HOSPITAL CASE MANAGEMENT™

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

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Florida case managers deal with the effects of back-to-back hurricanes

Discharge planners went into high gear

After weathering three major hurricanes in just over 30 days, case managers in Florida hospitals have some advice for their counterparts in other parts of the country: Plan ahead and be flexible.

Here is what some of them experienced:

- The three hospitals in Port Charlotte had to transfer 550 patients to other hospitals because of damage caused by Hurricane Charley.
- Sarasota Memorial Hospital took in 167 special-needs patients and admitted 35 other patients from South Florida hospitals.
- At St. Vincent's Hospital in Jacksonville, as Hurricane Frances approached, the case managers arranged for some patients who live alone to be discharged to a family member's home or temporarily to an assisted-living center.

When hurricanes Charley, Frances, and Ivan roared into Florida, hospitals in the predicted path of the storms pulled out their disaster plans and prepared to ride out the storms.

Florida hospitals are required by law to have a disaster plan that includes hurricanes and to conduct a disaster plan drill twice a year.

About seven days before a hurricane is expected to hit Florida, the hospitals activate their emergency plan and start making preparations for the possible evacuation and transfer of patients and preparing the physical plant for the storm, says **Rich Rasmussen**, vice president for strategic communication for the Tallahassee-based Florida Hospital Association.

If the storm appears to be heading toward their area, hospital discharge planners begin the process of identifying patients they can discharge earlier and looking for placements elsewhere in the state for patients who need to stay in the hospital.

The back-to-back storms presented a lot of challenges to discharge planners, says **Linda Quick**, director of the South Florida Hospital Association.

The hospitals needed to discharge as many patients as possible to free up beds for people who might be injured in the storms, but they often faced challenges in finding safe places for the patients to go.

"It was difficult discharging some of these patients, particularly if they lived alone. The discharge planners had to either find a family member or long-term care unit to take the patients," Quick says.

In fact, a few weeks after Hurricane Charley swept through the southern part of the state, a few elderly or medically fragile patients remained in special-needs shelters because they were on oxygen or a ventilator and still had no power at home.

"It was a very stressful situation for the hospital staff. South Florida hospitals transferred their patients further up north for cardiac catheterization and other interventions, and the patients ended up staying a long time because they had no air conditioning at home," says **Mary Ellen Beasley**, RN, BSN, division director for case management for HCA's West Florida division, with headquarters in Palm Harbor, FL.

Hospital staff had to copy patient records to send with patients being transferred to other facilities and to make sure the records that went with the patients were accurate, she points out.

Between Hurricane Charley and Hurricane Frances, the case management staff at Sarasota Memorial Hospital began to take a stronger role in coordinating the intake and care of special needs patients, says **Judy Milne**, RN, MSN, CHPQ, director of integrated case management and quality improvement.

Because the county does not have a special needs facility, people from the community who qualified for special needs care come to Sarasota Memorial Hospital. During Hurricane Charley, 167 special-needs patients went there.

Under the new plan, the case managers evaluated patients who came to the hospital as Hurricane Frances approached, determining what services, such as oxygen, medication, and home health, they would need when they departed.

"We redesigned the intake process to get more information on the front end to anticipate what we need to do to get these patients back home with the kind of medical support they had prior to the storm," Milne says.

After Hurricane Charley struck, the hospital admitted 35 patients who were evacuated from South Florida hospitals that were closed because of the storm.

"As patients started coming up from South Florida, our hospital filled up quickly. As they recovered, we were in the position of having to transition people to home who didn't have a home. We learned a lot about the whole

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

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

shelter system," Milne points out.

Shortly after Hurricane Charley hit the state, the hospital sent four case managers to local shelters to help the Red Cross and the state health department find placements for residents who fled their homes in South Florida and who had medical needs. Four case managers worked for two full days coordinating admissions for displaced residents to extended care facilities and assisted-living facilities.

"We had an increase in people coming to our emergency department. Many were from the hard-hit areas. They couldn't get to their usual physician because the office was blown down and their local hospital wasn't available, so they migrated north," Milne says.

Hurricane Frances presented a different set of challenges, because a large portion of the Sarasota area was left without electricity.

"We had patients who were in the hospital for a few extra days because they had oxygen concentrators that needed electricity or respiratory problems that meant they couldn't handle the humidity with no air conditioning," she says.

Massive evacuation employed

Immediately after the hurricane, 550 patients had to be evacuated to other areas. Hospitals in the Port Charlotte area sustained little damage and had power, but the area's water and sewage system was damaged, making it necessary to evacuate all three hospitals in Charlotte County. The Florida Hospital Association helped facilities transfer the patients, using helicopters provided by Florida hospitals, the Coast Guard, and the National Guard.

"We had to begin shifting those patients north to Tampa, Sarasota, and the Fort Lauderdale area," Rasmussen says. Patients on ventilators had to be evacuated by air by helicopters equipped to handle ventilator patients. Other critically ill patients also were evacuated by air.

Those who did not need immediate assistance were evacuated by ground transportation. "The important thing is that through all three storms, we had thousands of patients transferred across the state without incident. They were safely transported, and their health care continued in a new facility, and we did it all without a single patient's health being compromised," Rasmussen says.

South Florida hospices were challenged, especially if they were in areas where they were having problems providing services. In some cases, families had been dislocated and did not notify the hospice of their location, Quick says.

Case managers had to use their ingenuity during the storms and power outages, she adds. For instance, some people brought their oxygen with them to the special needs shelters in their local hospitals, but the oxygen ran out. "They were able to get the company that provides the hospital oxygen to provide some tank oxygen," Quick notes.

When the winds from Hurricane Frances hit Jacksonville, a large number of employees of St. Vincent's Hospital were left with wind-damaged homes and electricity outages.

"We watched the storm carefully and activated our disaster plan. We did a lot of planning at the department level to determine who could get in and who couldn't and to make sure that people came in early if they thought they might not be able to get in for their shift," says **Wanda Gibbons,** RN, vice president of patient care and chief nursing officer. St. Vincent's is a community hospital licensed for 538 beds, with a 240-bed nursing home on the same campus. The hospital's normal plans for discharge don't always work in the event of a natural disaster, she points out.

"The hurricane made it necessary for our discharge planners to be flexible in working with patients to meet their needs and find a situation where they would be safe," Gibbons adds.

For instance, some patients were discharged to a family member's house instead of their own home or to an assisted-living center for a short time. Just before the storm, staff had some difficulties in placing patients in some area nursing homes that were holding beds in case other facilities had to be evacuated.

As the hurricane approached the area, some staff slept at the hospital to make sure they would be available the next day. Other staff stayed late until the weather lifted. "We didn't want people to be unsafe by driving to work in the middle of the storm," Gibbons says.

Staff who stayed overnight slept in an older nursing unit that used to be a pediatric unit and in the same-day surgery area.

The bridges that cross the St. Johns River, which runs through the middle of Jacksonville, are closed when winds hit 40 miles per hour. "We had to anticipate that the bridges were going to be closed and bring people from the other side of the river in early," she explains.

The hospital arranged for a local cab company to bring in staff who typically ride the bus system

or who had other transportation issues.

In the days before the storm, the discharge planners went into high gear, working to discharge patients who were ready to go home to free up beds in case people were injured in the storm, Gibbons says. "The discharge planners were concerned about not sending someone home who might need to be in a special-needs shelter when the storm hit," she says.

Hospitals throughout the state of Florida staff special-needs shelters for medically fragile, elderly, and disabled people who don't need to be in the hospital but may need medical care or special assistance. For instance, patients on ventilators or those who use oxygen may come into the special-needs shelters because they don't have electricity.

When making plans for rural residents from Florida and South Georgia who come to St. Vincent's for cancer treatment, cardiac, and other specialty care, the discharge planners had to take into account that families who rely on a well for their water could be without a water supply, Gibbons adds.

After paying close attention to three hurricanes with the potential to hit the area, the St. Vincent's staff are considering additions to the disaster plan that include an area for family members and a place where staff can bring their pets.

"When school is closed and there's no electricity or telephone service at home, parents are reluctant to leave their children. There is a need for a place for family members to go when we have a disaster," she says.

The hospital is considering setting up an area in a well-ventilated garage where employees can leave their animals in a pet carrier and feed and care for them when they get a break.

"Some people don't know how long it will be before they get home or how long they'll be without electricity. Having their children and pets with them will give them a comfort level they wouldn't have otherwise," Gibbons says.

At Homestead Hospital, as soon as the area was under a hurricane watch, the discharge planners worked aggressively to start early discharge planning, says **Jill White**, RN, director of case management and performance improvement.

"Once there's a hurricane watch, the community resources start shutting down. The nursing homes stop accepting patients, and home health won't guarantee that they can provide services. It's difficult to place patients during a hurricane watch situation. We have to be very creative," she says. In some cases, patients have come to the hospital emergency department from a nursing home, but the nursing home won't take them back because of the storm. In that case, the hospital provides a safe shelter.

Case management staff pay close attention to the documentation for patients whose length of stay is extended by the storm.

"As long as the insurance companies are open, we work with them trying to set up a plan. They're very aware whether we can get a patient out or not," White explains. Hospital staff concentrate on making sure that patients get the care they need during a disaster and worry about reimbursement later, she says.

"Most of our concern about the payment angle is after the fact. When the storm is headed our way, our top priority is taking care of the patients, making sure they have what they need, and that if they are discharged, it's to a safe place," White says.

Here are some tips from hospital staff who have been through a disaster recently:

- **Develop a disaster plan and practice regularly.**

"You never know what you're going to encounter. Plan for the unthinkable," Rasmussen says, pointing out that Florida was hit with three hurricanes in 30 days with another one looming just afterward.

- **Plan ahead and know your plans will change as the storm moves through.**

"The key is to have everything planned out in advance, because during the peak of the storm, you can't do anything except ride it out," notes Gibbons.

For instance, most Florida hospitals have reciprocal arrangements with hospitals in other areas to take their patients in the case of an emergency.

- **Be flexible and creative.**

"Sometimes the staff take a lot of encouragement because they're worried about getting here. Our nursing supervisor spent a lot of time telling people how to get here using different routes, and we sent cabs out for people who couldn't come in," Gibbons says.

Constant communication is the key to a successful disaster management plan, Rasmussen says. A few days before the hurricanes hit Florida, the Florida Hospital Association developed a database of key hospital personnel in areas in the path of the storms. The advance planning paid off when Charley hit and disabled Charlotte County emergency operations center, leaving the area with limited communications. The hospital association was able to facilitate communication using its database, he adds. ■

Reorganization merges UM and social work

Cross-trained staff provide case management

Almost as soon as Homestead (FL) Hospital implemented an integrated model of case management, patient satisfaction scores went up and lengths of stay started to decline.

"Almost immediately after we went live, we noticed an improvement in our patient satisfaction scores related to discharge planning. We were able to impact length of stay quickly, within the first couple of months; and we continue to make progress in that area," says **Jill White**, RN director of performance improvement and case management.

The patient satisfaction questionnaire asks patients to rate the extent to which they felt ready for discharge and how well the home health care services were handled.

"Our scores went up dramatically almost immediately after case management was implemented," she says.

The department has gotten a lot of positive feedback from physicians, nursing staff, and patients who like the new model, White says.

The hospital is just beginning to get the information it needs to see the impact that the new program has had on revenue, she says.

"It takes about five months to be able to see a difference in cost data, and we're only beginning to get to that point," she says.

Until earlier this year, the hospital had a utilization management program staffed by RNs and a separate social work department that performed discharge planning.

When the two departments merged in the spring of 2004, the nurses who handled utilization management and the social workers who took care of discharge planning were cross-trained to do both roles. Now, staff from both disciplines are called case managers and have exactly the same job descriptions, performing functions traditionally handled by both disciplines.

The case managers coordinate patient care on the hospital units, in the emergency department (ED), and in the transitional stay unit (where patients are moved for observation or when they're being admitted from the ED and are waiting for a bed to become free).

The hospital made the decision to create an integrated case management model at a time when the average daily census was increasing and the average length of stay was going up.

"Our average length of stay was in line with that of other organizations, but when we drilled down on individual cases, we found that there were opportunities to better manage the care of patients who were in the hospital for 10 days or longer," White says.

White's department searched the literature to find out what other hospitals were doing and talked to a New York hospital with a similar patient mix and lower lengths of stay.

The hospital made the decision to create an integrated model that combines the social work and utilization management department into a case management department.

The hospital has two inpatient floors with three case managers assigned geographically to each. Every case manager carries a patient load of about 15, whether they are a nurse or a social worker.

There are two case assistants, one for each floor, who make copies and telephone calls and handle other clerical duties, freeing up the case manager to spend their time dealing with patient care issues.

The case assistants had a similar role in the social work department before the merger.

"They're right on the floor working closely with the case managers and providing whatever assistance is needed. They make a lot of phone calls, contacting home health agencies and assisting with setting up services," she says.

The department decided to assign the case managers geographically after getting feedback from the physicians and nurses.

"We contemplated having the case managers follow the patient from admission through discharge. The physicians and nurses felt that having case managers go from one unit to another could create a situation where they might miss some information and lose opportunities to talk with the physicians," White says.

All staff have the same job description, whether they are nurses or social workers.

"We spent a lot of time cross-training them on the other discipline's functions," White says.

Each case manager, whether a nurse or a social worker, is responsible for the care of 15 patients. Both disciplines track clinical information, conduct utilization review for payers, and handle discharge planning.

"With the two different disciplines, we have a good mix of experience and expertise. They learn

from each other and are able to handle anything that comes along," she says.

The staff underwent extensive training in the beginning of 2004. The hospital did a two-week pilot project in March 2004 to iron out any last-minute kinks and gradually went live on the other units.

McKesson Corp., based in San Francisco, presented a three-day training program for all the staff. A big portion of the training included how to review a medical record for clinical criteria.

"We felt that area was one that might be a challenge to the social workers who do not have a nursing background," White says. "Our social work staff was very experienced. They had worked in the hospital for a long time and had picked up a lot of knowledge about clinical aspects of patient care."

When the new model went live, staff started off with a smaller caseload than what they now handle. "They trained each other case-by-case. The nurses trained the social workers to review for clinical function, and the social workers trained the nurses about discharge planning," White says.

The nurses and social workers saw the patients together as long as they felt it was necessary. The case managers on each floor have a case conference every day to discuss any cases that may be challenging. "They learn from each other. The cooperative relationship has really been successful," White says.

The case managers take their laptop computers to the floor with them, using data ports on each unit. The hospital uses the MIDAS+ care management system software from Affiliated Computer Services (ACS), a Dallas-based information technology firm, for utilization review and discharge planning.

"The case managers are on the unit all day, easily accessible to the physicians and patients. They visit each patient each day," she says.

Before the integrated model was put into place, social workers saw patients only by referral from nursing or utilization management staff. If the referral didn't take place until the end of the stay, the patient often was not discharged in a timely manner.

Under the new system, all patients are seen by case managers, who start the discharge planning process upon admission.

The new model includes a patient transfer case manager who makes arrangements for patients with complex conditions who are being transferred to a facility that can provide a higher level of care.

Homestead is a 120-bed facility that doesn't offer some services, such as cardiac catheterization, thoracic surgery, cardiovascular surgery, or neurosurgery.

Before the new model was implemented, the nursing staff handled the transfers.

"It was a difficult job that nursing tried to do along with providing direct patient care. We had patients waiting multiple days to transfer to other facilities. Having a person dedicated to doing the hospital-to-hospital transfers has been a key component to reducing length of stay," she says.

Covering weekend duty

The hospital has abbreviated case management staffing on the weekend, with one case manager working on the floors each weekend day. Staff take turns handling the weekend duty.

"More managed care organizations are open on the weekends, and some require that clinical information be available seven days a week. We have patients who are ready to be discharged on weekends and need someone to facilitate that," White says.

Most of the discharge planning for weekend discharges is set up during the week, but the case managers are on hand if there is a discharge that wasn't expected or someone being discharged needs additional services. The weekend case manager also coordinates with the ED case manager to take care of any needs of patients being admitted.

Case managers covering the ED are all registered nurses who work 12-hour shifts and rotating weekend duty. The ED case managers were the hospital's first case managers and have been in place for two years.

"The emergency department case managers ensure that the patients need to be in the hospital and make sure that the patients who are discharged from the emergency department have the appropriate resources, such as durable medical equipment. They make sure they know where to follow up. If they are being admitted, they get the initial clinical information and start the discharge plan," she says.

Creating the ED case management role has helped the hospital move patients through the continuum of care in a timely manner.

"In the past, the utilization manager wouldn't have seen the patient until the day after they

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CRITICAL PATH NETWORK™

Algorithm guides ICP infection investigation

Mining for sentinel events in compromised patients

Infection control professionals in a group of cancer centers have developed an algorithm to help meet new patient safety goals by the Joint Commission on Accreditation of Healthcare Organizations. **(See algorithm, p. 168.)**

The Joint Commission requires health care organizations to manage as sentinel events all identified cases of unanticipated death or major loss of function due to nosocomial infections.

Because patients at cancer centers generally are at high risk for serious infections, such institutions face unusual difficulty in determining whether a nosocomial infection is unanticipated, says **Lisa Roman**, RN, BSN, OCN, infection control coordinator at Fox Chase Cancer Center in Philadelphia.

"We needed to address the fact that we have immunocompromised patients with multiple comorbidities," she says. "That makes it more difficult to determine if an infection is the cause of death or major loss of function."

The algorithm, which can be used to identify or rule out sentinel events caused by nosocomial infections, incorporates such data as reason for admission, cancer type and stage, cancer effect on immunity, and anatomic barriers to infection. The influence of these factors on infection likelihood and severity dictate the branch points in the algorithm, she explained.

For example, if a patient died of pneumonia but had advanced lung cancer that blocked lung drainage, the patient's death would be deemed "anticipated." Similarly, when a patient comes in under palliative or "comfort" care then "you know then that they are in a point of their disease state where death or major permanent loss of function may be impending," Roman adds.

When death or morbidity is unanticipated, the incident is reported as a sentinel event. The case is referred to the risk management and quality improvement departments for a root-cause analysis. An action plan is implemented and monitored in accordance with Joint Commission requirements.

Investigation of suspicious cases is prompted by ICPs conducting routine surveillance and reviewing death reports to identify nosocomial infections that result in death or major loss of function.

"If something strikes us from any of those areas as a potential to be an infection that caused harm, then we would put this algorithm into place," Roman says.

"If the nosocomial infection looks like it played a major role, then you are going to go right down that algorithm to consider it a potential sentinel event, go to a root-cause analysis, and develop an action plan."

Many deaths are explainable

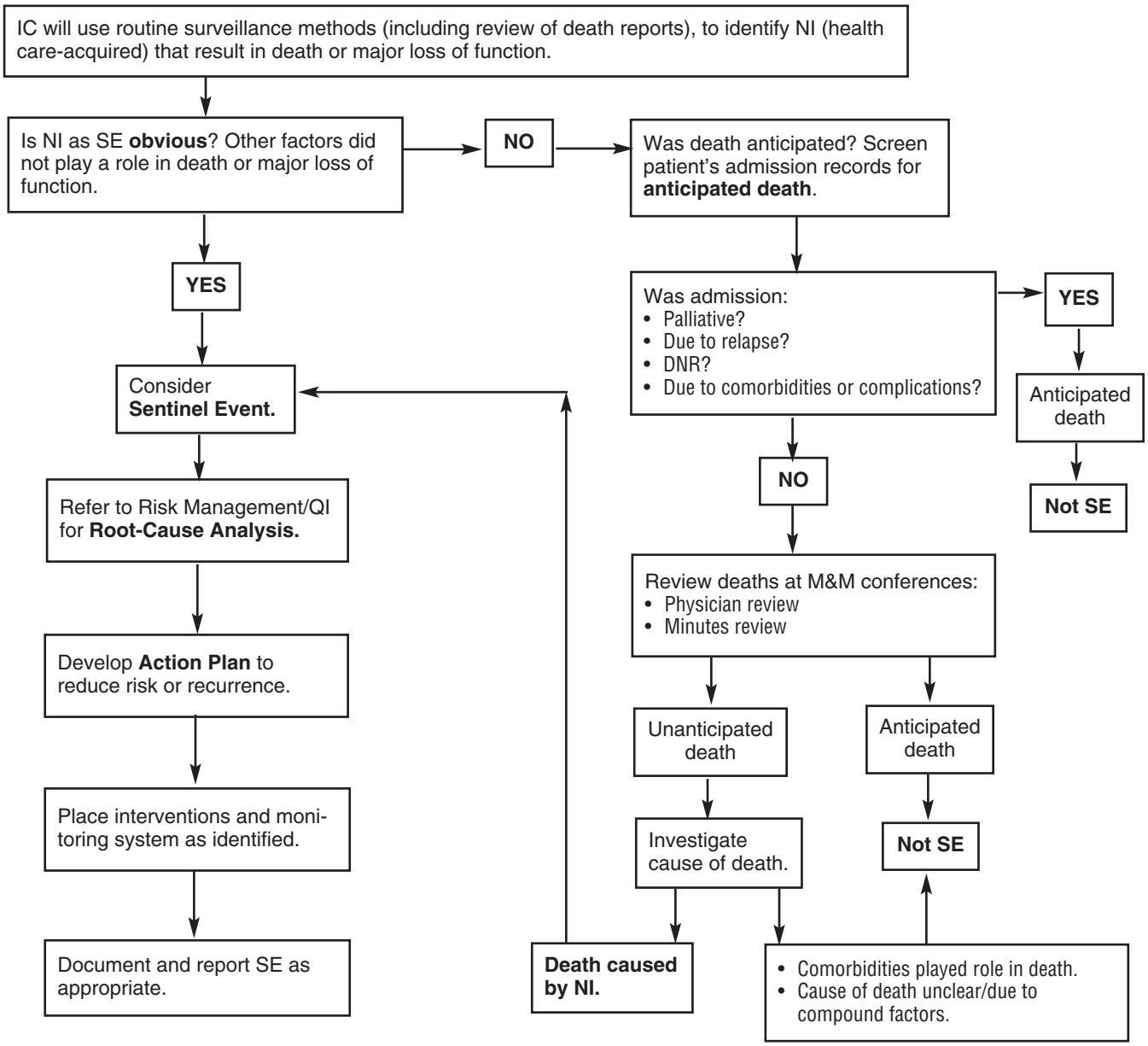
Much more often than not, of course, the cases will be explained by the existing patient conditions and not lead to a sentinel event investigation. However, the overall review process is a good quality improvement exercise in itself, she says.

"Protecting patients has always been our goal, anyway," Roman notes. "This is just finding new ways to try and achieve that. Any kind of ongoing effort to look at your process — that constant, continuous review — is really quality improvement. You can always do better no matter how good you are, and this is just one more opportunity to pursue that." ■

Algorithm for Investigation of Health Care-Associated (Nosocomial) Infections as Sentinel Events

Developed by Consensus of Infection Control Professionals from Consortium of Comprehensive Cancer Centers.*

Issue: Cancer centers are faced with multiple confounding factors in the assessment of health care-associated (nosocomial) infections (NI) as sentinel events (SE). Because of the high-risk populations of our institutions, these confounders must be considered when attributing death or major loss of function to NI.



Authors: C. Perego, MDACC; L. Roman, Fox Chase; B. Tegtmeier, City of Hope.

* Participants: MD Anderson Cancer Center, Fox Chase Cancer Center, City of Hope National Medical Center, Dana Farber Cancer Center, Roswell Park Cancer Institute, James Cancer Hospital, H. Lee Moffitt Cancer Center, University of Miami Sylvester Cancer Center, Kenneth Norris Cancer Hospital, Fred Hutchinson Cancer Research Center, Barnes Jewish Hospital.

Contact: Cheryl Perego, MPH, CIC, University of Texas MD Anderson Cancer Center, Houston, TX 77030. Phone: (713) 745-1800. E-mail: costing@mdanderson.org.

Patient privacy at risk in hallways and cafeterias

Researchers record regular breaches

Health care providers routinely discuss confidential patient information in hospital hallways, cafeterias, and lobbies, two researchers have concluded.

"The country has recently invested a tremendous amount of resources in the nation's largest set of federal privacy laws to prevent health care providers and institutions from divulging or selling patient information. But we found that the daily conversations of physicians, nurses, hospital staff, and technicians can jeopardize the same kind of personal information," says **Marifran Mattson**, PhD, associate professor of communications at Purdue.

Hospital staff need to be more aware and more careful about discussing protected patient information out in the open, Mattson asserts.

"Confidentiality breaches are occurring daily. While health care providers may not be malicious in their disclosures, they are still sharing patients' most personal information with unauthorized individuals, which has the potential to create problems," she adds.

Disclosure of patient information can lead to identity theft, discrimination, or social stigma if a medical condition or patient identification information, such as a Social Security number, is disclosed inadvertently, she adds.

As a result, a patient or family member could report the incident, resulting in a fine for the hospital under the Health Insurance Portability and Accountability Act legislation, she adds.

Mattson and her colleague **Maria Brann**, PhD, assistant professor of communication studies at West Virginia University, spent more than three months observing hospital staff in a 120-bed acute-care hospital in a small Midwestern town. The observations took place three days a week between the hours of 6:30 a.m. and 11:30 p.m.

"We primarily sat in open public spaces such as waiting rooms, hallways, and lunchrooms and observed what was happening with an eye toward looking for breaches in confidentiality," Mattson says.

The researchers didn't try to eavesdrop on conversations, she adds. "We just sat in place and could hear all these things going on."

In addition, the researchers interviewed 51 patients who were approached in open areas and asked about their experience with privacy in the hospital setting.

"Patients told us they want the hospital staff to be more aware that they're dealing with lives and to consider the ramifications of the information they divulge," she says.

It appeared that most of the breaches in confidentiality were unconscious. Hospital staff just forgot and discussed patient information out in the open, Mattson says.

The most frequent confidentiality breaches involved informal conversations between health care providers, she says. "We overheard health care providers talking to one another in the lunchroom about a fellow employee's health situation or discussing a patient's case right out in the open," she says.

The researchers also observed external confidentiality breaches — staff sharing confidential information with family or friends.

In many cases, hospital staff make telephone calls about patients while they are sitting at a desk in the waiting room or lobby, where they can be overheard by anyone within earshot.

"We observed people sitting at a desk and using the speaker phone to call the insurance company. They'd say the name and Social Security number, then take it off speaker phone. These conversations should be conducted in private offices," she says.

One patient in a hospital waiting room told the researchers: "I know that person. She's my neighbor. I had no idea she had that problem."

Hospital staff should conduct telephone calls in more private locations, rather than sitting at the desk in the waiting room, Mattson asserts.

"Hospitals need to change the arrangements of offices. In most places, you stand in a general line and wait and walk up to a booth. This creates situations where your personal information is overheard by everyone in the waiting room," she says.

The researchers recommend hospitals streamline processes so fewer people have to handle confidential patient information. Mattson cited another study that found 17 people on average have access to a patient's health information at a given time.[1]

"The hospital staff should look at whether that many people need to have access to the information and to change their procedures to limit access to the information to a few people," she adds.

Mattson recommends department managers have their entire staff sign a confidentiality

agreement in the hope that it will serve as a reminder to pay attention to inadvertent disclosures. Other recommendations include:

- Offer more thorough training to refresh the staff's memories about the need to think before speaking about a patient in an open area.
- Make staff aware when people can overhear their telephone conversations and ask them to make calls that involve patient information in a back room.
- Ask your staff: "Would you want this type of information revealed about you?" If people think about it in that way, they're more likely to be careful what they divulge, she adds.

1. Lazoritz M. Guarding patient confidentiality in a managed care setting, *Behavioral Health Management* September/October 1994; 46. ■

Tool locates alternative sites during bioterrorism

Initiative draws from integrated network process

Early this summer, several factors brought renewed attention to the possibility of terrorist attacks and appropriate responses on the part of the health care profession.

To help prepare for an effective response for such an event, the Agency for Healthcare Research and Quality (AHRQ) has released a tool to help state and local officials quickly locate alternate health care sites if hospitals are overwhelmed by patients due to a bioterrorism attack or other public health emergency. The alternate care site selection tool, produced by Denver Health, one of AHRQ's Integrated Delivery System Research Network (IDSRN) partners, was shared with emergency response planners at the 2004 Summer Olympics in Athens, Greece.

In the aftermath of a bioterrorism event or other public health emergency, hospitals may be overwhelmed by a sudden influx of patients, AHRQ explains.

The new alternate care site selection tool is designed to allow regional planners to locate and rank potential alternative sites — stadiums, schools, recreation centers, motels, and other venues — based on whether they have adequate ventilation, plumbing, food supply, and kitchen facilities, for example.

It is available free as an Excel spreadsheet on AHRQ's web site: www.ahrq.gov.

The effort to develop the tool began in October 2002, recalls **Stephen Cantrill**, MD, associate director in the department of emergency medicine at Denver Health Medical Center.

"It started with a task order from AHRQ that dealt with regional planning for bioterrorism," he notes. "We brought together partners from all of Federal Region 8 [Colorado, Utah, Wyoming, Montana, North Dakota, and South Dakota]."

The team included representatives from state departments of health, medical societies, and all the large hospital groups in the Denver metro area. Federal partners included the Public Health Service; the U.S. Northern Command in Colorado Springs, CO; the Department of Veterans Affairs; and the Federal Emergency Management Agency.

"We built on some of the earlier work that had been done by the command in terms of criteria," Cantrill says.

"We enhanced those, developed a kind of a grading scale to be used to look at facilities to be able, in a gross way, to determine the acceptability of potential alternative care sites — i.e., whether they fulfilled specific needs." The tool includes a list of about 30 different attributes, such as availability of toilet facilities, availability of communication lines, availability of a food service area, and so on.

"Basically, it's a big spreadsheet," he explains. "You go down, put your potential sites on one axis, your needs on another, rate them on a 0-5 scale [5 being the highest], add up your total, and see if it makes logical sense." This process aids in prioritizing different potential sites, to see which would be best to use, Cantrill adds.

"In an ideal situation, you do this as part of your advanced planning," he advises, so you are prepared if traditional health care sites are overwhelmed in a bioterror event.

While much of the data were specific to his region, Cantrill says the new tool demonstrates an approach of assessment of resources in any given region.

"We tried to develop some generalized tools. Naturally, there are variables, like the time of year, the nature of the incident," he points out. "If it's summertime, you may not care if you have heating, but you will want air conditioning. In Northern Montana, you want heating."

Therefore, there is no magic number in terms of a total score for a given alternative site. "What the tool does is give you the ability to do relative scaling," Cantrill adds. ■

(Continued from page 166)

were admitted, and it might have been as long as 24 hours later," White says.

The case manager for the transitional stay unit works an eight-hour shift Monday through Friday. She watches the patients on that unit closely and makes sure the test results get to physicians in a timely manner. She does utilization review, making sure that the patient is in the correct setting, whether inpatient or outpatient, and ensuring that the documentation is correct.

"These are patients that the hospital wants to manage more aggressively to either admit them to inpatient status or rule out a clinical condition that warrants hospitalization," White says.

The shift to an integrated model of case management was accomplished without an increase in budget and using the existing staff, White says.

"We took the current staff in each area and cross-trained them. At the time, we had the emergency department case management position staffed 24 hours a day. We decided we could make a bigger impact by having case management during the day and shifting some of the emergency department FTEs to the floor case management," she says. ■

Physician-specific CM pays off for hospital

Patients, physicians like continuity of care

A physician-specific case management program provides continuity of care for patients and creates a close working relationship between case managers and physicians at Nazareth Hospital in Philadelphia.

Nazareth Hospital is a 253-bed community hospital where many patients are admitted multiple times by the same primary care physician, often moving through the hospital's continuum of care from critical care to a medical-surgical bed, says **Monica Eckhardt**, RN, BSN, director of care coordination and emergency services.

The hospital made the decision several years ago to assign case managers (known as care coordinators) and social workers by physician.

"Our model has evolved from a utilization management model to a true case management model," Eckhardt adds.

The care coordinators work with the same physicians and the same patients, following them as they are transferred from floor to floor or department to department as they move through the continuum of care.

"Before the implementation of the physician-centric model, the care coordinators did not follow patients as they moved from telemetry to med-surg to a critical care bed. On many occasions, patients were seen by as many as three different care coordinators who would have to become familiar with the patients' plan of care. With the physician-specific model, the care coordinator is assigned from admission and follows them throughout the continuum of care to discharge," Eckhardt says.

An added benefit of having the same care coordinator manage a patient's care no matter where he or she is moved in the hospital is that patients and their families see a familiar face and have a greater level of comfort, she adds.

"Any hospitalization creates a stressful situation for patients and their families. Our goal is to make it as easy as possible for them by ensuring the continuity of the case management process. Switching case managers and social workers at every level of care is more stressful for the patient and the family," she says.

The model gives the care coordinators an opportunity to build a relationship with the patients and their families that continues over time instead of having to build a rapport each time the patient is admitted to the hospital.

When patients are readmitted, they already know their care coordinator and vice versa. The care coordinator is familiar with the patient's history and knows what problems to look out for, Eckhardt adds.

The hospital has nine care coordinators who work in acute care and typically manage the care for 17 or 18 patients at a time. The number of physicians to whom they are assigned depends on the volume of patients that physician admits. For instance, one care coordinator works with 10 physicians. Another is assigned to the patients of just three physicians who admit a lot of patients.

"As our relationship with the physicians has grown and improved, our outcomes and patient care have improved. When a care coordinator is off on vacation, the physicians say they feel lost without them. It's a nice working relationship that pays off for the hospital and the patient," she says.

The physicians work closely with the care coordinators and rely on them to be their eyes and ears

on the floor throughout the day, Eckhardt notes. Some physicians even call the care coordinator before a patient is admitted, notifying them when to expect the patient and discussing the plan of care. All of the care coordinators are available to go on rounds with the physicians, either in person or by telephone.

"Physician-specific case management builds trust with the physicians who work with us. They see the care coordinators as a resource that can make their lives easier," Eckhardt says.

The care coordinators work closely with the nursing staff. "They're seen as resource people, and the nurses call them up when difficult situations arise," she says.

When the care coordinators arrive at the hospital each morning, they look at their caseloads and set priorities as to which patients they will see according to acuity and patient and family needs.

"They facilitate the plan of care and assist the social workers in making the discharge arrangements," Eckhardt explains.

In addition to working with the physicians to whom they are assigned, the care coordinators have a close relationship with the hospital's clinical effectiveness physicians, two part-time physicians who work with the admitting physicians to develop and coordinate the patient's plan of care.

The care coordinators spend a lot of time on the floor, she says.

"A lot of case managers don't go to the bedside. Ours go to the bedside and develop a rapport with the patients," Eckhardt notes.

In addition to the acute-care coordinators, the hospital has disease-defined care coordinators, including a stroke care coordinator, an orthopedic surgery care coordinator, and a general surgery care coordinator who provide specialty care.

There are two care coordinators who work in the emergency department, coordinating care and discharge planning and notifying the care coordinators in acute care when a patient is being admitted. The emergency department care coordinators work 11 a.m. to 11 p.m. and cover six days a week.

All of the care coordinators in the hospital have tools available for quick communication, including Nextel mobile phones.

Eckhardt was a nurse manager at Nazareth Hospital eight years ago when the organization decided to develop a case management department. "I knew that case management was a good opportunity, and I wanted to get involved," she points out.

She and another nurse were the organization's first care coordinators.

The organization started out with disease-specific case managers who specialized in respiratory, cardiac, and orthopedic surgery case management. After nine months, the hospital staff and the case managers looked at how the model was working and decided to switch to a physician-specific model, Eckhardt says.

"Through the years, we've piloted other models, but we believe that the physician-centric model is the most advantageous for our patients," she explains.

The hospital is collaborating with a payer source on a pilot project to develop a way of sharing information between insurance case managers and the hospital's care coordinators.

The hospital's chief operating office is a nurse who often joins the morning rounds. "She has a unique awareness and appreciation for the duties of the care coordinators," Eckhardt says. ■

Team effort helps hospital exceed standards for CHF

Careful examination of indicators is the key

A team effort to improve care for congestive heart failure and heart attack patients has paid off for Saint Luke's Hospital and Mid American Heart Institute of Kansas City, MO.

The health care organization has been recognized by VHA Inc., a cooperative of not-for-profit health care organizations, for surpassing national standards for clinical excellence in treating the two cardiac conditions.

The hospital takes a different tactic with patients hospitalized with congestive heart failure and those with heart attack, but the strategy for managing both means keeping a close eye on the performance indicators recommended by the Centers for Medicare & Medicaid Services (CMS) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO), says **Geri Seavey**, quality resource analyst at Saint Luke's Hospital and Mid America Heart Institute.

The hospital's quality department examines all of the records of patients whose care doesn't meet expected performance measures to find out what has happened.

A heart failure team that includes physicians,

heart failure case managers, research nurses, and Seavey meets once a month to examine heart failure data and ways to improve patient care.

Before the meeting, Seavey reviews the previous month's data, including the indicators and the charts of each patient whose care did not meet the indicator recommendations. She reports her findings to the team.

"We look at our level of performance in terms of meeting indicators, and if we see a negative trend, we discuss why it might be happening and if any additional analysis needs to be done," she says.

Correct the shortcomings

The team determines what steps need to be taken to correct the shortcomings.

For instance, a significant number of the heart failure patients who were not discharged with ACE inhibitors were renal patients. The committee educated the renal and internal medicine physicians to make them aware of the performance measures.

In other instances, the physicians were not always documenting why the patients should not have the ACE inhibitors, particularly those who received an angiotensin receptor blocker (ARB).

"A lot of the problems with our past ACE inhibitor indicators performance were with lack of documentation. We could read the chart and understand that because of what is going on clinically with the patient, an ACE inhibitor shouldn't be prescribed, but the doctor should state that ACE inhibitors were not prescribed and include the reason," Seavey says.

If a patient did not receive a recommended treatment as defined by the indicators, the team sends a letter to the patient's physician, pointing out the missed treatment.

"We've gotten positive feedback from the doctors when they receive the letters reminding them of the quality initiatives. We have found that they didn't really understand that a variation from the recommended therapy required documentation. We want to raise physician awareness of the indicators for both heart failure and AMI [acute myocardial infarction]," Seavey says.

The heart failure physicians on the committee send e-mails to their colleagues periodically to make them aware of the indicators.

The committee compiles physician performance reports that are shared with the physicians when they go through the re-credentialing process.

When the team created a one-page discharge instruction sheet, covering all six required components of discharge teaching, performance under the discharge instructions indicators increased by more than 30%.

"We're not only talking to the patients, we're reinforcing that education in writing. We're giving it to them to put on the refrigerator as a reminder of what they need to do to improve their health," Seavey says.

Patients who have been hospitalized for congestive heart failure or a heart attack can be overwhelmed by the stress of hospitalization, and they often may forget verbal discharge instructions, Seavey says.

"The discharge instructions are a lot to be taking in when your health is a concern. The written instructions are a quick reference that reinforces what we tell them after they get home," she adds.

The written instructions contain information on the components required by the indicators: Physical activity, diet, weight monitoring, what to do if symptoms worsen, follow-up visits to the physician, and discharge medication.

The discharge instructions are formatted so they can be tailored to each patient. For instance, the instructions regarding weight monitoring and what to do if symptoms worsen are used for all heart failure patients.

The other components are changed for each specific patient, depending on the physician's orders.

The hospital is in the process of beefing up the discharge instructions to include more detail. The new instruction will be two pages, Seavey says.

The quality committee generates unit-specific reports so each nursing unit knows how well they are meeting the discharge instructions indicators. "We have found that if you cover it in one place, it doesn't mean you shouldn't cover it elsewhere," Seavey adds.

At Mid American Heart Institute, the care of heart failure patients is coordinated by case managers dedicated to that patient population.

They regularly examine the charts and progress notes to make sure the indicators are being followed, reminding the physicians when they are not. For instance, if a heart failure patient is not on an ACE inhibitor, the case manager puts a sticker on the chart and on the progress note to remind the physicians they need to document the reason.

The rehabilitation staff follow up on the indicators for the AMI patients.

"Their focus is to address risk modification and smoking cessation and to document it," Seavey says.

Any patient who has smoked at any time within the year prior to admission receives smoking cessation counseling. The hospital reinforces a smoking cessation discussion with videos.

"At one point, we tried having a nurse dedicated to smoking cessation. It worked very well. When she chose to take another position, we decided to incorporate the smoking cessation education with the risk modification instructions being provided by the rehabilitation staff, and this has been successful as well," Seavey says.

The hospital is updating all the order sets and pathways to include the core measures.

"With patients who have comorbidities, we can't always use the pathway and the order sets," she says.

The hospital currently uses paper records. The nurse prints out the order sets and pathways for the physician. The committees are in the process of revising the pathways and the order sets to include the indicators. The heart failure pathway and order sets have been complete. The AMI orders are still being revised.

"We review the patient charts retrospectively, abstract data from the charts, and enter it into the software. We tried concurrent review, but that's tough when people are scrambling for the charts. We didn't want to interrupt patient care," adds Seavey. ■

Holistic wound care yields better healing rates

One nurse provides hands-on care, plus CM

The wound care center at Presbyterian Hospital of Plano (TX) takes a holistic approach to patient care by assigning each patient to one nurse who provides hands-on care and case management.

"We found that providing all aspects of patient care and case management was a really good change for us. The nurses have expressed more satisfaction, and we believe we provide better patient care by taking a holistic approach," says **Kathy Zeller**, RN, BS, director of the wound care center, who adds that wound care case managers typically aren't found in the outpatient setting.

The case management piece is unusual in the outpatient setting. The outpatient wound care case management program has paid off in outcomes that have improved steadily, Zeller adds.

In 2003, the hospital's healing rate was 96%. This year, it exceeded 97% in the first quarter and was 100% in the second quarter.

"It has to do with having a good team that works together well," she says.

The staff at Presbyterian Hospital's wound care center all are registered nurses, with the exception of office staff and a nursing assistant.

Nursing staff all are cross-trained to handle both wound care and case management.

"Everyone knows the whole case management philosophy. They can pitch in and take care of patients' needs, document on the chart, and handle all of the patient coordination," she says.

The RNs provide the wound care and work as case managers for their patients, coordinating home health services, durable medical equipment supplies, transportation issues, and making sure the patients get their prescriptions filled.

"They get into the entire realm of case management, including documentation and medical necessity questions as they arise," Zeller says.

Case managers have been a part of the wound care center since it opened in 1995. In the first three years, some nurses provided the case management, with the others doing all the other work.

Zeller joined the center in 1998. In 2001, she decided to involve all the nurses in the wound care center in case management activities.

"I felt it would work better if everyone was trained the same way to provide the full level of care," she says.

Each nurse case manager handles all the patients of the physicians to whom she is assigned. The case manager accompanies the physicians when they see the patient and work with the primary care physician on any subsequent issues.

The nurse case managers make sure that everything the physician orders is carried out, that the patients get scheduled for the tests in a timely manner, and that the physician and patient are notified of test results.

The wound center runs 10 half-day clinics at Presbyterian Hospital of Plano, one all-day clinic in Allen, and one half-day clinic in Flower Mound each week.

The clinics are staffed by physicians in individual practices, among them a vascular surgeon, plastic surgeon, and a podiatrist.

The case managers typically cover patients in one to three clinics. For instance, one nurse works with a podiatrist at two of his clinics and a vascular surgeon at his clinic.

The rest of the time, she works as an intake nurse or a wrap-up nurse in other clinics, providing the patient education and making sure the patients understand what they need to do at home.

When patients are referred to the wound care center, intake staff handle the pre-certification or authorization process and send the patient a four-page detailed assessment form.

The nurse case manager accompanies the physician on the preliminary examination.

"The physician and case manager are a team. They go from patient to patient during the clinic. The nurse case manager is the primary contact for the patient," Zeller says.

The nurse case managers give their patients business cards and encourage them to call them with any questions about their care at home.

The case manager is also available to the home health nurse or other providers that may be caring for the patient. The patients come every week for the first four weeks and call the nurses if they have any questions. The nurses follow up on biopsy findings and other medical reports.

If a patient has to be admitted to the hospital, the nurse case manager organizes the admission.

The average healing time for most patients is 10 to 12 weeks. Some heal in a few weeks, and others visit the clinic over a longer period of time.

Some patients with chronic problems are in conservative care and come in every four to six weeks to make sure their wounds aren't getting worse.

The wound center has a vascular laboratory to evaluate patients with circulation problems.

"We offer one-stop care. Quite a few of our patients are elderly, and we make sure they don't have to go all over the hospital," she says.

The hospital contracts with Curative, a Hauppauge, NY-based company that provides wound care management for more than 100 centers and maintains a database of more than 450,000 patients.

CE *questions*

17. After Hurricane Charley, how many patients were evacuated from Southwest Florida hospitals?
    A. 300
    B. 1,000
    C. 550
    D. none
18. Homestead Hospital's integrated care management program gives the same title and job responsibilities to nurse case managers and social workers.
    A. true
    B. false
19. What is the average caseload of the care coordinators at Nazareth Hospital?
    A. 30 to 35
    B. 10 to 12
    C. 15 to 17
    D. 17 to 18
20. When St. Luke's Hospital and Mid America Health Institute implemented a discharge instruction sheet covering all six required components of discharge teaching, by what percent did the hospital's performance on that indicator increase?
    A. 10%
    B. 30%
    C. 15%
    D. 60%
21. By taking a holistic approach to wound care management, Presbyterian Hospital of Plano was been able to achieve what healing rate for last quarter?
    A. 100%
    B. 98%
    C. 89%
    D. 95%

Answer key: 17. C; 18. A; 19. D; 20. B; 21. A

The company provides the hospital's wound center with a clinical pathway for the care of patients with chronic, nonhealing wounds, documentation support and other forms, policies and procedures, educational materials, and marketing materials that offer CME programs for physicians and CE courses for nurses. ■

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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. ■

2004 SALARY SURVEY RESULTS

HOSPITAL CASE MANAGEMENT™

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Case managers are still fighting to prove their value

Challenges, opportunities are in the future

Salaries for case management are increasing, but the vast majority of case managers are working far more than the traditional 40-hour week, according to the results of the 2004 *Hospital Case Management* Salary Survey.

The 2004 survey was mailed to readers of *HCM* in the June issue. More than half the respondents (58%) were case management directors. Others were case managers, utilization managers, social workers, or had other titles.

(Editor's note: Some graphs do not add up to 100% because some participants did not answer every question.)

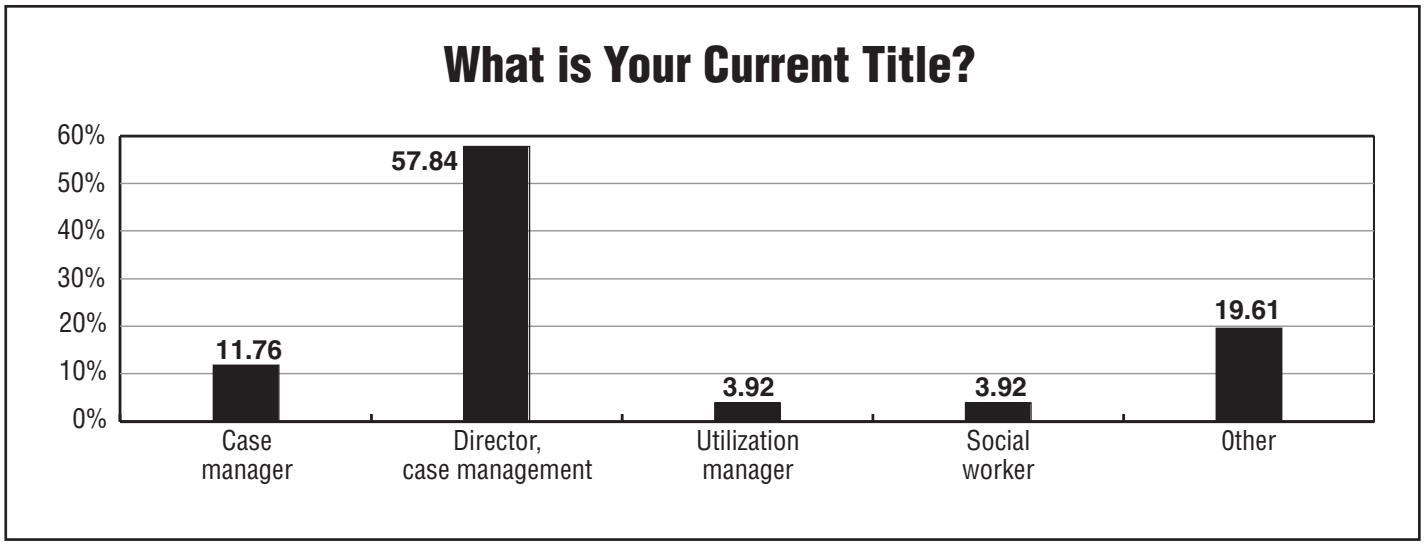
Respondents to the survey report putting in long hours. In fact, more than 80% report working more than 40 hours a week, with 18.5% working more than 50 hours a week.

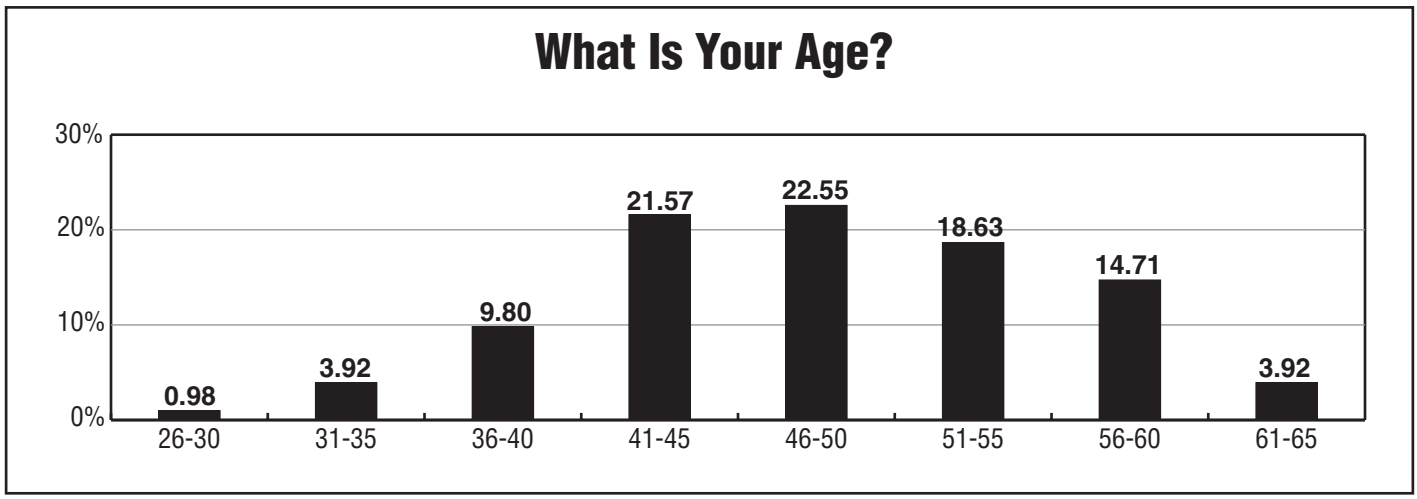
At the same time, 88% of respondents reported an increase in salary during the past year. The highest percentage (41%) reported getting a 1% to 3% raise, followed by 36% whose salary increases were between 4% and 6%.

Nearly 65% of respondents to the survey report salaries in the $60,000 to $90,000 range, with nearly 10% reporting salaries in excess of $100,000 and 16% reporting pay of $60,000 or less.

Salaries are still an issue when it comes to recruiting and retaining experienced case management staff, case management directors say.

Case management departments have problems recruiting at some hospitals because pay for case managers is less than the pay for staff nurses, says





Toni Cesta, PhD, RN, FAAN, vice president, patient flow optimization for North Shore-Long Island Jewish Health System in Great Neck, NY.

Disparity in pay by region

There's a big disparity in pay for case managers both by region and by hospital. Sometimes case managers are paid at the clinical nurse specialist level; sometimes at the management level, and sometimes at the staff level, Cesta adds.

"In a lot of areas, case managers don't make what nurses make, and that makes a big difference," adds **Mary Ellen Beasley**, RN, BSN, division director for case management for HCA's 15-hospital West Florida division with headquarters in Palm Harbor, FL.

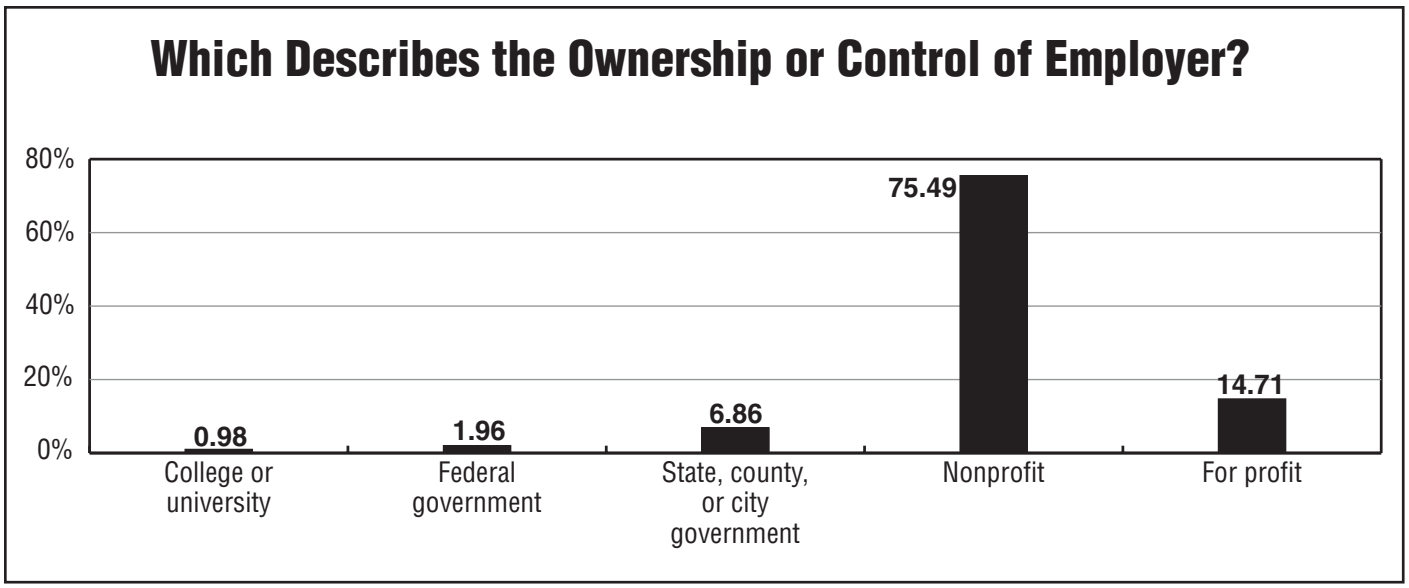
Beasley has had to replace five case management directors in the last year because they found jobs that paid more or changed careers paths.

"Some of them left nursing altogether, going into real estate or other professions. It wasn't just about moving up to be a nurse or case manager at a different facility," she says.

Not enough experienced case managers

Finding an experienced and competent person to fill the case management director's job presents a major challenge because case management is a fairly new field and there aren't a lot of experienced people available, Cesta adds.

"It's difficult to run an integrated case management department. A lot of people have been



plopped into case management by default. It takes years to really understand the complex job of case management. We just don't have people who started out as an assistant director and came to move up to director," she notes.

Case management directors find the nursing shortage another challenge to finding experienced staff to manage patient care.

"You can't just walk into this type of job. You need a wide body of knowledge, and it takes a while to get somebody trained," explains **Sharon Simmons**, CRNP, MSN, CNOR, director of clinical excellence for St. Vincent's Hospital in Birmingham, AL.

Often, hospital administrators think that case management is less difficult than nursing because it doesn't involve direct patient care, Cesta notes.

Multiple skills are needed

On the contrary, a good case manager is someone who has extensive clinical experience and multiple skills, she adds.

"Case managers are being asked to do more and do it faster and better than ever, " Beasley says.

The question is: just how much more can case managers take on and still do it appropriately, she adds.

Case management has become a complex specialty as regulations and requirements have increased, Cesta points out.

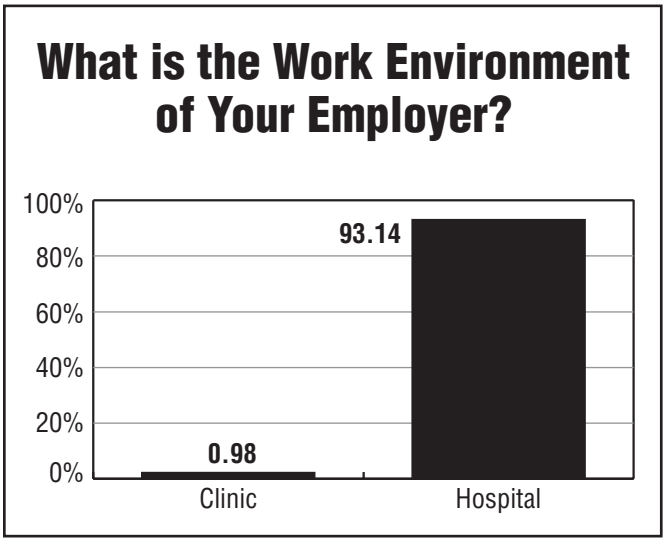
"When people look at it from the outside, it looks fairly simple. Many people don't understand the relationship between finances and case management. If the hospital doesn't give the case management department the money it needs to function well, it's shooting itself in the foot," she says.

Cesta is a firm advocate of an integrated case management model, which she says typically produces the best outcomes and is more user-friendly to physicians and staff.

Just not enough time in the day

The problem with integrated job functions is that in many hospitals, the caseloads have not been adjusted, she adds.

"When role functions increase, caseloads should get lower. If you do a time and motion study and look at how long it takes to accomplish all the tasks the case managers are expected to do, you can easily see that there's not enough



time in the day," Cesta points out.

Case management departments need to have floating staff who can take over the caseload when someone is absent, rather than spreading out the cases among the regular staff already struggling with a caseload of their own.

"If you double someone's caseload, they become useless. Case management departments should have a provision in their budget for floating staff," Cesta says.

A change in title only

When she speaks at conferences, Cesta often asks her audiences to raise their hands if they were a utilization review nurse on Friday and a case manager on Monday.

"It's not uncommon. The titles change and nothing else changes. It was a problem 10 years ago, and it's still happening. It's a product of administrators who don't understand case management," she says.

CMs need advocates

Case managers need an advocate, someone who can educate hospital leadership about their value to the organization, Cesta explains.

Hospital case management departments often face budget cuts because they're not revenue-producing departments and the hospital's financial people don't recognize their value, Simmons adds.

That's why she makes it a point to produce a monthly report for her hospital's executive team detailing what the case managers do and tying a dollar figure to their accomplishments.

She has compiled data on denials, length of stay, and case-mix index before the case management department was started four years ago and compares it to current data.

"We're able to show improved reimbursement based on documentation improvement and to track days we saved by intervening and moving patients out of the system," she says.

As a result, Simmons has been able to pay competitive salaries and offer flexible hours to retain her experienced staff.

Case management roles are changing dramatically, reports **Jan McNeilly**, RN,CPHQ, CPHE, principal for clinical advisor services at Premier, Inc. hospital alliance, a San Diego-based hospital purchasing group.

"Case managers are no longer concentrating on discharge planning and utilization review. They've taken on more responsibility, including being involved in what's going on clinically with the patients, coordinating care, and making sure that documentation is correct," she says.

Many of the hospitals that contract with Premier Inc. have increased their case management departments, McNeilly points out.

"There's a huge focus on length of stay and the types of beds that patients are in while they're in the hospital. The case managers are making sure the patient is always at the right level of care," she explains.

Always a need for case management

Case managers are going to be needed more than ever as the health care consumer, whether it's an individual or a corporation, becomes more aware of outcomes and cost-effective care, says Simmons.

"Case managers are going to be the driving force in improving outcomes, and they need to sell themselves to the administration that way," she adds. ■