HOSPITAL CASE MANAGEMENT™

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

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IN THIS ISSUE

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Help your hospital meet the new medication reconciliation requirements

JCAHO requires complete medication lists at admission, transfer, discharge

Case managers should be part of the team that ensures hospitals meet the Joint Commission on Accreditation of Healthcare Organizations' medication reconciliation requirements, says **Patrice Spath**, RHIT, health care quality consultant with Brown-Spath & Associates in Forest Grove, OR.

The 2007 National Patient Safety Goals call for hospitals to accurately and completely reconcile medications across the continuum of care to make sure there are no errors of transcription, omission, duplication of therapy, or drug-drug interactions, says **Carol Ptasinski**, RN, MSN, MBA, senior associate director of standards interpretation for the Joint Commission.

"Completely reconciling means comparing medications that the patient has been taking prior to admission with medications the organization is about to provide," she says.

In addition, the Institute of Medicine of the National Academies released a report in July, *Preventing Medication Errors,* in which it called for a series of actions for health care organizations, including medication reconciliation, electronic prescription writing, and better communication between health care providers and patients. **(For details on the report, see related article on p. 165.)**

Medication reconciliation needs to occur any time the organization requires that orders be rewritten and any time the patient changes services, setting, provider, or level of care and new medication orders are written, Ptasinski says.

Beginning in 2007, the Joint Commission will require an organization to provide the list of medications to the patient and his or her primary physician or send it to the post-acute facility that will care for the patient.

"The list should be provided to the primary care physician before the patient's next appointment to ensure continuity of care," Ptasinski says.

Some organizations were not sure that the medication list had to be given to the patient, under the 2006 goals. The 2007 goals clarify that and say if a patient is discharged to home, the list should be given to the patient in a form he or she understands, Ptasinski adds.

Case management's role in a hospital's medication reconciliation efforts depends on the case management model, Spath points out.

At the very least, case managers should be aware of the medication reconciliation requirements and should be involved in the discussions of how the hospitals will meet the requirements, Spath says.

"Unless case managers are managing the care of 100% of patients, they can't be totally responsible for medication reconciliation. If the case managers do not see every patient in the hospital, they are likely to have a secondary role in medication reconciliation efforts," Spath says.

Even if case managers don't have the primary responsibility for medication reconciliation, they can act as a backup or safeguard to make sure that the medication reconciliation process occurs as patients move through the system, she says.

At Calvert Memorial Hospital in Prince Frederick, MD, case managers are a safety net for the hospital's medication reconciliation efforts, says **Jennifer Stinson**, RN, BSN, CCM, director of case management.

The case managers round daily with the clinical pharmacists, who are located on every clinical unit in the hospital.

"The clinical pharmacist is on the unit and easily accessible by the staff. They are the medication gurus, and we can pull them in at any time to answer any questions the patient may have," Stinson says.

They go over the medications that are ordered while the patients are in the hospital, those they were taking before admission, and those they are supposed to take after discharge.

"The case managers are in a unique position at this institution. They see the patients from admission to discharge and are in a great position to monitor the medication reconciliation process to make sure it is taking place," Stinson says.

Under the JCAHO requirements, the hospital should make sure the patients are on the right medication regimen when they are transferred from the intensive care unit to a step-down unit and from the hospital to home or a post-acute facility.

At the time of admission, someone, usually a nurse, should collect information about what medications the patient is taking, according to Ptasinski.

The Joint Commission encourages hospitals to identify medications, such as insulin, that are higher risk and that should get priority in your medication reconciliation efforts.

"You don't want to wait 24 hours to find out a patient is taking some kinds of medications," Spath says.

One role for case managers is to serve as a

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Editor: **Mary Booth Thomas**, (marybootht@aol.com).
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcmedia.com).
Senior Production Editor: **Nancy McCreary**.

Editorial Questions

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

backup person who alerts the rest of the staff when the medication reconciliation requirements have not been completed.

Case managers can be particularly helpful as the hospital compiles lists of medications the patient was taking before admission, Spath points out.

"A lot of patients don't carry a list of their medications in their pockets, and they may not have the information when they are admitted," she says.

Case managers should encourage patients and family members, particularly those with chronic conditions, to create a list of medications and keep it with them at all times.

"Maybe hearing the case manager explain the importance of keeping the list will encourage them to write their medications down," Spath says.

Many hospitals develop medication wallet cards that they give patients with the admonition to keep them updated.

"Case managers can help reinforce the importance of keeping the medication list," she says.

El Camino Hospital in Mountain View, CA, has been involved in educating the public about the importance of letting their medical providers know exactly what medications they are taking.

"The community is getting more attuned to the medication reconciliation issue. Some patients are coming into the hospital with a bag of pills saying they know they're supposed to bring them," says **Michael Fitzgerald**, MS, RN, CS, who chairs the hospital's medication reconciliation committee.

The hospital plans to participate in community health events, handing out cards with places for people to list the medications they are taking.

"The goal is that they will bring the card with them when they see their physician or come into the hospital," he says.

The hospital is working with physicians to encourage them to update their patients' list of medications during every office visit.

At Calvert Memorial Hospital, the case managers support the efforts of the bedside nurses to educate patients on their medication use and other discharge issues from the beginning of the stay.

"Medication reconciliation and patient education is very much a team effort," Stinson says.

The case managers document that the patient has received discharge education about his or her medicines. For instance, if a patient is taking a lot of medication or his or her medication has been adjusted during the hospital stay, the case manager and pharmacist work together to make sure the patient understands the medication changes and that he or she should throw out the old medication after discharge.

Case managers often are the first to pick up if a patient is having a problem with his or her medication, Stinson says.

"Case managers are in such a unique position with patients. We see them from start to finish and are in a position to identify any system failures or risk management issues that occur," Stinson says.

Medication lists

The Joint Commission's 2007 goals call for an organization, with the patient's involvement, to create a complete list of the patient's medications at admission and to ensure that the medications administered to the patient are compared to those on the list and any discrepancies or problems are resolved. The list should include over-the-counter medicines, vitamins, and supplements, Ptasinski says.

"When a patient comes into the hospital, whether it's through the emergency department, a direct admit, or through ambulatory surgery, someone on the staff must get an accurate and current list of the patient's medications," she explains. The organization needs to determine which staff member will obtain the list of medications the patient is on.

In the inpatient setting, the list should be included on the patient's medical admission record. Any time new orders or prescriptions are written, whoever is writing the prescription should make sure it is included in the medical record.

Problems have occurred in the past when a patient was admitted to one unit, such as the intensive care unit with medication orders issued, then transferred to another unit where he or she would continue getting the medication ordered in the ICU along with new medications ordered on the unit, Spath says.

Another trouble spot for medication errors is the surgical unit. Sometimes when a patient is discharged after surgery, the surgeon writes, "resume all previous medication" without knowing what they were and without realizing that some could be discontinued after the surgery.

"When patients go home and resume taking one medication, they might not realize that their new medication is the same, but it's either generic or a different brand name. This can cause tremendous problems," Spath says.

This is why whoever is in charge of the discharge

process should make sure their patients understand what they should be taking and what they should not be taking, Ptasinski adds.

Before the patient is discharged, someone on the staff, as determined by the organization, should go through the entire list of medications, looking at what the patient was taking before admission and comparing them with what the patient will take after discharge, Ptasinski says.

She suggests that whoever writes the discharge instructions should write, "Do not take this medication," and "Now take this medication instead" to make sure that the patient clearly understands what to take and what not to take.

For more information, contact Patrice Spath, RHIT, health care quality consultant, Brown-Spath & Associates in Forest Grove, OR. E-mail: patrice@brownspath.com. ■

Multidisciplinary team leads reconciliation efforts

Proactive approach addresses challenges

At El Camino Hospital in Mountain View, CA, medication reconciliation is an essential part of the admissions process that needs to continue at discharge or transfer of care, reports **Michael Fitzgerald**, MS, RN, CS, clinical nurse specialist, who chairs the hospital's medication reconciliation committee.

The medication reconciliation committee is a multidisciplinary group that includes physicians, nurses, pharmacists, a representative from quality management and clinical effectiveness, the emergency department, clinical nurse specialists, and the education staff.

The hospital already was addressing medication reconciliation through its clinical documentation system when the Joint Commission issued its requirement, Fitzgerald says.

Medication reconciliation is an ongoing process that begins at admission, he says.

In the emergency department, the triage nurse, the physician, and the primary nurse are responsible for collecting information on the medications a patient is taking. The ultimate responsibility for medication reconciliation lies with the physician.

Patients who come into the hospital with a complete list of the medications they are taking are definitely the minority, he says.

"We can't always trust the bottles they bring in. Some patients bring in prescription bottles that contain pills that are not the medication listed on the bottle," he says.

Figuring out what the patient is taking can be like solving a puzzle, Fitzgerald says.

The staff gather what information they can from the patient and family, sometimes sending family members home to gather all the medication bottles and bring them back.

The emergency department staff have the option of calling the provider or the pharmacy for information.

"There's not an easy way for us to get information from their databases because of HIPAA and other security measures. It's also hard to get an answer from a doctor or pharmacist at 1 a.m.," Fitzgerald says.

The staff ask about alternative remedies, herbal medicines, vitamins and other supplements, and over-the-counter medications the patients may be taking.

"When we set up our medication reconciliation process, we identified potential failures before they became a problem. We broadened what we ask patients and don't limit it just to prescribed medications," he says.

The staff approach patients in a friendly, nonconfrontational manner when they talk about medications and use the term "medication adherence" rather than "compliance" because it sounds less negative.

"We do not make a judgment about what the patient is taking or about medication compliance. We tell them that we can help them better if we know whatever medications, drugs, supplements, or alcohol they are using," he says.

Very few people are compliant about taking their medication as prescribed, and many don't know what they are taking, Fitzgerald says.

"A lot of time, patients come into the emergency department and tell the nurse that they are taking a little blue pill or that they used to take one medicine and don't know the name of what they are taking now," he says.

The hospital's electronic medical record is set up so that physicians can view all medications a patient is taking and can compare side-by-side the medications ordered and what patients are taking prior to coming to the hospital.

If the patient wasn't sure of the name of the medication or just had a description, the staff can enter "little blue pill" in the record.

As a patient moves between floors of the hospital, a side-by-side review of medications is required.

"The challenge is keeping the surgeons involved in the process. For instance, if a patient is admitted to the hospital for a procedure, the surgeon may not be comfortable prescribing the patient's insulin. It takes a lot of advocacy on the part of the nurses to make sure the list of home medications is accurate and that it is addressed while the patient is in the hospital," he says.

Some patients bring their own medications and want to direct their own care, partly because of the expense of medications issued by the hospital and partly because they believe a certain combination of medications, including herbal medicines, has worked for them.

"We address these issues through the pharmacy and therapeutics committee, and if a medication isn't in our formulary, we do what we can to get it added," he says.

The hospital pharmacist reviews any medications ordered to make sure they do not have a negative interaction with other medications.

"We have educated the staff about the importance of getting the medication that patients bring with them to the pharmacy and making sure what is on the bottle is what is inside and that there are no contraindications with what else has been prescribed," he says.

Following admission, the hospital's primary care nurses are involved in the medication reconciliation process at the bedside.

"Their responsibility is to make sure that continuity of care is addressed when the patient is discharged. If there are issues with medication, they are involved," he says.

"The primary care physician needs to know what medications have been prescribed, and the patient needs to have clear instructions. The goal is to educate them about the medications they are taking and give them a list to take to the next provider of care," he says.

The hospital plans to develop a fax server that works in conjunction with the electronic medical record that will allow staff to fax the information to the next provider, rather than relying on the patient to be the link.

At present, the discharge nurse and the physician sit down and talk to patients about the importance of following the discharge instructions and letting their physician know what medications they are taking.

A newly implemented computerized discharge form, which includes discharge instructions and medications, is to be printed, and then signed by the patient.

The hospital has a facility transfer form that includes very specific information about medications. It is filled out by the care coordinator and reviewed by the physician.

The team looks at the receiving facility's formulary to make sure the medications will reconcile. For instance, a patient might be on one medication when hospitalized but on another one for outpatient, under MediCal's formulary.

The hospital's computerized documentation system created a challenge for the hospital's medication reconciliation efforts because it did not have the tracking built in, Fitzgerald says.

"Electronic systems don't necessarily have as much flexibility as a paper system. It was a difficult hurdle initially, but the electronic system has great potential to make the process easier," he says. ■

Be a patient advocate to prevent medication errors

Report calls for increased patient communication

As a hospital case manager, you can have an important role in your hospital's efforts to prevent medication errors, which harm at least 1.5 million people every year at a conservatively estimated cost of $3.5 billion, according to a report from the Institute of Medicine (IOM) of the National Academies.

"The report recommends having patients become a more active member of the health care team, but when patients are in the hospital, they are sick and sometimes confused. They need someone, like a case manager, to step in and become the patient's advocate on the health care team," says **Albert Wu**, MD, MPH, professor of health policy and management at Baltimore's School of Public Health at John Hopkins University, attending physician at Johns Hopkins University Hospital, and a member of the IOM committee.

The report, *Preventing Medication Errors*, issued in July, sets out a comprehensive series of actions for health care organizations, government agencies, pharmaceutical companies, and patients to prevent medication errors, which are common at every stage of the medication use process, beginning

with prescription and administering the drug and monitoring the patient's response.

The report cites estimates that there is at least one medication error per hospital patient per day.

"The rate of medication errors and the frequency of adverse events from medication are unacceptably high," Wu says. "It's actually possible that the number of errors is going up because the number of prescriptions has increased dramatically over the past 10 years to at least 4 billion prescriptions a year."

In addition to recommending that all prescriptions be written electronically by 2010 and suggesting ways to improve the naming, labeling, and packaging of drugs to reduce confusion and prevent errors, the report recommends a paradigm shift in the patient-provider relationship so that patients take a more active role in their own medical care.

"One of the most effective ways to reduce medication errors is to move toward a model of health care where there is more of a partnership between the patients and health care providers," the report concludes.

Patients should understand more about their medications and take more responsibility for monitoring those medications, while providers should take steps to educate, consult with, and listen to the patients, the report says.

That's where case managers can be valuable members of the health care team, Wu says.

Case managers should make sure that all of the information they have collected about the patients, particularly a list of all medications, allergies, and medical problems, is available to the treatment team, he suggests.

"They should have a role in reconciling current medication at the time of discharge from the hospital with the medications that patients were taking at home before admission," Wu says.

Medication errors encompass mistakes that involve over-the-counter products, vitamins, mineral and herbal supplements, as well as prescription drugs. That's why case managers should make sure that everything a patient has been taking and intends to resume taking after discharge is in the patient record, he adds.

There's a lot of confusion among patients about medication given in the hospital vs. what they were taking at home, Wu says.

Case managers should go over the medication with the patient and make sure that the patient understands what to take after discharge and what to discard, checking with the physician for clarification as necessary.

When patients receive educational materials or other information from the pharmacy or hospital, the case managers should make sure that they are written in a language that patients understand.

"Patients need to understand medication adherence, side effects, conditions related to food or drink, and interactions with other medications. Information on all of this can be collected and presented to the patient at a time when he or she can understand it," he adds.

Another important role for case managers is to ask questions of the attending physician if the patient isn't clear on his or her treatment regime and relay the answers in a language the patient can understand.

"Treatment recommendations and discharge instructions can also be confusing. As an advocate for the patient, case managers can make sure they understand," he adds.

As they visit their patients, case managers should proactively ask them if they are having symptoms that could be a side effect of medication, even if it is not their responsibility.

"This may be a little redundant, but it's something that other staff may forget to do," he says.

Help your patients prepare for a visit from the doctor so they can have better and more efficient discussions during the limited time the physician has.

"It's important for the patient to have goals for the encounter to make sure that things that are most important to them get addressed," he adds.

For more information, visit the Institute of Medicine web site: www.iom.edu. ■

Proactive approach reduces denial rate to 5.8%

CMs work with medical director on potential cases

The denial rate at Southern Ocean County Hospital dropped from the double digits to an average of 5.8% in less than 18 months, thanks to a proactive approach by the case management staff and the medical director.

"The case managers and medical director Sekander A. Ursani, [CPE, MD] work as a team to reduce denials and avoidable days and ensure

(Continued on page 171)

CRITICAL PATH NETWORK™

Case managers take the lead in clinical quality indicators

Hospital meets CHF, AMI, pneumonia indicators 96% of the time

When NorthEast Medical Center in Concord, NC, began an initiative to improve compliance with clinical quality indicators in 2003, compliance for the congestive heart failure and pneumonia clinical indicators was at 84%. In the most recent quarter, the hospital met those indicators 96% of the time.

When the Centers for Medicare & Medicaid Services (CMS) introduced its quality indicators, Leesa Bain, the hospital's vice president for clinical effectiveness, looked for the most effective way to meet the requirements while remaining cost-neutral. She chose the case management department as the most qualified and logical staff to monitor and affect compliance and collect the data without duplicating job functions, says **Deb McGowan**, RN, director of case management.

"The case managers open every chart, collect all the clinical information, and see every patient. They have a good relationship with the physicians and bedside nurses, which is critical to changing physician and nurse behaviors and processes. It made sense that this was the right group of people to be in charge of the CMS quality indicators," she adds.

In addition to collecting data for the CMS core measures, the hospital participates in the Institute for Healthcare Improvement's 100,000 Lives Campaign.

At NorthEast Medical Center, case managers are responsible for coordination of care and discharge planning, as well as making sure that all protocols and guidelines are being used appropriately. The hospital has a separate utilization review staff who also assist in data collecting retrospectively, utilizing the hospital's case management software.

The case managers also collect information concurrently and can identify when the clinical quality indicators are not being met.

A key component of the initiative is a quality improvement tool, developed by the case management department, which is used weekly to identify the bedside or emergency department nurse and the physician who are responsible for an indicator not being met. The tool, referred to as the Weekly QI Tool, is a spreadsheet with all the clinical quality indicators on it. The tool highlights, in real time, areas for process improvement and identifies the responsible staff.

The case managers make a note of the staff who were responsible for the patient every time a quality indicator isn't met.

At the end of every week, the case managers generate a report that goes to every nurse manager, the chief executive officer, and the vice president of quality. The report contains data on the cases that did not meet the clinical indicators, along with the clinicians who were responsible.

For instance, if a patient did not get an antibiotic within four hours because the physician didn't order it, the report includes that information along with the name of the physician. If the physician ordered the antibiotic but the nurse didn't give it within the four-hour window, the report identifies the nurse involved.

"No one wants their name on the list that goes to the CEO," McGowan says.

The information goes back to the manager's level, where it is used to make quality improvements. If a physician is the person who failed to follow the recommended quality indicator, the medical director talks to the physician and makes

sure the oversight doesn't become chronic. Incidents of missed quality indicators also are addressed at department meetings.

"This tool has been very helpful in identifying where gaps occur and has helped the clinical staff understand how the clinical indicators affect patient care," McGowan says.

The report is particularly useful because staff get reports on the clinical indicators every week, when the lapses are fresh in their minds, rather than at the end of the quarter, when they may have forgotten the particular incidents when they failed to meet the indicators, she points out.

The hospital has staff who assign patients to case managers upon admission. Case managers receive their daily census when they come in.

"Each case manager has a set of priorities. The clinical indicator patients are the No. 1 priority. They are seen early in the day so the case manager can make sure that they are receiving the recommended care," McGowan says.

For instance, case managers on the cardiac units see all heart attack and congestive heart failure patients to make sure that the clinical indicators are considered, every single day.

Affecting outcomes

If there is a missing indicator that can be taken care of concurrently, the case manager goes in person to the nurse and reminds him or her that the indicator needs to be followed.

"Their review is done in real-time, which means that can actually impact the outcomes," McGowan says.

For instance, if a patient is being discharged at 2 p.m. and the case manager observes that smoking cessation education has not taken place, she can alert the bedside nurse to make sure it occurs.

In addition, the hospital's discharge system is coded to prompt the nurse to make sure the indicators are being met.

For instance, if the patient was hospitalized with an AMI, the discharge system prompts the nurse to make sure the ACE inhibitors and beta-blockers have been prescribed.

If there is something that can't be impacted, such as an incidence in which a pneumonia patient did not get an antibiotic in a timely manner, the case managers collect the information and enter it into the quality improvement tool.

"If we can't impact it, we don't do any education concurrently, but by entering it into the tool and tracking it on a weekly basis, we can quickly identify the people who are not meeting the indicators," McGowan reports.

The case managers who are responsible for the emergency department work with the staff educators to make sure that the pneumonia indicators are being met.

If a patient is admitted overnight and the case manager finds that the recommended indicators were not followed, she does a root-cause analysis of what might have happened to cause the oversight.

"We still have an issue with the antibiotic being administered to pneumonia patients within four hours. We meet with the emergency room physicians almost every month to share the information with them. In addition, we go over the records, case by case, to determine if it is a nursing process issue or an ordering issue," McGowan says.

When the quality indicator initiative began, the case management staff worked closely with the hospital's surgeons to make sure the appropriate antibiotics were being administered for infection prevention in a timely manner following surgery.

"The surgery service line coordinator met with the physicians and pointed out the times when the physician didn't give the antibiotic in a timely manner and when the right antibiotic was not prescribed. The surgeons changed their practice patterns and began using the correct antibiotics," McGowan says.

In some cases, they modified their standing orders to ensure compliance.

"At a recent surgery meeting, one of the early noncompliant physicians was actually lecturing new physicians on the importance of these indicators in affecting patient outcomes. What a great moment," McGowan adds.

In one case, the team called in a pharmaceutical representative to explain to a physician why the antibiotic he was prescribing was not the best one for patients who had had bowel surgery.

In 2005, the hospital was meeting the surgical infection prevention indicators 85% of the time. By July 2006, the figure had risen to 99%.

McGowan attributes the success of the program to the high esteem in which case managers are held by the rest of the staff.

"At this hospital, case managers are seen as people who coordinate the care. The clinical indicators just become part of what they coordinate. One role is to ensure that the patients get the best evidence-based clinical care. For instance, if a patient needs to have certain medications prescribed when they leave the hospital, ensuring

that happens is just part of coordinating the care," she says.

The physicians and service line nurses already had a good relationship with the case managers and welcomed their help in meeting the indicators, McGowan adds.

"It wasn't like someone from the outside, in a newly created position, coming to interfere with patient care. The case managers are respected clinicians, and the rest of the treatment team knows they can depend on them for help," she says.

For more information, contact Deb McGowan, RN, director of case management, NorthEast Medical Center, Concord, NC. E-mail: dmcgowan@northeastmedical.org. ■

Wireless laptops improve CMs' efficiency, cut LOS

Documentation is completed in patients' rooms

Wireless laptops at Montefiore Medical Center in New York City have dramatically increased the efficiency and effectiveness of the case managers, improved throughput, and enabled them to monitor patients who are readmitted frequently.

The hospital's 10 nurse case managers began using their wireless laptops, connected to the hospital's district server in December 2005, according to **Alex Alvarez**, RN, BSN, director of the care management resource unit at the two-hospital medical center. The nurse case managers are employed by the Network Management Service Organization.

The hospital has had universal work stations equipped with computers on every unit for years.

"The problem has been that the computers are always in use and there simply was no place to put extra computers. By using laptops, the case managers can access the hospital's server from anywhere. They do more because they're much more efficient," he says.

Having a laptop they can take with them into patients' rooms minimizes the time the case managers spend in the office and gets them out on the floor, working with patients and the treatment team, Alvarez says.

The case managers, who are assigned by unit, received new laptop tablet-type computers in December 2005. Earlier in the year, the hospital deployed an electronic patient folder (EPF) that makes previous medical records available on the hospitals' computer system.

The combination of the laptops, access to the hospital's clinical information system, and the EPF saves the case managers time in organizing their day, gives them constant access to their patients' medical records and past medical history, allows them to track the patient's progress, and monitor laboratory and other procedures in real-time. They can take the laptops into the patient rooms and document while they are talking to the patients, rather than relying on their notes and entering the information later.

When a patient is discharged from Montefiore Medical Center, his or her chart is scanned into the hospital's computer system within 48 hours.

This allows the case managers to research a patient's chart and get notes on his or her last admission.

"The case managers now have full access to the previous medical record. In the past, they had to go to the medical records department, request a chart, and wait a day or two to get it," he says.

When the case managers log on to the computer, they have a list of new admissions from the day before, divided by unit. The hospital's clerical support staff identify patients who meet the criteria for review and place them on each case manager's electronic work list. The wireless laptops have allowed the case management department to initiate a project to reduce frequent readmissions by drilling down to determine the reason for the readmissions.

Each day, the hospital's admission system identified all admissions from the previous day that meet the criteria for multiple admissions. Those patients are flagged as they are assigned to case managers.

Using the electronic medical records system, the case managers review the previous admissions to look for the reason the patient was readmitted and then interview the patient and family members and talk to the admitting physician, in an effort to identify why the patient is readmitted frequently.

"It may be that the patient can't pay for the medications they need, lack of knowledge about their condition, missing follow-up visits with the physician, social issues, or other problems," Alvarez says.

The case managers contact the primary care physicians to find out what has been going on

with the patients and to find out whether the physician knew that tje patient had been admitted to the hospital.

They discuss the discharge plan with the primary care physician and work with him or her on strategies to prevent readmissions.

The case managers and the utilization management staff can use the laptops to make referrals to skilled nursing facilities directly from the patient's hospital room, often getting a response while they still are with the patient and family.

"It saves a lot of time on the telephone and gives the case managers more time to spend with their patients," Alvarez says.

The network care management department, made up of case managers and utilization management nurses, uses an electronic discharge planning system that allows case managers to create referrals and send them automatically to participating skilled nursing facilities.

"Using this system allows us to give the patients a choice of facilities, and, with one keystroke, we can send a referral to numerous facilities and get a response on-line, sometimes within minutes," Alvarez says.

The system allows the hospital to leverage the competitive skilled nursing home market, Alvarez added.

"The nursing homes in our area are looking for a way to be ahead of the competition, and they respond very quickly. It's really helped us on throughput issues," he says.

The hospital began using the electronic post-discharge placement system in July 2004. In 2003, the average length of stay for patients being discharged to a skilled nursing facility was 10.01 days.

"This system was slowly deployed and made available to the entire hospital in December of 2005. On the units where the system had been deployed, length of stay was down to 8.5," Alvarez says.

Alvarez attributes the drop in length of stay to the efficiencies of the electronic post-acute referral system, which allows case managers to make numerous referrals at the same time, and the medical center's computerized clinical information system, which allows case managers to monitor patients' progress and ensure that they are referred to a skilled nursing facility in a timely manner.

For more information, contact Alex Alvarez, RN, BSN, director of the care management resource unit at Montefiore Medical Center, New York City. E-mail: aalvarez@montefiore.org. ■

UMICH launches flu pandemic site

Examining how communities in the United States coped with the 1918 flu pandemic could help today's public health planners in their preparations for the next flu pandemic, according to the Center for the History of Medicine at the University of Michigan Medical School. The center has unveiled a web site, called the "1918-1920 Influenza Epidemic Escape Community Digital Document Archive," of primary source materials covering the infamous 1918-1920 influenza pandemic.

"The web site is the result of a project funded by the federal Defense Threat Reduction Agency to identify and research a very important group of American communities. These are called escape communities, and they experienced extremely low morbidity and mortality rates during the 1918-1920 influenza epidemic," says **Howard Marke**l, MD, PhD, George E. Wantz professor in history of medicine and the center's director.

Researchers at the center identified seven of these types of communities, gathering several thousand pages of primary and secondary source materials from a range of public and private archives, special collections, libraries, and other institutions. Using these materials, they composed a report detailing how the escape communities met the challenges of epidemic influenza.

Primary source documents

The web site is organized around each of the seven escape communities and provides abridged versions of the community case studies included in the longer report. Researchers can view or download digital copies of any and all of the almost 2,000 pages of primary source documents that were collected and reviewed as part of the study. All the original documents are on the site and are freely available to the public for research or educational purposes.

A copy of the entire report, "A Historical Assessment of Nonpharmaceutical Disease Containment Strategies Employed by Selected U.S. Communities During the Second Wave of the 1918-1920 Influenza Pandemic," is available on the archive web site.

The archive can be accessed at: www.med.umich.edu/medschool/chm/influenza/index.htm. ■

(Continued from page 166)

that the patients get timely and efficient care. If the case managers foresee a denial, a downgrade in acuity level or length-of-stay issue, they can contact him immediately," says **Marilyn Butler**, RN, MSN, CCM, director of case management at the Manahawkin, NJ, hospital.

At Southern Ocean County Hospital, the case managers and social workers are unit-based and work as a team, with two case managers and a social worker covering 32 beds. The team works eight-hour shifts Monday through Friday.

Butler and Ursani make rounds every day on every unit, sitting in on rounds that are in progress whenever possible. Alternatively, they meet with the case managers, social worker, and clinical coordinator of the unit while the nursing staff come in one at a time to discuss their cases.

"We go over every case every day, looking at length of stay, acuity, and if there are issues in moving the patient forward. We look at the managed care cases to determine if we are being reimbursed at an acute level or if we have been downgraded and, if so, why," she says.

Access to data

In the case of patients who have been downgraded, Ursani talks with the case manager, reviews the chart, and calls the medical director at the managed care company if he feels the patient still is at the acute level.

"He has a good rapport with the medical directors at the managed care companies and has been very successful in getting denials and downgrades overturned by using this proactive approach. The case managers can call him at any time if they see a case that may be denied or downgraded, rather than waiting for him to come on the floor," Butler says.

When Butler was hired to create a case management program at Southern Ocean County Hospital in February 2005, the hospital had utilization review nurses and social workers who functioned separately, an unacceptable average length of stay of 5.1, and a denial rate of 14.1%, she recalls.

"When I arrived, the department lacked the ability to monitor the reasons for denials and delays in progression of care and also lacked continuity in how denials were being handled. We knew that we had to become concurrent in our denial management. In the past, denials had been dealt with retrospectively," Butler says.

Before she began the denials management initiative, Butler developed a dictionary for the computer system that includes reason codes for delays and denials and avoidable days for Medicare patients.

"I reviewed some of the dictionaries that other hospitals have developed but made ours very specific to what we are seeing so we can better track denials and delays in service," she says.

Now the case management team has easy access to data that help them identify problems and take steps to correct them.

"Now that we have the codes that show the reason for delays, we are able to identify the system delays and work with the department on ways to remove the roadblocks to discharge," she says.

For instance, the team discovered that getting the results of stress tests was holding up the discharge of some patients.

"We have a lot of patients who come in with basic chest pain and, as long as their cardiac enzymes are normal and the stress test is negative, they can go home," she says.

Butler worked with the head of the department to work out a process that expedites the test results for patients who are ready for discharge pending the stress test results.

Now when a patient's discharge hinges on the stress test results, the case manager calls the department and requests that the patient's file be put on the top of the pile for the doctor to read.

"The case managers are proactive in getting all the pieces together and making sure that every test is done and the results are back so the patient can move through the continuum," she says.

The case managers take a proactive approach to moving the patient through the continuum, alerting the physician far in advance of discharge or transfer if a patient is going to need an evaluation or test.

For instance, swallowing evaluations frequently hold up the discharge of stroke patients.

The case managers make sure that the physicians order swallowing evaluations for stroke patients early in the stay.

As soon as the case managers know that a patient probably is going to be moved to a subacute rehabilitation unit, they leave a note for the physician asking for orders for a physical therapy evaluation.

The hospital has created transfer forms to be used when a patient is transferred to a rehabilitation unit, a nursing home, or other post-acute care facility.

The case managers work closely with the

physicians to get the forms filled out up front, rather than having to fax them over to the office.

The team has tackled the problem of patients who come to the emergency department with a psychiatric crisis and end up staying there from 24 to 48 hours because no one is available to screen them for admission to a psychiatric hospital.

"What we found is that there aren't enough screeners and that these patients are staying an inordinate amount of time until we can get them cleared to go to the psychiatric hospital," she says.

As a result of meetings between hospital officials and a local psychiatric hospital, the case managers and social workers who work in the emergency department are going to be trained as crisis screeners.

The hospital is not reimbursed for keeping the patients until the screening takes place. In addition, the patients are taking up beds that could be used by another patient.

"It's not fair for the patient to be lying in bed and not getting the psychiatric care they need. It is a benefit for the patient to be moved as quickly as possible," she says.

When Butler arrived in 2005, Southern Ocean County Hospital had four utilization review nurses and four social workers.

Now, the hospital has four social workers and nine full-time case managers, along with several per diem positions. The case managers are assigned by unit and also cover the emergency department.

The case manager-social worker team on each unit conducts concurrent reviews of cases on a daily basis to make sure patients meet criteria to remain in the hospital.

The case manager who covers the critical care unit also is the gatekeeper for denials and keeps a close watch on denied days and the reasons for the denials.

For more information, contact Marilyn Butler, RN, MSN, CCM, director of case management, Southern Ocean County Hospital, Manahawkin, NJ. E-mail: mbutler@soch.com. ■

ACCESS MANAGEMENT QUARTERLY

Care starts on arrival with centralized admissions area at Elmhurst Memorial

Assessment, initial testing done before patient goes to nursing unit

A centralized admissions area (CAA) at Elmhurst (IL) Memorial Healthcare handles much of the workups and assessments that unit nurses typically do, minimizing treatment delays and enhancing patient throughput.

Patients who go through the CAA arrive on the nursing unit having received a complete evaluation, with lab work and tests done and antibiotics and pain medication ordered, says **Matthew J. Lambert III**, MD, MBA, FACS, FACHE, senior vice president, clinical operations.

The CAA is one of several Elmhurst Memorial initiatives prompted by a hospitalwide operations improvement program that began several years ago, adds Lambert, who oversees the program along with the chief financial officer and director of process redesign.

"We spent about a year in the nonclinical areas and the last 2½ years in clinical areas," he says. "We identified a lot of problems with interdepartmental communication. Every department was doing an excellent job, but they were not cognizant of, or sensitive to, the demands they were putting on other departments. They were optimizing their own particular enterprise."

As is true of many hospitals, Lambert says,

"there were areas where patients that needed to be admitted to the hospital were sort of stuck."

More than 50% of admissions come through the emergency department, where patients are often hung up waiting for beds, he says. While Elmhurst Memorial is an older hospital with capacity constraints, Lambert notes, conversations with nurses indicated there was another reason for the long wait.

"We found out that there was a reluctance to accept new admissions related to the amount of work involved," he says, "so there was a lack of cooperation [from nurses], a passive-aggressive attitude."

As the operations improvement team investigated further, Lambert continues, they realized that just streamlining the ED process would not solve the problem. "Patients would just wait longer — getting to the floor faster did not mean getting care faster.

"We also found that admissions and discharges peaked at the same time — between noon and 3 p.m. — as physicians come in later in the morning to discharge patients," he adds. "We realized we had to fix everything, not just one thing."

The CAA originally was designed to address direct admissions, Lambert says. "Patients directly admitted from the physician's office or by phone would wind up on the unit without orders because the physician hadn't sent them. They would be languishing up there and [hospital staff] couldn't get hold of the physician."

Even if the orders came, nurses would be busy with something else, he says, "so the patient would be in bed, but nothing was happening. They might not get a meal, or they might not get pain medication for several hours."

To accommodate the five-bed CAA, Lambert says, the hospital designated a space formerly used by physicians to see patients for exams or minor procedures on an outpatient basis.

"We staffed it with a couple of RNs and a couple of technicians," he notes. "We insist that orders come with the patient, and if they don't come, [an access nurse] calls the physician's office and asks [staff] to fax them over."

Patients go through the registration process, which is done at bedside, and the initial orders are completed in the CAA, Lambert says. "We try to get as much done as possible before the patient goes up to the unit."

There are five private treatment rooms in the CAA, he notes, where family members can sit with patients while the initial orders are completed.

CE *questions*

17. Beginning in 2007, the Joint Commission will require an organization to provide the list of medications to the patient and his or her primary physician or send it to the post-acute facility that will be caring for the patient.
A. True
B. False

18. In the emergency department at El Camino Hospital, the ultimate responsibility for medication reconciliation lies with _____.
A. The admissions clerk
B. The case manager
C. The staff nurse
D. The physician

19. The Institute of Medicine of the National Academies estimates that medication errors harm 1.5 million people every year. What is the estimated cost for treating these patients?
A. $3.5 billion
B. $100 million
C. $5 billion
D. $750 million

20. A proactive approach to denials dropped the denial rate to 5.8% in less than 18 months at Southern Ocean County Hospital. What was the average denial rate before the initiative started?
A. 10.8%
B. 20.3%
C. 14.1%
D. 12.5%

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

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

Patients typically spend about three hours in the CAA, Lambert adds, and once the X-rays, blood work, or other procedures are finished, they go to the nursing unit.

"For the nurses on the floor, [the CAA] has eliminated what, with the documentation that is required, could be a two-hour process," he says.

The CAA's hours of operation initially coincided with physician office hours, but have now been expanded to seven days a week, Lambert says, and the CAA now is picking up a lot of overflow from the ED. "About half the patients [the CAA is] seeing are direct admits, and half are from the ED."

The maximum number of patients seen in the CAA on a given day is in the mid-20s, he adds, which is about half the daily admissions.

The CAA has been a key factor in improving the flow into the hospital, Lambert says. "In the past, it was not unusual for a patient to wait several hours for antibiotics. Now that wait is down to less than an hour."

Two years ago, patients admitted from the ED spent an average of 348 minutes, or 5.8 hours, waiting there before admission, he says. As of June, that wait had been reduced to 234 minutes, or 3.9 hours.

Patient reaction to the CAA has been mixed, Lambert notes. "From those coming from the physician's office, it's positive, but ED patients have a little trouble understanding why they are being moved from one area to another. Some patients assume once they leave the ED they're going to the floor, and that doesn't always happen."

Some patient education is required, he says. "We explain to them that before they go to the room we're going to finish the rest of their testing and procedures, so they won't have to come down again [right away]."

Getting a bed was 'like pulling teeth'

Historically, it was "like pulling teeth to get a reservation" when a registrar called to find a bed for a patient, with unit nurses always saying beds were not ready, notes **Cindi Ruffner**, manager, registration and scheduling.

Now access nurses — who have been in place about five years, three years before the CAA was established — take reservations from physicians and arrange for bed placement, among other functions, she says.

Their role, according to **Sue Prestipino**, RN, one of two access nurses, was created from a quality and financial perspective, to make sure patients are placed appropriately according to clinical needs.

The nurses, who report to the quality resource management department, look at whether the patient is under the correct admission status and at the right hospital according to payer guidelines, she says. The main focus, however, is on quality, Prestipino adds. "We were trying to organize the process so that once people arrive, we can expedite them through the system in a timely manner."

The access process

From the access nurse's perspective, she says, the process works as follows: "The physician will call with an admission request. We screen for medical necessity and appropriate placement, and set up an appointment for the patient to come over. We are able to discuss the clinical course, which helps us place them."

Orders are either given verbally by the physician, faxed over, or arrive with the patient, she adds.

For the past year, Prestipino notes, access nurses have handled bed control for the entire hospital, so they take care of that piece as well. "It's a good fit," she says. "Before that, a clerical staff did bed control and [patients] just came when the physician sent them."

The access nurses work with a computerized bed board, Prestipino adds. "We know when there is a discharge, so we know when there is room for them.

"We make the reservation for admission, secure the orders, and when the patient arrives, one of the access nurses meets them in the lobby," she continues.

That step is both a customer service gesture and an opportunity to assess whether the patient is able to go through the regular admission process or needs additional help, Prestipino says. "People like to know they're expected."

Then the access nurse takes the patient to the CAA, she adds, noting that all the areas involved — admissions, the access nurse office, and the CAA — are close to each other and to the main entrance of the hospital.

At that point, the CAA staff take over, doing the assessment, computer work, and any orders that need to be done immediately, Prestipino says. "The goal is to get them in and out in two hours," she notes. "Patients in the CAA have priority in

our testing areas."

Access nurses perform a similar function with patients who are being admitted from the ED — reviewing the case and working to find the most appropriate placement, Prestipino says.

If there is an opening in the CAA, she explains, the patient is taken there to complete the process, which is not as lengthy because of the testing that has already been done in the ED. If the CAA is full, Prestipino adds, the patient will go directly to the nursing unit.

"The idea is to maintain a smooth patient flow, and [to avoid] having a lull in care," she says. "The patient is always being treated, always being worked on."

In addition to the CAA being "a big satisfier for nursing staff," it has helped promote good relations with physicians, Prestipino says. "There is also more personal contact with patients, who are reassured that when they come in, somebody knows who they are, why they're there, and we guarantee their safety."

Elmhurst Memorial runs a very high census, as do most of its neighboring hospitals, she notes. One of the indicators of the organization's success with operations improvement, Prestipino suggests, is that the facility has never had to go on hospitalwide bypass. "We feel we're able to manage patient flow because of these processes," she says. ■

CMS announces preventive care demonstration project

The Centers for Medicare & Medicaid Services (CMS) has issued a solicitation to implement a health promotion and disease prevention program through the Medicare Senior Risk Reduction Demonstration. The program enhances CMS' focus on prevention of chronic disease in the Medicare population.

The program aims to determine whether health risk reduction programs that have been developed, tested, and shown to be effective in the private sector can be tailored to the Medicare program. According to CMS, 82% of seniors have one chronic condition, and about 50% have two or more. Seniors with these conditions have better outcomes with fewer costly complications when they are diagnosed early and when they take lifestyle steps that are proven to improve their health.

Preventive benefits

In addition to the demonstration project, Medicare has instituted "Welcome to Medicare" visits for new Medicare enrollees that provide education and counseling about important preventive services as well as screening tests, shots, and appropriate referrals. Other preventive benefits Medicare offers include: cardiovascular screening blood tests, diabetes screening, counseling to quit smoking, and glaucoma screening for Hispanic Americans.

CMS will select up to five existing health promotion, disease prevention, and risk reduction organizations to participate in this three-year demonstration. Final award decisions should be made by spring 2007. For more information, go to: www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/Senior_Risk_Reduction_Solicitation.pdf. ■

CE objectives

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

- identify particular clinical, administrative, or regulatory issues related to the profession of case management;
- describe how those issues affect patients, case managers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■

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- Tips for meeting the new requirements from CMS
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- Getting the most out of your hospital's information technology

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2006 SALARY SURVEY RESULTS

HOSPITAL CASE MANAGEMENT™

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Salaries are rising, but so are the hours case managers work

Nursing shortage, night and weekend work present challenges

Salaries for case managers are increasing, but the vast majority of case managers are working far more than the traditional 40-hour week, according to respondents to the 2006 *Hospital Case Management* Salary Survey.

The 2006 Salary Survey was mailed to readers of *Hospital Case Management* in the June issue. More than half the respondents (55%) were case management directors. Other respondents were case managers, utilization managers, social workers, or had other titles.

Recruiting challenges

Respondents to the survey report putting in long hours. In fact, almost 89% report working more than 40 hours a week, with 26% working more than 50 hours a week.

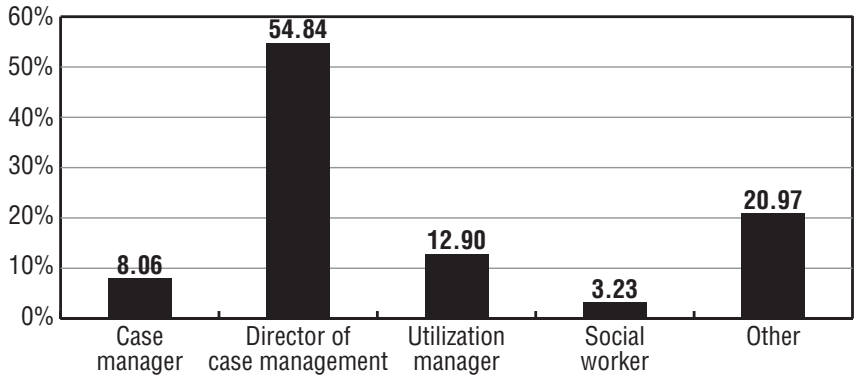
At the same time, salaries are on the increase, but raises are not as big as in the past. In this year's survey 84% of respondents reported an increase in salary during the past year, down from 89% in 2005.

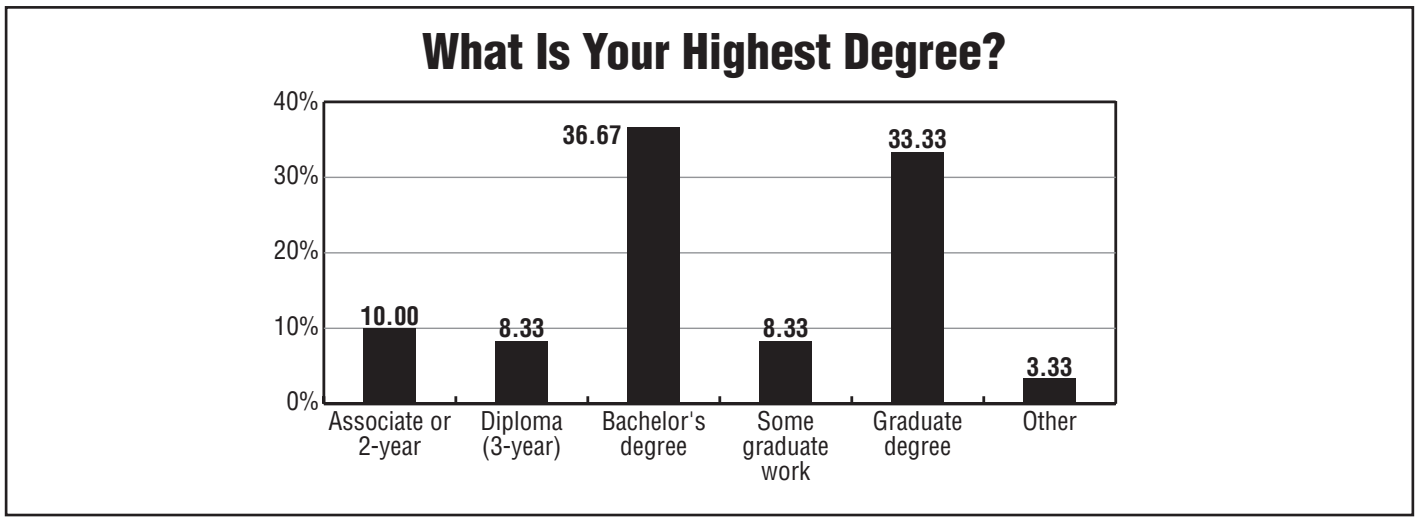
The highest percentage (50%) reported getting a 1% to 3% raise, followed by 23% whose salary increases were between 4% and 6%. More than 11% reported a salary increase of 7% or more. Just more than 16% reported no change in salary over the past year compared with 2005 when only 11% of respondents reported no increase or a decrease in salary.

About 73% of respondents to the survey report salaries in the $60,000 to $99,000 range, with more than 11% reporting salaries in excess of $100,000 and 17% reporting pay of $60,000 or less.

The current nursing shortage presents two challenges to many case management directors when it comes to recruiting qualified case managers,

What is Your Current Title?





says **Beverly Cunningham**, RN, MS, director of case management at Medical City Dallas Hospital.

First, there are fewer nurses available in today's job market.

At the same time, many hospitals are paying sign-on bonuses and higher hourly rates for critical positions, such as bedside staff nurses. Often, a case manager is not seen as a "critical position," Cunningham points out.

In some hospitals, due to the nursing shortage, clinical nurses also may receive incentive bonuses throughout their employment. They are paid hourly and get overtime, points out **B.K. Kizziar**, RNC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

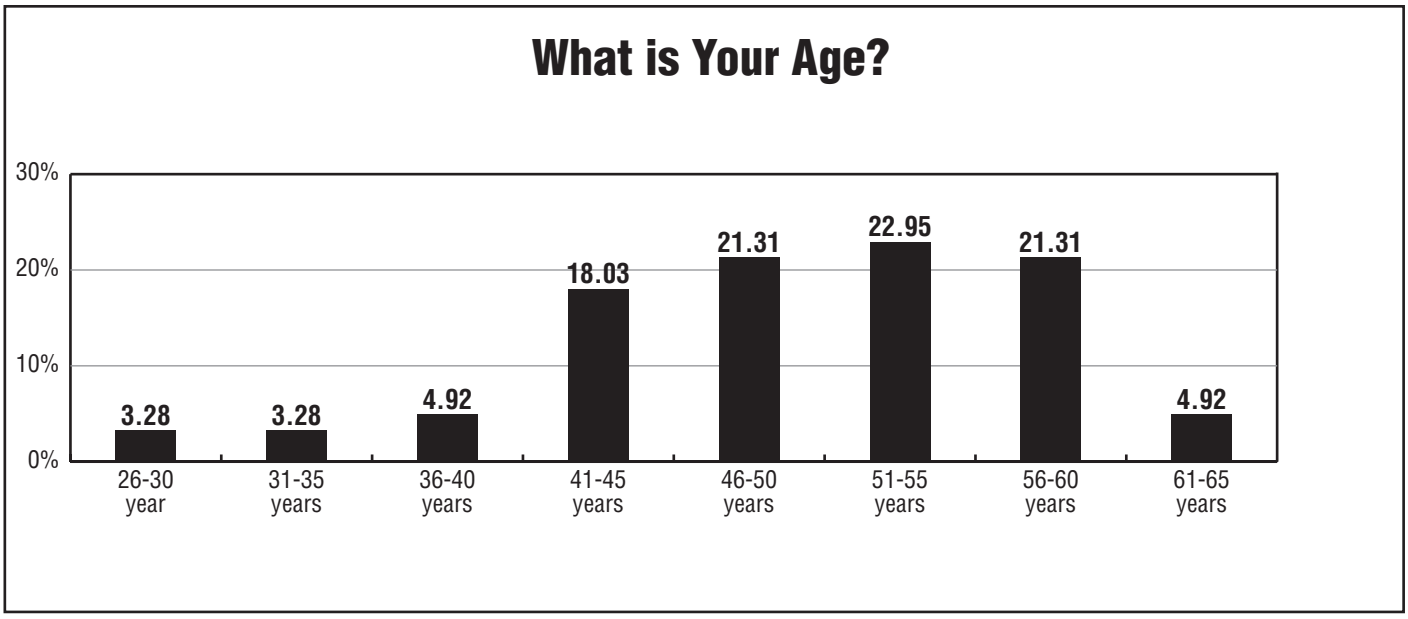
"When I'm talking with bedside nurses about changing to case management, there are also the issues of the weekend and after-hours additional pay that bedside nurses receive. That's a challenge for nurses when they can't afford a pay cut but are ready for a change," Cunningham says.

On the other hand, case managers have some flexibility to be away to take care of personal business during the workday as long as their work gets done, which makes the job desirable for many people, Kizziar says.

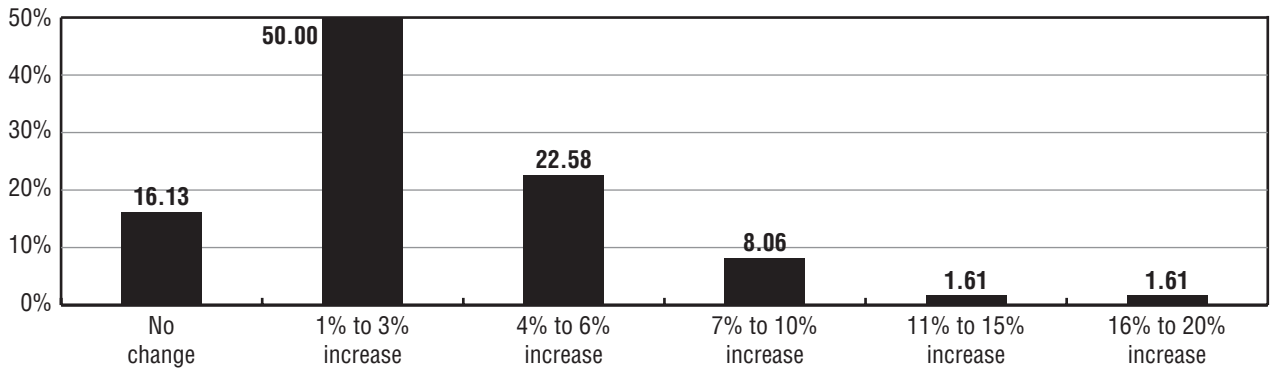
She expressed concern that many hospitals do not provide a sliding pay scale for case managers who have achieved certification and, in many cases, case managers are not reimbursed for all the fees involved with gaining certification.

"It's disappointing that all the work that goes into achieving certification is not rewarded by employers," Kizziar says.

In some hospitals, the nursing shortage has prompted hospitals to raise nursing pay levels overall, bringing case management salaries along with them.



In the Last Year, How Has Your Salary Changed?



That's the case at St. Vincent's Hospital in Jacksonville, FL, where case managers are paid at the save level as an assistant nurse manager, according to **Jamie Zachary**, LCSW, director of case management.

"The nursing shortage has affected staffing at the bedside, but I find that experienced bedside nurses want to transition to work that is not as physically demanding," she says.

At the hospitals where Kizziar consults, she has observed that the nursing shortage has had more of an effect on bedside nursing positions than case management positions.

"Case managers tend to be experienced nurses who are seeking something beyond clinical work, and that may contribute to the fact that there are less practicing nurses," Kizziar says.

In fact, nearly 71% of respondents to the *Hospital Case Management* survey report having been in health care for 22 years or more. Fully 55% have been in health care more than 25 years. Only 6.5% have 10 years or less experience in the health care field.

Rural case management

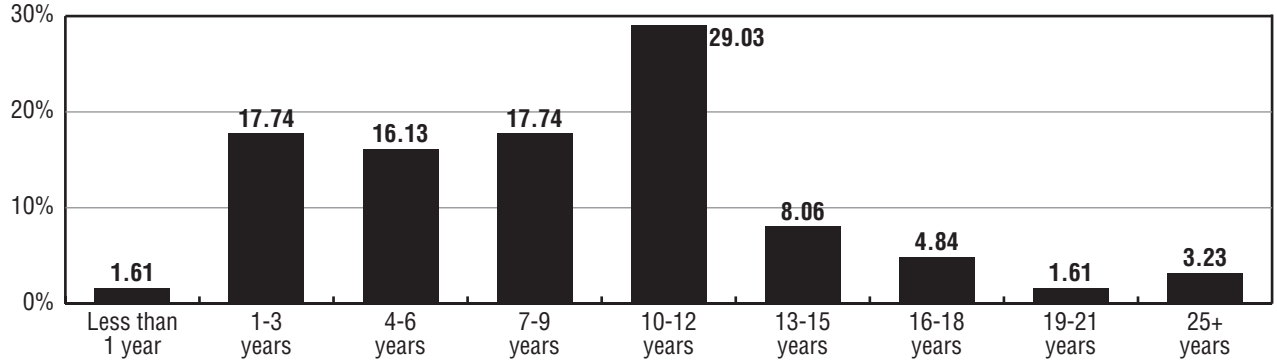
Case management directors in rural areas face the challenge of finding experienced case managers.

"The case managers at LGMC are all nurses, but not all bedside nurses have the skills and experience to be case managers," says **Lyn Clark**, RN, BSN, director of case management at Granbury (TX) Medical Center, a 59-bed facility.

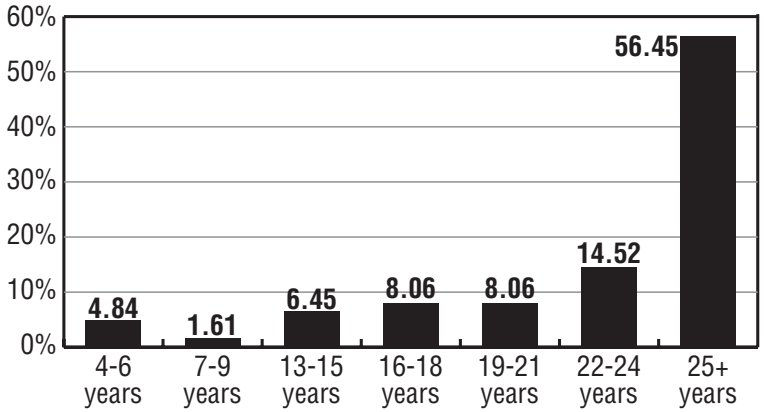
The hospital pays bedside nurses higher salaries than case managers and cuts down on the case management positions when the census is low.

It used to be that case management positions were desirable because case managers worked just five days a week, but in recent years, case managers have been called on to work evenings

How Long Have You Worked in Case Management?



How Long Have You Worked in Health Care?



and weekends.

At LGMC, the case management department provides seven-days-a-week coverage with two FTEs split into three positions. Two case managers work four days a week. The other works two days. Between them, they provide coverage 10 hours a day.

"Most do not want to work weekends or evenings, but we try to rotate the shifts around in a fair manner," Clark says.

The situation is different at St. Vincent's Hospital and Medical City Dallas Hospital, where weekend positions are filled by special staff.

"I hire special staff for weekends, and that makes my regular staff much more satisfied," Cunningham says.

At St. Vincent's, weekday positions are filled by full-time salaried staff, with part-time staff working in evenings and on weekends.

"We have two distinct positions, so the nurses who apply generally want those hours and days," Zachary says. ■