AMERICAN HEALTH CONSULTANTS®

HOSPITAL CASE MANAGEMENT™

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

IN THIS ISSUE

NOVEMBER 1999

VOL. 7, NO. 11 (pages 185-200)

American Health Consultants® is A Medical Economics Company

Benchmarking Tools

Benchmark for success: A good data source is a case manager's best friend

Compare and connect your data to other departments and the community

Gaining access to accurate benchmarking data is the bread and butter of your case management program. Case managers need good, timely numbers to justify length of stay (LOS) targets and discharge plans.

"The path to a successful, strong case management department is a really good data source," says **Sandra Sperry**, RN, MPA, senior vice president of clinical resources at Sisters of Charity Health Care System in Staten Island, NY. "Database decisionmaking simply makes sense as you move forward. And, in terms of our own performance standards evolution, we can look at where we are as compared to our competitors and other benchmarks and see how our practices are reflected in the community." For example, Sisters of Charity can link congestive heart failure (CHF) or asthma benchmarks within the state, benchmarks external to New York, and the system's own internal performance — physician to physician and program to program — and see where opportunities for improvement are.

For about $30,000 a year, your facility can acquire an enormous database that is updated regularly and decision-support software to go with it. Training in use of the software takes less than a day, according to most company representatives. For much less, you can order individually tailored reports by subscription. Consider taking a look at a few software programs that evaluate your facility's internal practice patterns and costs, identify areas for improvement, and compare them to those of competitors, in-state and beyond.

Purchasing comparative analysis software is a call most likely made by the CEO, CFO, or financial department of your institution. "A major purchase like this would have to go through a capital proposal process at my facility," says **Debbie Caskey**, RN, administrative director of

cardiovascular services for The Jewish Health System in Cincinnati. "First, we'd do a financial analysis and a cost-to-benefit study, then present it to the financial department. We'd have to demonstrate the benefit of the decision-support system over what we could generate ourselves."

Get your hospital's director of finance or CFO on your side, recommends **Kathy Fox**, MSN, RN, cardiac service line director for St. Francis Hospital & Health Centers in Beech Grove, IN. Preview what's out there by calling at least three vendors and asking them to come to your facility to demonstrate their products, first to you, then to the financial entities who would approve the purchase. "Then," says Fox, "at your next planning or operations council meeting, present the concept. Wait a week, then discuss your proposal in detail. Be armed with specific information on what the products do and what they cost."

Sisters of Charity uses benchmarking data supplied by HealthShare Technology, based in Acton, MA. The facility leases the software, and data are updated every six months.

Statewide database proves useful

"Their product lets us access the SPARCS [Statewide Planning and Research Cooperative System], the database for New York state, and manipulate it to our needs," says Sperry. "We can look at utilization detail by physician or by diagnosis." Each health care organization in New York state is required to submit clinical and financial data to the state, including line-by-line detail on each patient. When accessing SPARCS, you can look at an individual case, but you cannot identify that case by name, number, or social security number. "But I can pull up on my screen a listing of every case in the state over any time frame and build my own data sets from that to help me run focused queries and report on a whole range of variables," says Sperry.

She says physician profiles are essential for critical pathway efforts. "We completed a report on total knee replacement last year. That should have been pretty straightforward from a case management standpoint, but there turned out to be some significant variations in terms of length of stay, cost, and how we delivered care within our own sample from one physician to another." She says her information was "pretty soft and anecdotal" until her facility had access to the database. "Now," she says, "I can substantiate my information by graphs and hard data on how our staff is doing in and among themselves as well as how they look against some of our competitors." She can also benchmark their data against facilities that are optimal performers. "That's pretty strong stuff," says Sperry, "and it's not anything physicians have had access to before we got this program."

One factor identified through the studies component of Sisters of Charity's total knee report was that approximately half of those cases are having dopplers done. "You can get down to detail on X-rays or lab tests," says Sperry, "and I saw the timing of the dopplers, how they were facilitated, and what needs criteria were met."

Physicians look at most data with some degree of suspicion, she says, especially when statistics are not as up-to-date as they should be or are not severity-adjusted. "Nothing is more powerful than having solid timely information and data to help clinicians look at opportunities for improvement and start to shift behavior," she continues. "It's the best kind of feedback."

Sperry says her facility has seen a significant change in physician response to the information. "The industry is moving forward so fast. Anything I used to take to the physicians was probably three years old, and I got a 'been there, done that' kind of response," Sperry says. The data provided by her decision-support software are current — within six months to a year — and severity-adjusted. You can ask your own questions, then reformat them to delve deeper for different levels of detail.

Sperry says she had a request about a year ago from a general surgeon who wanted to know about Sisters of Charity's patient base — who they are, where they go for care, and what diagnostic categories they fall into. He also wanted to know how Sisters of Charity compares to other facilities.

"That level of information has not been available to physician leaders or individual practitioners until now," says Sperry. "Physicians are scientifically trained — they do very well when you give them good, hard information. They also do very well when you're honest with them about the limitations of information." She says your credibility with a group of physicians takes huge strides forward when you are honest with them.

"I think one of the classic mistakes we make is to overestimate the accuracy of our data," says Sperry. "Every database, including New York State's, has flaws, and you have to be responsible and know and disclose the limits of your database.

Benchmarking Tools

Do-it-yourself method: Penny-wise, pound-foolish

Hiring a consultant can cost more in the long run

If you're looking for essential benchmarking information, why not just buy the information from your state for a couple of thousand dollars each year? Hospitals in 30 states are required to regularly report data to their states.

"The issue for case managers is not the cost of the data," explains **Richard B. Siegrist Jr.**, CEO of HealthShare Technology in Acton, MA. "It's the cost of doing something with it. If a hospital attempts to get this job done by itself, it has to involve the facility's [information systems] department and develop a query system. It could end up costing a hospital five times as much as leasing or buying decision-support software. That's not a cost-effective way to go."

The advantage of a decision-support program is that the programmers clean up the data, make it user-friendly, and provide solid cost information. In addition, your state will only have information from facilities in your state; companies like HealthShare, HCIA in Baltimore, and others provide data from other states, usually for an extra fee.

Would it save money to buy data from the state, then hire a consultant to mold it into meaningful information? Hiring a consultant often costs more in the long run, and results can be much less effective.

"Consultants are expensive and often never get a good grasp of what's going on," says **Debbie Caskey**, RN, administrative director of cardiovascular services for The Jewish Health System in Cincinnati. "Sometimes you spend as much time educating them as if you were mining the data yourself." At the end of the day, they make their recommendations and go away, leaving the institution to deal with reality, she says.

The decision-support software that's available today can compile and analyze in a few minutes what once took a consultant days or weeks to do. "We've done it both ways," says Caskey. She explains that when an institution is having a difficult time with physician buy-in, it's sometimes more effective to have a third party, like a consultant, present the data. After that stage, the physicians are convinced the data are valid, and a computer decision-support program becomes valuable.

For more information, contact the following:

Richard B. Siegrist Jr., CEO, HealthShare Technology, Acton, MA. Telephone: (508) 263-6300.

Debra Caskey, RN, administrative director, cardiovascular services, The Jewish Health System, Cincinnati. Telephone: (513) 891-8159. ■

Once you do that, you can go ahead and develop strong reports."

Sperry's role at Sisters of Charity is to look at the clinical integration of the facility, as well as cost containment and performance improvement. "What I'm really looking at is how we are making this delivery system function as a vehicle for true continuum of care," she says. "We have all the pieces, but we need to make those pieces work more efficiently. Our physicians need to be able to manage the forest *and* the trees simultaneously. They need to relate their individual practices to the global picture."

Sperry says if you expect physicians to make global, far-reaching decisions, you have to give them timely, meaningful information that supports those kinds of decisions. "That's been a significant dichotomy for hospitals, looking at old data and not being clear on its limitations."

She says for a long time, hospitals defined power bases based on the control of information. Clinicians had the clinical data, while the finance department had all the numbers. "You never sat around one table and discussed those matters together," says Sperry. "It's essential to do that."

She takes information from Sisters of Charity's internal clinical and financial information systems and compares it to historical performance from years back. "With those data, I can draw a good picture for the physicians."

She points out that to implement a successful case management program, you must feed data back to all levels involved in the process. "Clinical integration programs are a significant and critical factor in stakeholder management. If you want people to participate, they've really got to have a sense of getting immediate feedback — particularly physicians."

McKenzie-Willamette Hospital in Springfield, OR, often sees multiple diagnoses in its largely senior population, and those patients' care usually is complex. "In the geriatric population, typically more than one body system is in jeopardy," says **Ruth Danos**, RN, CPUR, the utilization review (UR) coordinator at McKenzie. "Average lengths of stay are not easily determined because comorbidities influence the primary diagnoses."

Benchmarks in that facility have to be realistic and timely, and they have to reflect the complexity of the patient population.

Danos' facility uses Baltimore-based HCIA's *Length of Stay* benchmarking tool, in conjunction with the InterQual Clinical Decision Support Criteria (McKessonHBOC, Marlborough, MA). HCIA's product addresses the illness complexity of patients with multiple diagnoses. The benchmarks are based on all-payer data gathered from inpatient records that represent one-third of the annual discharges from U.S. hospitals. Broken out into five age groups, the LOS ranges are represented as percentiles so the user can determine a more or less aggressive LOS, depending on individual variables.

Using criteria across the continuum

InterQual's criteria enable the user to determine the appropriateness of admission, continued services, and discharge across the continuum of care. The criteria use clinical indicators to determine the proper level of care, based on the patients' severity of illness and intensity of service requirements.

"We look for the 50th percentile in HCIA's data and use that as a standard anticipated LOS if things go well," says Danos. McKenzie runs its HCIA / InterQual reviews on-line.

The staff use HCIA LOS data and InterQual criteria only as guidelines; clinical judgment is required to come up with appropriate care. "Our nurses don't use just HCIA or InterQual in their decision-making," Danos says. "Those systems depend on their clinical judgment as well." And when the RN sees a need for help on a very complex case, it can be taken to the medical director, who reviews the situation and makes a judgment call on what action needs to be taken. "Those are the train wreck cases," says Danos. But the majority of patients can be managed using a nurse's clinical judgment along with HCIA and InterQual.

Community Memorial Hospital in Ventura, CA, also uses the electronic version of HCIA LOS data in conjunction with InterQual criteria. **Carol Levy**, RN, MS, manager of UR and social services there, says InterQual has been around for about 20 to 30 years as a provider of criteria for admission, continued stay, and discharge. But now that all this information is in an automated format, Community Memorial purchased a license to use HCIA as well to fit in with InterQual's information.

"I was looking for standardized guidelines for our nurses as they do their rounds," says Levy. "They can enter an ICD-9 code and pull up the LOS by patient comorbidity, sex, and age. Then they don't have to review that chart for a few days — not until the day before the LOS is up."

She says it is only in the past few years that managed care has made inroads into her part of California, meaning hospitals haven't taken a close look at their data as they compare to other hospitals until recently.

"The HCIA data is a means of comparing ourselves against someone else," Levy says. "It's a yardstick. If another hospital keeps its CABG patients five days, and our patients stay an average of six, I want to know why. I benchmark against the Western region and the 50th percentile," she says. "That way, I can disregard all the outliers. It gives me an idea of what a patient's LOS should be simply by knowing his ICD-9 code or diagnosis and the LOS of other patients within that diagnosis and age group. I don't have to know anything else about the patient."

Community Memorial purchased the electronic version of the HCIA and InterQual programs so staff at the facility could generate reports based on diagnostic code, physician code, and reviewer code. "That information helps me, for example, to have some support for whatever anecdotal evidence I may have on which physicians are keeping patients longer than others," says Levy. It also allows her to look at inter-reviewer reliability.

"I have to make sure all of my nurse case managers are using the same set of criteria to determine whether an admission, a stay, or a discharge is appropriate," says Levy. InterQual's program allows the case manager to go in and pull up a set of intensive service or severity of illness measures and click on the ones that are appropriate. "That makes it easy for them," says Levy.

Benchmarking Tools

Check out these sources of decision-support systems

The following companies are among many that produce decision-support systems:

Care Management Science Corp.
CaduCIS
3600 Market St.
6th Floor
Philadelphia, PA 19104
(215) 387-9401

HCIA Inc.
300 East Lombard St.
Baltimore, MD 21202
(800) 568-3282
www.hcia.com

HealthShare Technology Inc.
360 Massachusetts Ave.
Acton, MA 01720-3700
(978) 263-6300
www.healthshare.com

Landacorp
4151 Dunwoody Road
Suite 505
Atlanta, GA 30319
(404) 531-9956
www.landacorp.com

McKessonHBOC InterQual Products Group
293 Boston Post Road West
Marlborough, MA 01752
(800) 582-1738
www.interqual.com

Market Insights
1000 Brannan St.
Suite 2110
San Francisco, CA 94103
(415) 553-8888

Milliman & Robertson Inc.
1301 Fifth Ave.
Suite 3800
Seattle, WA 98101
(206) 504-5536
www.milliman-hmg.com

Per-Se Technologies Inc.
2700 Cumberland Parkway
Suite 300
Atlanta, GA 30339
(770) 444-4000
www.per-se.com

State hospital associations and the federal Agency for Health Care Policy and Research in Rockville, MD, also collect public information that can be used in making comparisons of the use and cost of health care services.

Agency for Health Care Policy and Research
Executive Office Center, Suite 600
2101 East Jefferson St.
Rockville, MD 20852
(301) 594-6662
www.ahcpr.gov
info@ahcpr.gov

Community Memorial is licensed for 242 beds, and Levy supervises a staff of eight and a half full-time employees.

Levy says the MediCal LOS for CHF with no comorbidities is five days. "There's no good way to account for comorbidities using MediCal data," Levy says. "When you enter the ICD-9 code, you come up with one condition." She says HCIA data are a little better because they allow the user to factor in complexities, but "it's not perfect. It doesn't say which comorbidities or how many."

InterQual gives specific information, such as admission criteria for a cardiac patient going into a CCU. "The InterQual criteria give thresholds — parameters to determine whether a patient is sick enough, from their perspective, to be admitted," says Levy. The criteria are guidelines, and not meant to define medical practice.

"InterQual and HCIA represent a sizable investment," says Levy. Community Memorial uses two sets of InterQual criteria — adult and pediatrics — and the company charges a per-bed licensing fee. "We pay $3,500 per year for the license to use the information. HCIA also charges based on the number of beds in your facility; we pay between $600 and $700 a year."

For more information, contact the following sources quoted in this article:

Sandra Sperry, RN, MPA, senior vice president, clinical resources, Sisters of Charity Health Care System, Staten Island, NY. Telephone: (718) 354-5515.

Debra Caskey, RN, administrative director, cardiovascular services, The Jewish Health System, Cincinnati. Telephone: (513) 891-8159.

Kathy Fox, MSN, RN, cardiac service line director, St. Francis Hospital & Health Centers, Beech Grove, IN. Telephone: (317) 783-8367.

Ruth Danos, RN, CPUR, utilization review coordinator, McKenzie-Willamette Hospital, Springfield, OR. Telephone: (541) 726-4504.

Carol Levy, RN, MS, manager, utilization review and social services, Community Memorial Hospital, Ventura, CA. Telephone: (805) 652-5010. ■

CM models cut cesarean rates and preterm births

Two hospitals monitor high-risk moms-to-be

Lawrence General Hospital in Lawrence, MA, and Community Memorial Hospital in Menomonee Falls, WI, ran innovative case management projects recently that resulted in outstanding improvements. Both facilities initiated new models of care that targeted maternity care. They were focused on lowering cesarean section rates and improving access to care in the first trimester to reduce preterm births.

Some initial findings were common to both Lawrence General's and Community Memorial's projects:

• When pregnant women receive early prenatal care and concomitant screening for risk factors, preterm births are reduced. That's where the case manager comes in. She follows high-risk patients and provides education so the mother-to-be can be on the alert for signs and symptoms of early labor. One way to identify pregnant women early so their monitoring begins early is to institute systematic follow-up procedures after a positive pregnancy test. Once contacted, the women can be referred to a case manager or prenatal care coordinator, who can then screen for risk factors. The case manager keeps in close contact with the women and their clinicians.

Getting patients more involved

• When women with modifiable risk factors such as smoking and substance abuse can be identified early in the pregnancy, they can be recruited into cessation programs, reducing preterm labor.

• With education, patients can be encouraged to take an active role in their own care. This is accomplished by using creative coaching strategies designed to influence how patients manage their daily needs.

• When physicians become involved in making decisions regarding change, such as determining when to perform a cesarean, rates go down. Peer-to-peer communication should be encouraged, and ongoing performance data feedback, both individual and aggregate, should be provided.

• When nurses play an active support role during labor, the time a woman is in labor is lengthened, sometimes allowing a vaginal birth.

• When mothers-to-be are educated about vaginal birth after cesarean (VBAC) and the choices open to them, VBACs tend to increase.

• There should be guidelines for the diagnosis and management of preterm labor.

Susan Leavitt, RNC, BSN, is now director of the maternity center and labor and delivery at Elliot Hospital in Manchester, NH, but at the time of Lawrence's improvement project, she was nurse case manager and clinical coordinator of labor and delivery at 180-bed Lawrence, which is affiliated with Tufts Medical School. In May of 1995, Lawrence joined with other hospitals, including Community Memorial, to participate in the Institute for Healthcare Improvement's (IHI) Breakthrough Series on cesarean reduction.

"Initially, this was a hospital effort," says Leavitt. "We'd been looking at our cesarean rates on a departmental level for a few years, but with no success. Then we joined with 28 other hospitals in IHI's national project to do this in a year." Using an interdisciplinary approach including mother-to-be, physician, and nursing staff, they reinforced the expectation of a vaginal birth by providing support to help the patient learn to tolerate labor.

"We did achieve good results," says Leavitt. "We changed a lot of patient care practices that had been going on here for a long time." The team accomplished five major changes to their regular procedures:

1. With the participation of physicians, they developed and implemented guidelines to prevent admissions for false labor. They now do not admit patients until they are actively in labor.

2. They encouraged walking during labor by reducing unnecessary fetal monitoring and IV lines.

3. They increased pain management through support and pharmaceuticals.

4. They encouraged nurses to support patients more. The role of the nurses changed and they were empowered to take ownership of patients and their care.

5. They educated women about VBACs at 20 to 24 weeks (formerly, that information was given at 30 to 36 weeks). They also educated physicians about appropriate indications for VBAC.

(Continued on page 195)

CRITICAL PATH NETWORK™

DVT/PE path: Specific, detailed, and effective

Duke University Medical Center in Durham, NC, developed its inpatient clinical path for the treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) late last year. "It's been up and running almost a year," says **Lori H. Postal**, RNC, MS, the facilitator in the department of disease management at Duke. Like paths used at other facilities, Duke's DVT path is an outline that addresses patients' care each day of their stay, from preadmission through discharge and follow-up care. Like others, it streamlines and provides a coordinated approach to care. That's where the similarities end, though.

"What's different about our path," she says, "is that it is more specific than those used by other facilities. The dosages and frequency of treatment are very precise. Many of the other paths I've benchmarked with are not as specific as ours, especially relating to medication and antibiotics." The physician order set is a companion to Postal's work product, and contains orders exactly as they are written on the path. The doctor checks what he or she wants. "If it's checked," she says, "it's ordered. If not, it's not done." This allows individualization for each patient. Other parts of the clinical path include a patient version of the path, outcome and documentation forms, and an education record.

Hospital Case Management asked Postal if any physicians balked at her pathway due to a belief that it represented cookbook medicine. "Very few," she answers. "We've had good buy-in. The majority think this is good and go on to use it as a teaching tool for their house staff and residents.

"The care of 80% of patients is fairly routine, and physicians feel that they should be spending 80% of their time on the remaining 20% of patients that have complex needs," she explains. Formatting her path in template fashion allows physicians to check off the routine tasks, and "that saves them quite a bit of time," she says. "Then they can spend the majority of their time thinking about their complicated cases or aspects of their patients' care that is more complicated."

The average length of stay (LOS) at Duke for DVT/PE is running 2% under the disease management department's target of four to five days. "Considering that our path is brand new," says Postal, "we are pleased. On average, patients stay 4.9 days in the hospital now." Her department benchmarks internally against the population they had prior to the path being implemented as well as against other similar institutions with similar populations — large teaching institutions in metropolitan areas.

Before patients with suspected DVT undergo an ultrasound, their diagnosis considers:

- swelling;
- pain;
- risk factors — stasis, injury to vein, hypercoagulability;
- (if low risk for bleeding) baseline labs — prothrombin time (PT), partial prothrombin time (PTT), automated blood count (ABC), chemistries (ChemCS).

A negative ultrasound is followed by a repeat ultrasound in five to seven days or an MRI or venogram if calf DVT is suspected or patient has persistent symptoms. If results are still negative, no treatment is given.

Then care is driven by an algorithm in conjunction with clinical judgment.

Before patients with suspected PE undergo a lung ventilation and perfusion (VQ) scan or spiral

(Continued on page 194)

DUKE UNIVERSITY MEDICAL CENTER CLINICAL PATH FOR:
DEEP VEIN THROMBOSIS/PULMONARY EMBOLISM (Adult)
M040-CO
12/98 Goal: Out-patient management of uncomplicated DVT
LOS for in-patients: Uncomplicated DVT as a primary or secondary diagnosis 4-5 days
PE as a primary or secondary diagnosis 8-9 days
Inclusion Criteria: Adult patients with confirmed deep vein thrombosis or pulmonary embolus
Exclusion Criteria: Pregnant patients or those on research protocols
DRG# 128, 130 ICD-9 CM: 451.1, 451.19, 451.81, 451.84, 451.89, 453.8, 453.9, 415.11, 415.19
Date Initiated: _____ **Date Discharged:** _____ **Date Discontinued from Path:** _____
☐ **See new Path:** _____ **(name)** ☐ **See new Plan of Care M052B**
Order sets need to accompany the Clinical Path and must be signed prior to implementation. There is room for individualization of patient care within the order sets and clinical path.
Pre-printed forms do not preclude clinical judgment. **IF modifications are made: cross out text with single line using black ink, initial, date & time; full name and signature at the bottom.**

ADDRESSOGRAPH

Advance Directives:
☐ Deferred ☐ Resolution of Deferral _____ Date/Time ____/____ ☐ Waiting for a copy ☐ Copy now on chart _____ Date/Time ____/____

Clinical Path	Day of Diagnosis - Day 1 NOTE: CARE IS DRIVEN BY ALGORITHMS ATTACHED IN CONJUNCTION WITH CLINICAL JUDGEMENT	Day 2	Day 3 through Day of Discharge
Consults	Pulmonary prn Coagulation prn Vascular radiology for vena cava filter prn MICU prn Social worker/discharge planner Case Manager Pharmacy prn		
Laboratory Tests	ABC, PT/PTT, Chem CS prior to therapy PTT q 6 h **if on heparin** until PTT is therapeutic Thrombosis panel prn ABG's when PE diagnosed	Daily PT/PTT after therapeutic level has been reached **if on heparin.** **PTT is <u>not necessary</u> if the patient is receiving enoxaparin** Daily PT while on warfarin ABC, Chem C/S prn ABG prn	Daily PT/PTT after therapeutic level has been reached and only if on heparin. **PTT is <u>not necessary</u> if the patient is receiving enoxaparin** Daily PT while on warfarin ABC, Chem C/S on day 5

Source: Duke University Medical Center, Durham, NC.

Diagnostic Tests	**See Diagnosis Algorithm** Ultrasound, venogram or MRI if DVT suspected Chest x-ray and EKG if PE suspected VQ Scan or Spiral CT if PE suspected Pulmonary arteriogram prn		
Treatments	Vital signs q 4 h, q 1 h in ICU Oxygen prn Oximetry	Vital signs q 8 h, q 1 h in ICU Oxygen prn Oximetry	Vital signs q 8 h Oxygen prn Oximetry
Medications	TPA/Streptokinase/Urokinase prn **or** Heparin by nomogram Coumadin 5 mg po QD. Begin when PTT is therapeutic and adjust per nomogram **or** Enoxaparin 1 mg/kg sq Q12 h Coumadin 5 mg po QD. Begin when at least 12 hours have elapsed since first dose of enoxaparin Docusate Sodium 100 mg PO BID Mylanta II 15 cc PO q 4 h prn Acetaminophen 650 mg PO q 4 h prn	Enoxaparin 1mg/kg Q12H or Heparin by nomogram D/C heparin/enoxaparin when INR is in therapeutic range for 2 days Coumadin by nomogram Docusate Sodium 100 mg PO BID Mylanta II 15 cc PO q 4 h prn Acetaminophen 650 mg PO q 4 h prn	Enoxaparin 1mg/kg Q12H or Heparin by nomogram D/C heparin/enoxaparin when INR is in therapeutic range for 2 days Coumadin by nomogram Docusate 100 mg PO BID Mylanta II 15 cc PO q 4 h prn Acetaminophen 650 mg PO q 4 h prn
Diet	Low Vitamin K diet	Low Vitamin K diet	Low Vitamin K diet
Activity	Strict bedrest in ICU. Bedside commode may be ordered Bedrest with bathroom privileges on intermediate care units	Ambulate as tolerated	Ambulate as tolerated
Teaching	Plan of Care Diagnostic tests and medications Home administration of enoxaparin or heparin prn Follow up lab testing Signs and symptoms of bleeding or recurrent thrombosis	Home administration of enoxaparin or heparin prn Medications and drug interactions Follow up lab testing Signs and symptoms of bleeding or recurrent thrombosis	Follow up lab testing Follow up care
Continuum of Care	Patient to be discharged as soon as stable with appropriate follow up and home health referral if indicated	Home Health referral if indicated	

Initial	Signature/Title	ID#

Initial	Signature/Title	ID#

Source: Duke University Medical Center, Durham, NC.

(Continued from page 191)

CT, their diagnosis considers:

- shortness of breath, hypoxemia, chest pain;
- risk factors — stasis, injury to vein, hypercoagulability;
- chest X-ray;
- (if low risk for bleeding) baseline labs — PT, PTT, ABC, ChemCS.

A VQ scan is preferred if there is a history of previous PE and a previous VQ scan was done or if creatinine is elevated. A spiral CT may be appropriate if a non-embolic cause of abnormality is suspected or if other underlying lung or pleural pathology is present or suspected.

Thrombolysis in any case is handled medically by enoxaparin, warfarin, and/or heparin, according to Duke's path. "Some patients may have a vena cava filter inserted," says Postal, "but the management is mostly medical." ■

Outpatient treatment cuts LOS from days to hours

As of September, nine patients have been screened and identified as potential candidates for outpatient management in the outpatient program for uncomplicated DVT/PE begun about six months ago by Duke University Medical Center in Durham, NC. The program is still in its pilot phase.

"When DVT/PE patients are treated as outpatients, their lengths of stay can be cut from 4.9 days to 12 to 24 hours," says **Lori H. Postal**, RNC, MS, facilitator in the department of disease management at Duke. The staff is monitoring the cost and quality outcomes of those cases before rolling the program out to the whole institution. Among the indicators they are looking at are ease of obtaining meds, complications, and managing the nomograms of warfarin as an outpatient.

"We're excited about our outpatient program," says Postal. "Some patients still prefer to be admitted, but most patients prefer to be at home with self-administration of their meds or with home care." If a patient opts for self-management, he or she is instructed to self-administer two injections of enoxaparin, one at 8 a.m. and one 8 p.m., and then to go to an anticoagulation clinic to give a blood specimen for an INR test. The patient is then given instructions on how to take his or her warfarin. The patient is referred to a dedicated pager number to use if there are any signs of bleeding, such as vomiting blood, blood in the urine, or black stools.

If a patient requires home health management, a nurse administers the morning and evening shots of enoxaparin and draws blood. The nurse contacts the doctor to determine the daily dose of warfarin and is available if there are signs of bleeding.

A patient is eligible for the program only if he or she does not have:

- a history of two or more episodes of DVT or PE;
- presence of current active bleeding process, active peptic ulcer disease, or familial bleeding disorders;
- concurrent symptomatic pulmonary embolism;
- inability to receive outpatient enoxaparin because of associated comorbid conditions;
- potential for noncompliance — mental confusion, inability to care for self, poor vision, no support;
- inability to attend follow-up visits or obtain home care because of geographic inaccessibility;
- known history of an inherited hypercoagulable disorder;
- history of cerebral vascular accident known to be hemorrhagic;
- recent surgery within one week (potential for bleed);
- recent trauma within two weeks (potential for bleed);
- severe uncontrolled hypertension — SBP > 180 or DBP > 110;
- renal failure (SCr > 2.0 mg/dl) and/or hepatic failure.

Pregnant or lactating women and women of childbearing potential who are not covered by a medically recognized contraceptive method are also ineligible.

For more information, contact Lori H. Postal, RNC, MS, facilitator, department of disease management, Duke University Medical Center, Durham, NC. Telephone: (919) 416-5216. ■

(Continued from page 190)

Educational inservice training was performed on an ongoing basis. Gains that were accomplished were reviewed monthly and continually recognized and celebrated.

"What made this project work," says Leavitt, "was that the vice president of nursing, the chief of obstetrics, and I met four times a year at a site away from the hospital. The facility allocated significant resources for those trips, and that gave us time away when we could concentrate on planning the initiative." She says a larger quality improvement committee then met to work on the project.

Planning legwork done in weekly meetings

"We met weekly for six months at the hospital," says Leavitt. "For each session, we had goals to accomplish, such as changing policies and educating people about the changes. It was good that we met weekly rather than waiting for monthly department meetings to take on the project, because we were able to do a lot of the legwork during those sessions." Everything was done by the time the monthly meetings rolled around, and all those participants had to do was agree on issues.

"It was quite a different process than we were used to," Leavitt says. Her team utilized IHI's rapid PDSA (plan-do-study-act) cycle. She says all the concepts they were working on had already been backed up with research in the literature. "But they hadn't been implemented in most obstetrics departments," she says. "Since they had already been documented, we implemented the concepts in the units, brought people on board, and educated patients, staff, and physicians." Leavitt says Lawrence's project has been copied in other facilities across the country.

She says case management has a major role in the application of research to reality. "Getting facilities to be proactive in patient treatment is an important part of case management. We have to educate these patients so they know they have options like VBACs and vaginal deliveries *instead* of cesareans."

In 1993, 153-bed Community Memorial Hospital, near Milwaukee, developed a prenatal case management program called "Right from the Start." *Hospital Case Management* asked **Kathy Seamandel**, RN, a case manager in the obstetrics unit of Community Memorial, what the case managers' role was in the prenatal project. "One of our roles was educating the patient about risks of repeat cesarean — risks of surgery rather than vaginal delivery," she explains. The case managers had an integral role and worked closely with the physicians and staff nurses. The case managers perform the following functions:

- contact women with first pregnancies, previous cesareans, referrals from the physicians, or other high-risk factors and actually assess every pregnant woman (all low-risk women who have had a previous delivery are sent a self-assessment tool; those who have risk factors are reassessed with a phone call);
- make referrals to social service agencies;
- contact women one month prior to their due date to assess, do pain evaluation, and review labor support;
- review each case during the postpartum hospitalization and prepare for discharge;
- call the new mother at home within 48 hours of discharge.

Cesarean rate falls in program's first year

"Our hospital was very successful in reducing our cesarean rate," says **Alice Maki**, RN, director of obstetrics and women's health at Community Memorial. The facility's cesarean rate had been 14.4% in 1994. Within a year, it was reduced to 9%; in 1998 it went up to 10.2%. "We all think those rates went back up a bit due to the fact that there had been some information in the consumer media regarding VBACs and how they may not be as safe as thought in the past," says Seamandel. "I've never seen evidence of it here, but patients have the right to accept or decline VBACs."

In conjunction with its Right from the Start program, Community Memorial also became involved in IHI's first collaborative for reduction of cesareans in 1995. "It was a wonderful experience," says Maki. "Our prenatal project and the IHI project seemed to be made to go together."

Seamandel says there were 11 staff nurses who acted as case managers between 1993 and 1995. "Then we revised the program because we weren't meeting our goals of getting patients called in a timely manner," she says. "In 1995, three of us became exclusively case managers. That way, we can devote our time to the high-risk patients."

For the IHI collaborative, a team comprising physicians, nurses, and a quality assurance specialist focused on two high-risk groups: women

Perception, not LOS, may influence satisfaction

New moms judge care by perceived adequacy

The days of "drive-through deliveries" — discharging women within 24 hours of giving birth — are over, ever since 1996 legislation required that insurers cover a postpartum length of stay (LOS) of up to 48 hours for an uncomplicated delivery. But how satisfied are women with their stay, regardless of its length?

Researchers supported by the Agency for Health Care Policy and Research in Silver Spring, MD, looked into that question and administered a post-discharge survey to 15,000 women admitted for labor and delivery to 18 hospitals over a three-year period. They found that a woman's *perception* of the adequacy of her hospital stay, not the actual LOS, affects her satisfaction with care.[1] Satisfaction scores were higher for patients who felt their stay was "just right" and lower among those who perceived it as being " too short" or "too long."

Patients who perceived their stays as inadequate or unnecessary reported that they were dissatisfied with six aspects of their care:

- physician care;
- nursing care;
- provision of information;
- preparation for discharge;
- overall assessment of care;
- willingness to return to the hospital.

Women who had vaginal deliveries and stayed one day were less apt to say their stay was adequate. Those who stayed two days or longer perceived better care. Women who stayed for two or three days following cesarean deliveries were less happy with their care than those who stayed four or more days.

Reference

1. Finkelstein BS, Harper DL, Rosenthal GE. Does length of hospital stay during labor and delivery influence patient satisfaction? Results from a regional study. *American Journal of Managed Care* 1998; 4:1,701-1,708. ■

with a history of cesareans and women with dystocia. Physicians and nurses used evidence-based research and practice in providing medical and nursing care.

Now physicians send a woman's clinical history and physical at 16 weeks to the case managers with an indication of any high-risk factors. Their office staffs distribute binders with descriptions of the care program. "Our patients are very compliant," says Maki. "They bring that binder with them to prenatal education classes and to the hospital when they come in to give birth."

She says, "When we started looking at cesarean reduction in 1993, we were looking at 24-hour inpatient care for OB patients. Nationwide, the standard had gone from 48-to-72-hour lengths of stay [LOS] to 24 hours." (The 24-hour LOS after birth has now reverted to 48 hours nationwide.)

"But we knew there was no way we could send mothers out of the hospital prepared for their new parenting experience within 24 hours of their birth," Maki continues, "so a group of nurses and case managers sat down and brainstormed. It took us nine months to implement the prenatal continuum of care program." They decided that all patients needed to be assessed prior to coming to the hospital for their baby. Case managers now develop the plan of care while patients are still pregnant. When the mothers-to-be come to the hospital, the labor and delivery nurses have a care plan developed by the case manager and the patient at their fingertips.

"When the labor and delivery nurses have a patient in active labor, they know everything about her, including what *her* wishes are," says Maki. The case managers developed a pain assessment tool, and they talk with each patient about the types of pain she has experienced and what she expects her childbirth to be like.

"We needed a great deal of cooperation from the physicians' offices to do those prenatal assessments," she says. "We have two large multispecialty clinics nearby the hospital, and those physicians nearly all practice at our hospital. So we have good cooperation with them and their office staffs." At 16 weeks of gestation, the physicians send the case managers all the clinical information they have collected on each of their patients. The case managers take over and do another complete assessment then, and again right before delivery.

Seamandel and Maki agree that a key to their program's success was the cooperation among

the physicians' office staffs, the labor and delivery staff, and the case managers, who all attended meetings and discussed new ideas. Community Memorial's orthopedics and gynecology departments have adapted ideas on prehospital assessment from obstetrics case management.

For more information, contact the following sources quoted in this article:

Susan Leavitt, RNC, BSN, director, maternity center and labor and delivery, Elliot Hospital, Manchester, NH. Telephone: (603) 669-5300.

Kathy Seamandel, RN, case manager, obstetrics unit, Community Memorial Hospital, Menomonee Falls, WI. Telephone: (414) 251-7766.

Alice Maki, RN, director, obstetrics and women's health, Community Memorial Hospital, Menomonee Falls, WI. Telephone: (414) 532-3502. ■

GUEST COLUMN

Arm yourself with data on your overall CM system

Don't underestimate performance measures' power

By **Patrice Spath**, ART
Brown-Spath & Associates
Forest Grove, OR

"How's it going?" How many times have you been asked that question about case management at your facility? Many of us answer the question in terms of what's happening with patients today. But can you answer that question for your overall program?

The case management department must have a performance measurement system that gives managers and staff the feedback they need to guide program decisions and future patient care activities. Without it, the facility and its staff are flying blind. Just knowing how you are doing today is important, but even more important is knowing what needs to be done to improve case management services in the future.

A performance measure is nothing more than a tool you can use to assess your performance in a particular area. Measurement is at the heart of a good, customer-focused case management system. Clearly, case managers need to measure the effect of their efforts on the facility's financial performance. However, most case management departments today find that they also need to assess several aspects of the process itself. The case management measurement system should cover at least the following areas:

- **Customers.** Measure case management performance against customer requirements. This requires that you ask internal and external customers what they want from the case managers. Once the customers' expectations are clear, measures can be developed to evaluate how well case managers are meeting these requirements. Measures of customer satisfaction are an important element of the case management measurement system.
- **Performance of work processes.** Case managers have specific tasks that must be performed in the course of doing their jobs. Performance measures can be used to evaluate timely completion of these tasks. Service quality can also be measured: Are case managers' notes sufficiently detailed to ensure effective communication with other caregivers? Cost performance, such as productivity and budget vs. expenditures, also can be measured.
- **Employee satisfaction.** Measures of staff morale, satisfaction with working conditions, and staff turnover can provide important information about the case management department.

Once you've chosen a comprehensive set of measures that relate to each of these aspects of the case management department, ask yourself, "Will these measures inspire case managers to do the right things?" In other words, will the measures help the case management department achieve the best results, both for today and for tomorrow?

Do not underestimate the power of your performance measures. Staff will take action to achieve what you, by the measure, have told them is important. In some cases, the action they take may surprise you. It may not be at all what you had intended. For example, by measuring the completeness of patient transfer forms, you are telling staff to be sure all required areas are filled in. The case manager's attention may be inadvertently diverted to ensuring all boxes are checked off rather than ensuring that the most pertinent information is recorded on the form.

Developing case management performance measures may seem easy at first, but many

departments have fallen into common traps that can be avoided. Following are two of the most common:

— **Using so many different performance measures that staff are overwhelmed with data collection and the department experiences excessive overhead costs.** Be sure to only collect data about relevant case management activities. This simply means don't measure things that are not important.

— **Developing performance measures that are complex and difficult to explain to others.** If your performance measures require a lot of explanation and definition, then collecting data and translating those data into actions becomes more difficult. When measures are easy to understand, it is clear when you chart your performance over time which direction is "good" and which direction is "bad." Also, simple measures have a stronger impact on the process and the people who are involved.

The best performance measures are those that are specific and targeted to the topic you want to know more about. For example, if you want to know how satisfied your customers are with case management services, a good measure would be direct feedback from customers. A poorer measure would be the number of customer complaints. While complaints may be something you can count, they are an indirect measure of customer satisfaction. As such, the results can be misleading.

Steps for selecting measures

To select performance measures for your case management department, start by identifying your customers and the outputs of your processes. Customers may include end-users of case management services (patients, other providers, payers) and process users (physicians, staff nurses, therapists). It may help to draw a flowchart to identify all the customers of case management.

Next, determine what each of the customer groups needs from case management. It is useful to meet with important customers, such as physicians, to discuss what they hope to gain from case management services and what their requirements are as customers of case management. Not only do these meetings provide you with valuable information for your performance measurement efforts; the discussions also can help in gaining customer buy-in.

You'll also begin to understand which of the many case management tasks are most important to customers. These key activities should be the focus of your process measures. For example, if patient families tell you that early involvement in discharge decisions is important to them, then develop a performance measure that can be used to evaluate how quickly families are contacted to discuss discharge plans. Your customers also may make good suggestions about how to measure how well you are meeting their needs.

Next, determine what you'll measure. Remember to focus case management performance measures on at least three areas: customers, work processes, and employee satisfaction. During this step, you may find that brainstorming is a particularly effective tool for identifying measures. Then, develop a data collection strategy by answering the following questions for each measure:

☐ What data elements are needed to create this measure?

☐ Are the data elements currently available? Where? Does a new data collection instrument need to be developed?

☐ Who is responsible for gathering the data and creating periodic reports of the results?

☐ What individual or group is responsible for evaluating the performance data and selecting appropriate actions?

When you have completed determining what to measure in the case management department, ask yourself:

☐ Do the performance measures make sense?

COMING IN FUTURE MONTHS

- Special two-part series on managing the patient with diabetes
- Don't waste dollars on a software system you can't use
- Social workers and case managers square off on discharge planning
- Reusing reprocessed devices: Safety issues
- Harris Poll on consumer attitudes about nursing

☐ Will the data provide a comprehensive picture of the department's performance? For example, have you adequately covered the needs of customers, important work processes and employees' attitudes?

☐ Do the measures reinforce desired behaviors? Will staff be working toward the right goals?

Once you are satisfied with the performance measures you've selected for the case management department, have them in place, and are gathering data, you can begin tracking your progress. Ideally, you'll use run charts to show how you're doing. A run chart is a graph with time along the "x" axis and your performance measurement data on the "y" axis. As you gather data over time and add it to the charts, you will begin to see a trend over time. The data will allow case managers and the facility's leaders to see how well the case management department is meeting the needs and requirements of its customers. Armed with this type of data, the next time someone asks, "How's it going?" you'll have some very powerful and meaningful results to share with them. ■

Hepatitis C study launched

Next year begins an eight-year, $28 million clinical trial to test antiviral drug treatments for patients infected with chronic hepatitis C virus (HCV). Government-funded researchers will set out to determine if long-term treatment can slow or prevent the progression of liver disease. The study will also provide information on the natural history of hepatitis C and help researchers identify factors that predict or correlate with liver damage caused by the virus.

For the study, researchers will recruit patients with the disease who have previously been treated with alpha interferon but who could not sustain reduced enzyme and virus levels. Recruitment is tentatively scheduled to begin in early 2000. The trials will begin at nine centers around the country: University of California, Irvine; University of Southern California, Los Angeles; University of Colorado Health Sciences Center, Denver; Massachusetts General Hospital, Boston; University of Massachusetts Medical School, Worcester; St. Louis University; University of Michigan, Ann Arbor; University of Texas Southwestern Medical Center, Dallas; and Medical College of Virginia, Richmond.

"As the largest and longest study of hepatitis C, this trial should provide answers to difficult questions concerning management of hepatitis C," said **Jay H. Hoofnagle**, MD, in a statement.

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

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6:00 Mon.-Thurs.; 8:30-4:30 Fri. EST. E-mail: customerservice@ahcpub.com. World Wide Web: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $399; with approximately 18 nursing contact hours, $449. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $319 per year; 10-20 additional copies, $239 per year. For more than 20 copies, contact customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $67 each.(GST registration number R128870672.)

This continuing education offering is sponsored by American Health Consultants®, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, provider number CEP 10864, for approximately 18 contact hours.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Senior Editor: **Dorothy Pennachio**, (201) 760-8700, (dorothy.pennachio@medec.com).
Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@medec.com).
Executive Editor: **Susan Hasty**, (404) 262-5456, (susan.hasty@medec.com).
Managing Editor: **Paula Stephens**, (404) 262-5521, (paula.stephens@medec.com).
Senior Production Editor: **Brent Winter**, (404) 262-5401.

Editorial Questions

For questions or comments, call **Dorothy Pennachio** at (201) 760-8700.

United States Postal Service

Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication No.	3. Filing Date
Hospital Case Management	1 0 8 7 - 0 6 5 2	9/24/99
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$399.00

7. Complete Mailing Address of Known Office of Publication *(Not Printer) (Street, city, county, state, and ZIP+4)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta,
Fulton County, GA 30305

Contact Person: Willie Redmond
Telephone: 404/262-5448

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*
Brenda Mooney, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*
Dorothy Pennachio, same as above

Managing Editor *(Name and Complete Mailing Address)*
Paula Stephens, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
American Health Consultants	3525 Piedmont Road, Bldg. 6, Ste 400
	Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Medical Economics Data, Inc.	Five Paragon Drive
	Montvale, NJ 07645

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526**, September 1998 *See instructions on Reverse)*

13. Publication Name: Hospital Case Management

14. Issue Date for Circulation Data Below: November 1999

15. Extent and Nature of Circulation			Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*			1676	1700
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	1435	1400
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	0	0
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	0	0
	(4)	Other Classes Mailed Through the USPS	0	0
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			1435	1400
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	0	0
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*			14	14
f. Total Free Distribution *(Sum of 15d and 15e)*			14	14
g. Total Distribution *(Sum of 15c and 15f)*			1449	1414
h. Copies Not Distributed			210	300
i. Total *(Sum of 15g, and h.*			1659	1714
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			99	99

16. Publication of Statement of Ownership
Publication required. Will be printed in the November issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Publisher — Date: 9/24/99

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
4. Item 15h., Copies not Distributed, must include (1) newsstand copies originally stated on Form 3541, and returned to the publisher, (2) estimated returns from news agents, and (3), copies for office use, leftovers, spoiled, and all other copies not distributed.
5. If the publication had Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or if the publication is not published during October, the first issue printed after October.
5. In item 16, indicate date of the issue in which this Statement of Ownership will be published.
6. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of second-class authorization.

PS Form **3526**, September 1999 *(Reverse)*

"The study will also set clinical criteria for grading, staging, and assessing the prognosis of people infected with HCV." Hoofnagle is director of the Division of Digestive Diseases and Nutrition at the National Institute of Diabetes and Digestive and Kidney Diseases, a division of the National Institutes of Health. ■

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. ■

AMERICAN HEALTH CONSULTANTS® A Medical Economics Company

1999 SALARY SURVEY RESULTS

HOSPITAL CASE MANAGEMENT™

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

Information will be your key to opportunity

Computer- and data-savvy? If so, you could command more than your colleagues

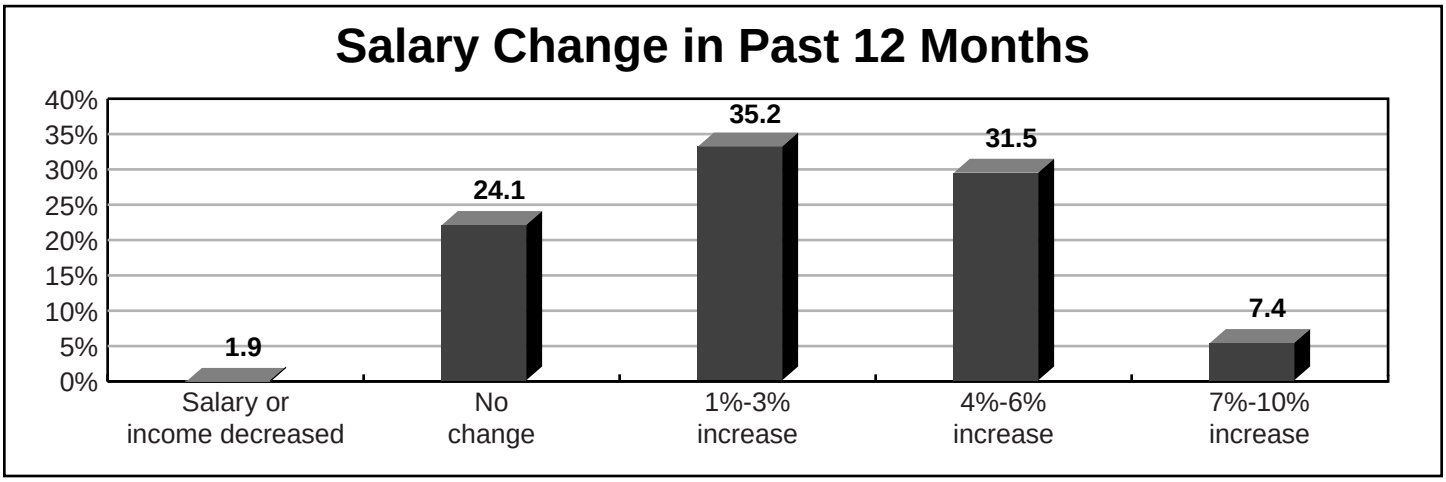
Keeping up with information technology and honing your communication skills in general could get you the job of your dreams — or at least help you keep the job you have and perhaps get a promotion down the road. "Case managers getting paid the most today are the ones who are good at producing outcomes data and know how to use the data they retrieve," says **Janice Schriefer**, RN, MSN, MBA. Computer and statistical skills are highly valued at Schriefer's facility, Spectrum Health in Grand Rapids, MI. "Computer-savvy, outcomes-savvy case managers have a good future," she maintains. "They are the ones I see succeeding because of their ability to help the organization."

She says that in her experience, an ability to communicate with physicians is also highly valued. "The case manager who can go to a physician and say, 'How do you want this done?' and then *get* the job done is a very valuable member of the staff."

Those two skills — information technology and verbal communication — fit well together, because, as Schriefer says, "then the case manager is able not only to implement good care but also to measure it. That helps get patients cared for better."

She says the more vulnerable employees are the ones about which a hospital administration can say, "What are they doing? The physicians don't seem happy. We don't have any reports that they've made a difference."

Michigan, like other states, is having to tighten all its hospitals' budget belts because of the federal Balanced Budget Act, and Schriefer says her hospital is experiencing a lot of problems related to that. Rather than cutting the number of full-time employees at Spectrum, the administration



decided to give everyone pay cuts instead. "Just imagine how that went over!" says Schriefer, who is clinical system improvement specialist there. "When you cut staff and employees leave the facility, they are no longer around to complain. But when you do it this way — keep people on, but cut salaries — there's a lot of talk." The facility scaled the pay cuts; some cuts were as low as 3%, but the executives, she says, took as much as a 15% cut in salary.

"Certain jobs," she says, "the IT [information technology] jobs, for example, didn't take any cuts whatsoever because there's such a shortage of people who can do that work. Physical therapy also didn't take cuts because recruiting for those jobs is difficult." But all the nurses, including all the hospital-based case managers, took it on the chin. "Overall, there's a lot of downward pressure on salaries," says Schriefer. "And a lot of hospitals in Detroit had to fire staff."

What if you are fired or downsized? What if your pay should be cut to an extent that you feel you have no choice but to leave? One place for a hospital-based case manager to get a better job may be the outpatient setting, says Schriefer. "Physician offices weren't hit as hard this year as hospitals, and some of them are hiring case managers. Physician offices used to pay lower than hospitals, but now they are paying more. The hours are better — they are not open in the evenings, weekends, or holidays."

Do physicians prefer 'care managers'?

Does calling yourself "care manager" make you sound more modern or more accomplished than "case manager"? In Schriefer's opinion, what a case manager calls herself or himself should not matter, but "some time back, the physicians here didn't like the term 'case manager,' so we changed our name to 'care facilitators.'" In ways other than nomenclature, too, Spectrum's care facilitators tailor their programs to the physicians. "The bottom line is, physicians write the orders for all the care," says Schriefer. "If they don't see you as part of their team — if they see you as an HMO-minded utilization review person — they don't want to have anything to do with you. But if they see you as someone who can help them facilitate care quickly — get the right care to the patient and be able to measure what has been done — they like that."

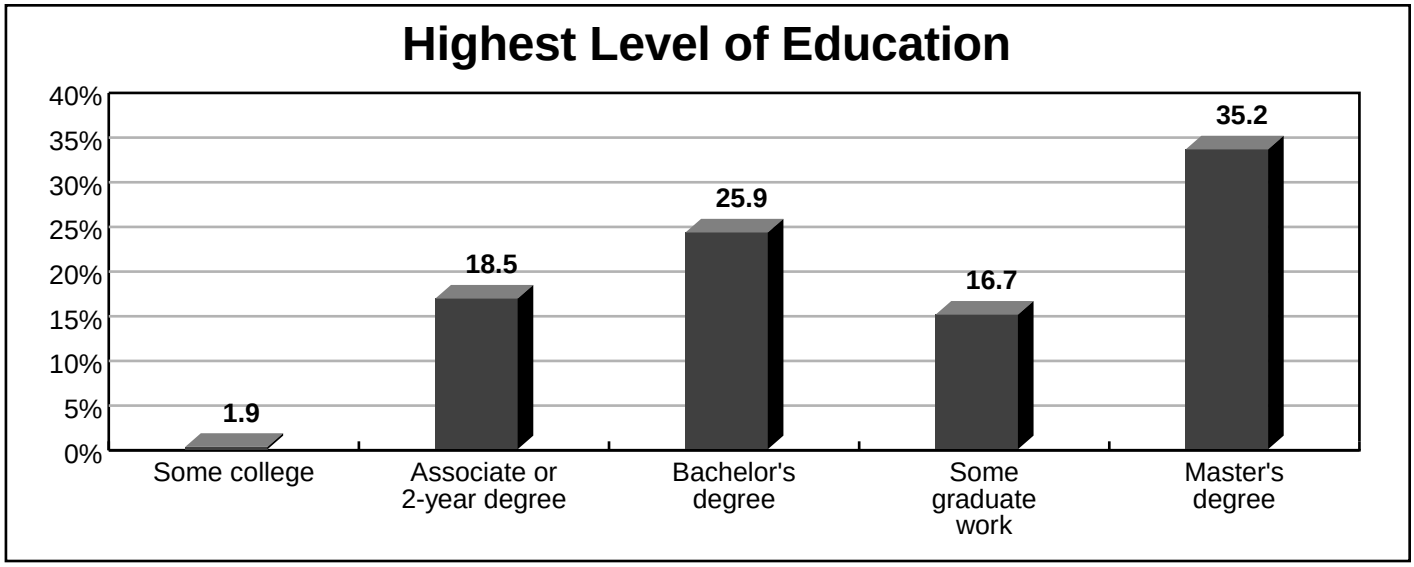
She says she thinks the term "care facilitator" is better from the patient's perspective, too. "If you say to a patient, 'I'm your case manager,' he or she may feel like a 'case' — no more important than a bunch of numbers. 'Care' has such a nicer ring." She says the problem with managed care is that the word "managed' comes before the word "care." "The nice thing about 'care management' is you put the word 'care' first."

Salary Levels by Title

Annual Gross Income	Director of CM	Case Manager/ Coordinator
less than $20,000	1.72%	2.7%
$20,000 to $24,999	0%	0%
$25,000 to $29,999	0%	0%
$30,000 to $34,999	0%	2.7%
$35,000 to $39,999	0%	16.2%
$40,000 to $44,999	5.17%	13.5%
$45,000 to $49,999	7%	16.2%
$50,000 to $54,999	15.5%	13.5%
$55,000 to $59,999	12%	16.2%
$60,000 to $64,999	10.34%	10.8%
$65,000 to $69,999	13.8%	2.7%
$70,000 to $74,999	20.7%	0%
$75,000 to $79,999	1.72%	2.7%
$80,000 to $84,999	1.72%	0%
$85,000 to $89,999	1.72%	0%
$90,000 to $94,999	3.44%	0%
$95,000 to $99,999	1.72%	0%
$100,000 to $104,999	0%	0%
$105,000 to $109,999	0%	2.7%
$110,000 to $114,999	0%	0%
$115,000 to $119,999	0%	0%
$120,000 to $124,999	0%	0%
$125,000 to $129,999	0%	0%
$130,000 to $134,999	0%	0%
$135,000 to $139,999	1.72%	0%
$140,000 to $144,999	0%	0%
$145,000 to $149,999	0%	0%
$150,000 to $154,999	0%	0%
$155,000 to $159,999	1.72%	0%
$160,000 or more	0%	0%

How we did the survey

Hospital Case Management's annual salary survey was mailed to readers in the July 1999 issue of the newsletter. Questionnaires, response forms, and postage-paid envelopes were sent with the newsletter. Of the 1,600 surveys mailed, 84 were returned, for a response rate of approximately 5.25%, which, because it is low, is not projectable across *HCM*'s readership. The confidential surveys were compiled and analyzed by American Health Consultants, publisher of *HCM*. ■



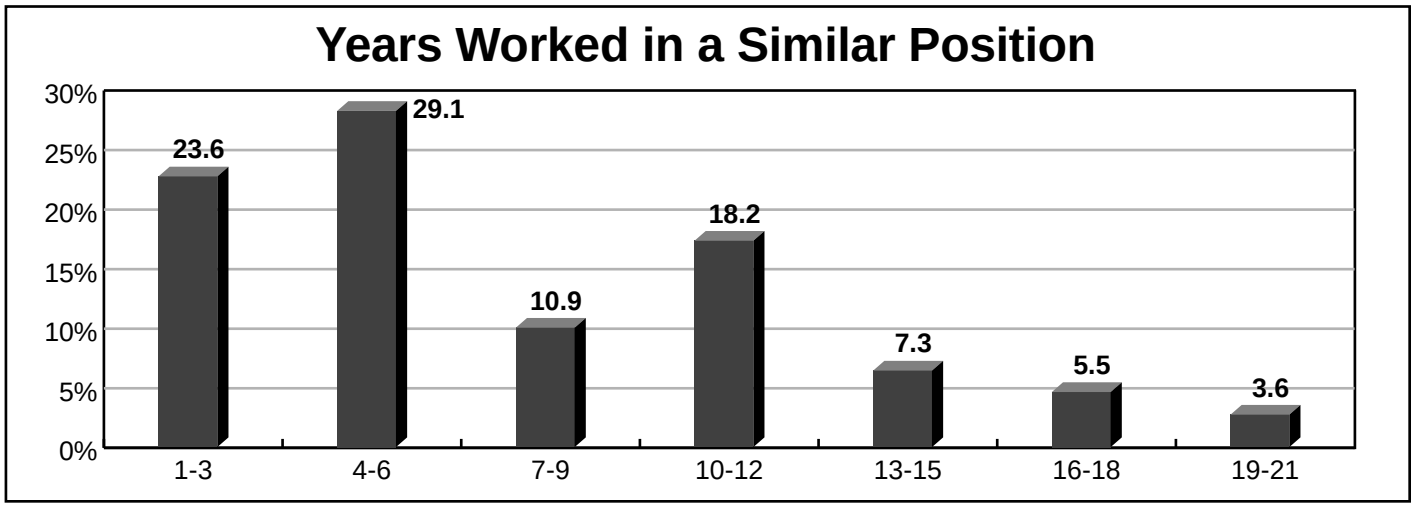
However, not everyone shares this viewpoint. "I don't like the word 'care' as opposed to 'case' to describe what we do," says **Carol Fodge**, RN, MS, director of care management at Provena Saint Joseph Hospital in Elgin, IL, on the outskirts of Chicago. "'Care management' sounds more like what bedside nurses do, and we do something beyond that, and on a parallel avenue. To me, the term 'care manager' doesn't ring true. If I were going for a job, I would call myself a case manager."

A case manager at Fodge's facility earns $35,000 to $45,000 a year, she says. "We can't offer as much as they do in Chicago." She says her position as director of care management would pay between $47,000 and $70,000. "If I went into the city, 30 miles away, I could make $20,000 more — up to $90,000." She says her hospital is part of a seven-hospital corporation, and "we all make different salaries for the same job."

Fodge is interviewing for a new case manager now, and she says what she is looking for is a "true" case manager — "a person who can do utilization review, quality assurance, risk management, and discharge planning. The whole gamut." She says a person who fits that description is not easy to find now, according to headhunters who are looking for applicants for her. "Experience is probably the most important factor I look for in an applicant. That and certifications."

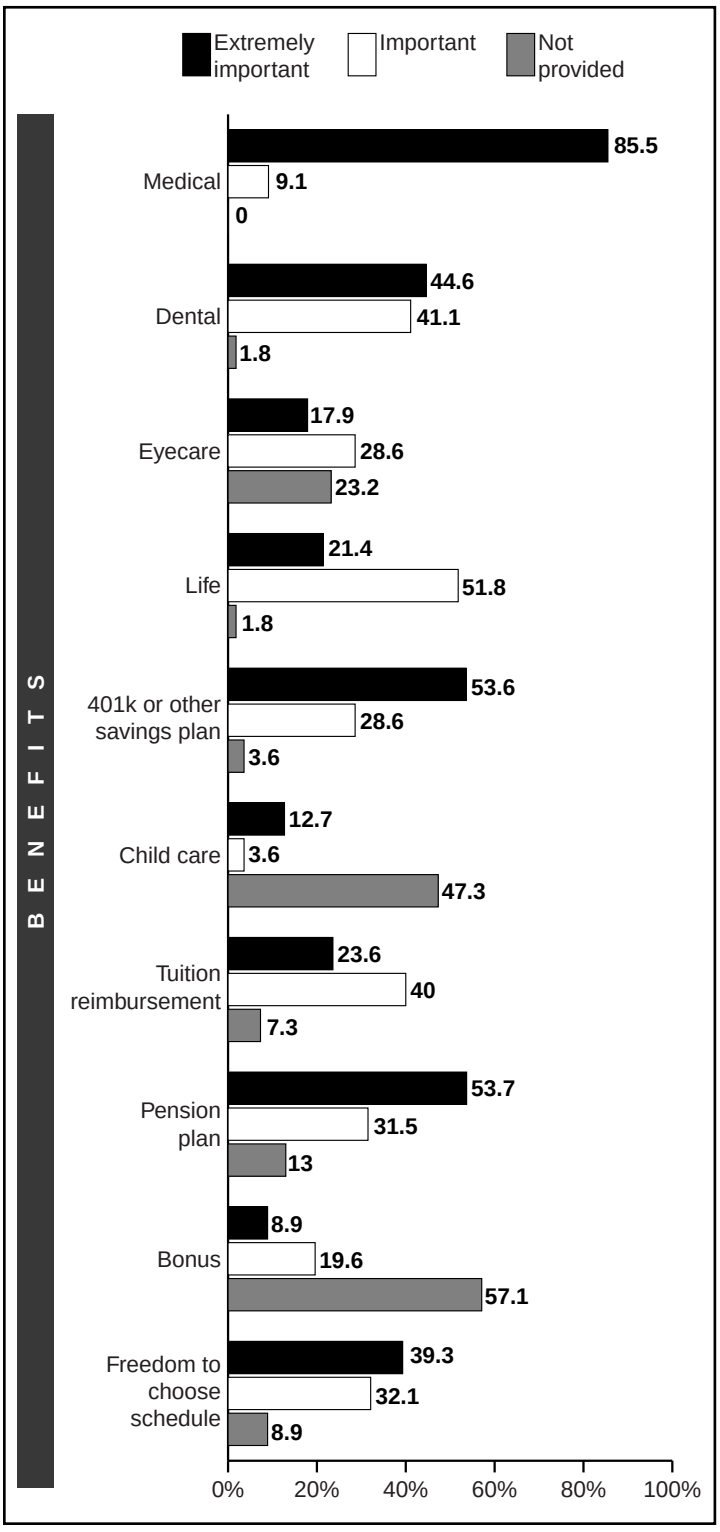
Certifications boost credibility

Schriefer says certifications not only help you get a job but also help in getting raises and promotions. Credentials help your employer know what skills you have and add a lot of value to you as an employee. "If I didn't value my credentials, I wouldn't go back to keep all of them up," she says. "Back when I was certified for critical care nursing, I studied my butt off for that test. I did well, but it wasn't easy. My skills as an ICU nurse improved a great deal." She says case management certifications are tough, too. They are not



expensive, and they encourage you to keep up your skills. Fodge agrees and says certifications help your credibility.

A vice president of Fodge's facility, a physician, encouraged her to get certified by the American Board of Quality Assurance and Utilization Review Physicians (ABQAURP) in Tampa, FL. That board administers the Certified in Quality Assurance and Utilization Review (CQAUR) credential. "A nurse certified in case management would more likely hire someone with the CCM credential," she says. "But, if you interview at an institution where a physician is the director of the program, he may prefer you to have your CQAUR. It depends on the person interviewing you and what he or she thinks is important." Fodge says her CQAUR credential has given her plenty of clout with Provena Saint Joseph's physicians. "A couple of physicians on our staff have it, and it gives someone like me an edge."



Annual Gross Income

Less than $20,000	1.7%
$30,000 to $34,999	1.7%
$35,000 to $39,999	6.8%
$40,000 to $44,999	5%
$45,000 to $49,999	11.86%
$50,000 to $54,999	13.56%
$55,000 to $59,999	13.56%
$60,000 to $64,999	11.9%
$65,000 to $69,999	13.56%
$70,000 to $74,999	11.86%
$80,000 to $84,999	1.7%
$90,000 to $94,999	1.7%
$105,000 to $109,999	3.4%
$155,000 to $159,999	1.7%

Fodge says ABQAURP's continuing education program is excellent. "They require you to go to one of their seminars every three years to recertify, and they present the latest in utilization review, quality, and Joint Commission rules and regulations. It's hard to keep up with those things now without help. If I were reapplying for my job, the fact that I keep up to date would be a big plus — that, and being master's-prepared." She went back and got her master's degree in health services administration. "I got that instead of a master's in nursing," she says. "Many case managers today are getting an MBA. A master's degree with a business background is what employers are looking for now."

She says employers are looking for an expert in the field. "They don't want to hire someone who has to learn while she is on the job. Things are moving too quickly."

For more information, contact:

Janice Schriefer, RN, MSN, MBA, clinical system improvement specialist, Spectrum Health, Grand Rapids, MI. Telephone: (616) 391-2974.

Carol Fodge, RN, MS, director, care management, Provena Saint Joseph Hospital, Elgin, IL. Telephone: (847) 695-3200, Ext. 5432. ■