."

Sometimes, just knowing the name of the botanical isn't enough to enable a physician or pharmacist to evaluate potential interactions, says Leak. "Botanicals are not regulated as a drug by the Food and Drug Administration. They are included in the same category as food," she says.

This classification results in less stringent requirements for the production of botanicals. For example, consider echinacea, which is used to enhance the immune system. Echinacea from one manufacturer may not contain the same amount

of echinacea mixed with other ingredients as a second manufacturer, she explains.

If you want to ask patients about use of herbal medications or other alternative medicine treatments, be careful how you address the patient, warns Swanson. Staff cannot be judgmental or skeptical, and can't offer advice regarding the effectiveness of treatments, she says. "It is also important that your surgery staff is aware of potential interactions."

Most importantly, says Swanson, "You must convey the idea that it is OK to integrate alternative medicine with traditional medicine in order to make the patient feel comfortable enough to give you the information. Not only do we have to ask the patient about herbs, but we have to make them want to answer."

Suggested reading

O'Hara MA, Kiefer D, Farrell K, et al. A review of 12 commonly used medicinal herbs. *Arch Fam Med* 1998; 7:523-536. ■

NEWS BRIEFS

Elderly readmissions drop with special discharge planning

Discharged elderly patients are less likely to be readmitted if they receive comprehensive discharge planning and home follow-up visits, according to a recent study conducted at the University of Pennsylvania.[1]

Researchers analyzed the effectiveness of a special discharge plan in two urban, academically affiliated hospitals in Philadelphia that included contact with one advanced practice nurse throughout the hospitalization plus at least two home visits, the first occurring in the first 48 hours post-discharge and the second occurring seven to 10 days following discharge. The plan also included additional home visits by the nurse on an as-needed basis, plus everyday telephone availability and a call from the nurse once a week. A control group of elderly patients received standard discharge planning.

By 24 weeks after discharge, 37% of the control group had been rehospitalized, compared with 20% of the intervention group. Comprehensive, nurse-centered discharge planning also increased the time between initial discharge and readmission and decreased health care costs. At six months, savings in Medicare reimbursements were almost $600,000 for the intervention group beneficiaries, or $3,000 per patient.

One of the investigators said in a statement that the findings show that elderly patients with complex chronic conditions need someone who can act as a broker — someone who can negotiate for them, not only around the clinical issues, but also around assistance issues after they leave. Planning, she added, can stop the cycle of ongoing rehospitalization.

Reference

1. Naylor MD, Brooten D, Campbell R, et al. Comprehensive discharge planning and home follow-up of hospitalized elders. *JAMA* 1999; 281:613-620. ▼

Nearly half of patients die in blood trials done without consent

The company that manufactures the blood substitute HemAssist conducted a trial of its product without the informed consent of patients in the study. Of the 52 critically ill patients given the substitute, 24 died — a 46.2% mortality rate. Deerfield,

COMING IN FUTURE MONTHS

- Decision support systems: What others have learned
- Medical malls and hospital 'lite' settings
- Managing chronic conditions: The patient collaborates
- What your colleagues are saying: More survey results
- Dealing with workers' comp: Experts' advice

IL-based Baxter International was able to test its product without consent because of a 1996 change in federal Food and Drug Administration (FDA) regulations that changed a 50-year rule requiring consent for nearly all experiments on humans.

The rule change was designed to help research in emergency medicine that could not take place if doctors had to take time to get consent. But the outcomes of the HemAssist trial are prompting some medical ethicists to question the rule change. No other company has conducted a no-consent experiment under the rule, FDA officials said. Baxter officials halted their clinical trial after reviewing data. The trial came on the heels of an intense push to find an effective blood substitute that could ease the effects of whole-blood shortages. The artificial substance lasts longer than conventional blood, eliminates the time-consuming need to match blood types, and does away with the risk of contamination with such viruses as HIV and hepatitis. No lawsuits have arisen from the blood substitute trial, Baxter officials said. ▼

NCQA: External appeals added to health plan standards

Beginning in 2000, health plans seeking accreditation will most likely have to allow patients to appeal medical decisions to an outside body and allow patients to continue to see a physician who has left the plan.

Those two provisions were added to draft accreditation standards issued by the National Committee for Quality Assurance (NCQA). The new standards are projected to go into effect July 1, 2000.

Under the proposed standards, a patient who exhausts a plan's internal appeals process will have the right to a hearing before an independent review organization. Patients already have that right in about 20 states, and it is afforded to all federal employees and Medicare beneficiaries enrolled in managed care plans. It is also included in the Patient's Bill of Rights legislation being considered by Congress.

The draft also stipulates that members who are currently under an active course of treatment, such as new mothers, pregnant women, or patients receiving chemotherapy, would be allowed to continue seeing their physician for up to 90 days after the physician leaves the health plan. ▼

Feeding tubes are significant infection source, data show

Patients are at increased risk of acquiring infections with *Clostridium difficile* if they receive tube feedings, say researchers at the University of Minnesota School of Nursing in Minneapolis who compared those patients' data to that of patients not tube-fed.[1]

Investigators compared 76 tube-fed patients with 76 non-tube-fed patients at a Veterans Affairs Medical Center in Chicago. They found that those who were tube-fed acquired infection

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significantly more often (15 out of 76, or 20%) than those who weren't (6 out of 76, or 8%). The proportion of patients who developed *C. difficile*-associated diarrhea was also greater among tube-fed patients. The research team examined the connection between the location of the feeding-tube tip and the development of infection and found that postpyloric tube placement was a risk factor. The researchers speculated that food delivery below the gastric acid barrier may facilitate the introduction and survival of *C. difficile* organisms.

Comparable numbers of both tube-fed and non-tube-fed patients had been on antibiotic regimens, especially third-generation cephalosporins and aminoglycosides, according to the report.

Reference

1. Bliss DZ, Johnson S, Savik K, et al. Acquisition of *Clostridium difficile* and *Clostridium difficile*-associated diarrhea in hospitalized patients receiving tube feeding. *Ann Intern Med* 1998; 129:1,012-1,019. ▼

Hospital costs reported higher for older asthma patients

Asthma patients over 45 are at greater risk of hospitalization than younger asthma patients, and their average costs per hospital stay are higher as well, according to a recent study report.[1]

The one-year study tracked 3,223 asthma patients who sought care in emergency departments at 27 different hospitals. Thirty-three percent of the patients were hospitalized, with an average length of stay of 3.8 days. For patients aged 18 to 45, the hospitalization rate was 28.8%. Among patients older than 45, the rate was 42.3%. The average cost per hospital stay for younger patients was $3,102, compared to $3,601 for the older group. Three areas accounted for a majority of the cost of acute care for the entire group of asthma patients: nursing care (43.6% of total costs), respiratory therapy (13.6%), and medication (10.4%).

The study authors wrote that because most of the inpatient costs of treating asthma are unavoidable, the most effective cost reduction strategy would be to target older asthma sufferers for prevention efforts aimed at reducing the rate of hospitalization.

Reference

1. Stanford R, McLaughlin T, Okamoto LJ. The cost of asthma in the emergency department and hospital. *Am J Respir Crit Care Med* 1999; 160:211-215. ■

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. ■