HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

AHC Media

MARCH 2016 Vol. 24, No. 3; p. 29-44

Financial stakes rising as auditors set their sights on providers

CMs should keep informed on CMS rules, review every admission

Just when you thought the stakes couldn't be any higher when it comes to getting patient status right and medical necessity documented properly, the Centers for Medicare & Medicaid Services has raised the ante.

Beginning at the first of the year, hospital records are being subjected to review by a range of auditors, all of them looking for errors that could result in loss of reimbursement.

Quality improvement organizations (QIOs) are evaluating hospitals' compliance with the two-midnight rule. Beginning Jan. 1, CMS shifted the enforcement of the rule from the Medicare Administrative Contractors to two Beneficiary and Family-Centered Care Quality Improvement Organizations, Livanta and KEPRO.

"The QIOs will conduct the first-line reviews of cases with short inpatient stay to evaluate whether they comply with the two-midnight rule and will refer

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) is continuing to tweak its various audit programs, and the changes make it imperative that case managers stay current so they can educate the rest of the staff.

- Hospitals have got to get patient status right up front, and that means case managers should review every patient who comes in from every point of access.
- Hospitals should eliminate the silos within their various departments and outside the hospital walls with post-acute providers so everyone can work together for better patient care.
- Case managers should work closely with their physician advisors and admitting physicians as well as being involved in revenue cycle activities.

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HOSPITAL CASE MANAGEMENT

Hospital Case Management™,
ISSN 1087-0652, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
Hospital Case Management
P.O. Box 550669
Atlanta, GA 30355.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
customerservice@ahcmedia.com.
www.ahcmedia.com
Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

SUBSCRIPTION PRICES:
U.S.A., Print: 1 year (12 issues) with free Nursing Contact Hours or CMCC clock hours, $519. Add $19.99 for shipping & handling. Online only, single user: 1 year with free Nursing Contact Hours or CMCC clock hours, $469.

Outside U.S., add $30 per year, total prepaid in U.S. funds.

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Back issues: $78. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.
GST Registration Number: R128870672.

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Provider approved by the California Board of Registered Nursing, Provider # CEP14749, for 1.25 Contact Hours.

This activity has been approved by the Commission for Case Manager Certification for 1.5 clock hours. The target audience for Hospital Case Management™ is hospital-based case managers. This activity is valid 24 months from the date of publication.

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EDITORIAL QUESTIONS
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hospitals with high denial rates to the Recovery Auditors for further review and corrective action," says **Deborah K. Hale**, CCS, CCDS, president of Administrative Consultant Services, a Shawnee, OK-based healthcare consulting firm.

The Recovery Auditor program has cranked back up and the auditors are allowed to look at any issue that CMS has approved with the exception of patient status. So far, the RAs have been performing mostly DRG validation reviews, reports **Steven Greenspan**, JD, LLM, vice president of regulatory affairs for Executive Health Resources, a Newtown Square, PA, healthcare consulting firm.

"If a RA happens to pull a case for review and find patient status issues, it can still end up denying the case for patient status. Once the claim is reopened, the entire claim is vulnerable to review," Greenspan says.

The Medicare Administrative Contractors (MACs) continue to conduct prepayment reviews.

CMS has reined in the RAs somewhat with changes in the auditors' scope of work, and plans more changes when it issues new contracts, possibly in mid-year. *(For details, see related article on page 33.)* For instance, effective Jan. 1, additional documentation requests (ADRs) from RAs are restricted to 0.5% of a provider's total number of paid bills for all types of claims in the previous year.

"Providers should note that, also effective Jan. 1, CMS can adjust the number of additional documentation requests hospitals can receive depending on the hospital's denial rates," says **Elizabeth Lamkin**, MHA, chief executive officer and partner in PACE Healthcare Consulting, LLC, based in Bluffton, SC. As a provider's denial rates decrease, so may the number of files the RAs can request. On the other hand, if your hospital has a high rate of denials, the RAs will be allowed to request the maximum number of records allowed to review, she adds. "This alone should be an added incentive to ensure systems and resources in care management to screen and monitor continued care in order to get medical necessity right concurrently and avoid denials," she says.

The consequences for getting patient status wrong are equally troubling under today's rules, Greenspan says. For instance, if the QIO or RA believes a hospital may be gaming the system, they are required to alert the Office of Inspector General (OIG) or the Zoned Program Integrity Contractors (ZPIC) to investigate for fraud and abuse and possibly bring criminal charges.

What does all of this mean for case managers?

"It is critical for hospital staff members who are responsible for case management and for utilization review to have comprehensive knowledge of CMS requirements. As CMS modifies the audit programs, providers have to be aware of the changes and make sure they comply with them," Hale says.

Because case managers — along with their physician advisors — are the bridge between the financial piece and the clinical piece, they should have a system to keep up with what is going on with CMS and other regulators so they can share it with the rest of the clinical and revenue cycle staff, Lamkin adds.

"Today's healthcare environment has so many moving parts and CMS is moving so quickly and being so aggressive that it's almost impossible to keep up with everything that is happening. By the time providers

hear what is going on with other providers, it's almost too late to react. That is why care managers proactively seek out the most current rules and changes directly from CMS and give feedback to physicians on what they need to do to avoid denials," Lamkin says. Avoiding denials means getting the patient status right at the onset and documenting thoroughly to support medical necessity, she adds. *(For more on the importance of getting the patient status correct and how to do it, see related article on page 32.)*

The best thing that today's case managers can do is to stay informed about what is going on with CMS and other payers, Greenspan says. "CMS is not the most transparent organization. They sometimes update their requirements but don't always alert the provider community that they have issued another edict," Greenspan says. He recommends checking the CMS website as well as the Recovery Auditor's and QIO's websites and reaching out to your compliance partners to see if there are any updates.

All of the fast-paced changes make it a confusing time for everyone in the healthcare arena, adds **Donna Hopkins**, MS, RN, CMAC, vice president at Novia Strategies, a national healthcare consulting firm. "CMS has shortened the timelines for review and is adding new layers and efficiencies to the appeals process to improve responses to providers. All discussions and appeals will need to be done more efficiently and within a shorter timeframe," Hopkins says.

"There are multiple cooks in the kitchen now. The QIOs are reviewing for patient status and the RAs are reviewing for everything else. As the audits stretch beyond the inpatient setting into home health services, durable medical equipment providers, acute rehab and skilled nursing facilities, it will become essential for appeals and response management to become interconnected. This is particularly the case within more integrated organizations," Hopkins adds.

To survive in today's healthcare environment, hospitals need to eliminate the walls that exist between various departments and make sure everyone on the staff understands the current healthcare environment and how it is rapidly changing, Lamkin says.

> "THINK ABOUT THE HEALTHCARE PROCESS AS A TEAM ENDEAVOR WITH MANY DIFFERENT PLAYERS. EVERYBODY HAS TO PLAY THEIR PART PERFECTLY AND COLLABORATE WITH ALL THE OTHER PLAYERS."

"Think about the healthcare process as a team endeavor with many different players. Everybody has to play their part perfectly and collaborate with all the other players," she says.

Hospitals need an entire operational focus just to manage the appeals, Hopkins says. "The databases hospitals created to keep track of the RAC requests won't be sufficient when you have reviews by the QIOs, the RAs, and the MACs, all with different timetables and all looking at different issues," she says. Hospitals may need to create a new division or department to manage all the changes, she adds.

Lamkin suggests that the case management department partner with its physician advisors to help the admitting physicians understand the CMS regulations, including the difference between an inpatient admission and observation services as well as the level of detail that must be included in the documentation.

"Case managers can give advice, but the physician makes the ultimate decision unless there is a dispute and the case is referred to the utilization management committee," she says.

Work closely with the admitting physicians and your physician advisor, Greenspan suggests.

"Developing relationships with physicians is more important than ever. Case managers should be talking with the physicians, reminding them about properly documenting medical necessity, and should be involved with the utilization review committee," he says.

Lamkin recommends that hospitals create a joint billing and audit compliance committee that includes representatives from finance, administration, clinical departments, and case management to review what is happening and make sure that everyone is trained and up to date on the regulations. "The committee should review auditor activity, reasons from denials, bill holds, and other problem areas and give feedback to the front-end providers to correct any problems," she says.

The case management department needs to have a seat at the table and be involved in all aspects of the revenue cycle, she adds. "Case managers are one of the hospital's most important assets, but not everyone recognizes this. It's very important that case managers be involved in all aspects of the revenue cycle," she says. ■

Get status right up front for fewer headaches later on

Case managers should review patients at every point of entry

As CMS' audit program evolves, it's crucial for hospitals to prevent denials on the front end, says **Elizabeth Lamkin**, MHA, chief executive officer and partner in PACE Healthcare Consulting, LLC, based in Bluffton, SC.

"The real key for hospitals is to focus their efforts on the front end and review every patient at every point of entry. It won't prevent all denials but it will go a long way toward helping the hospital comply," she says.

Lamkin strongly recommends that hospitals use an evidence-based criteria set to help them determine if a patient's admission would be medically necessary.

"CMS does not acknowledge any one criteria set but by using criteria, hospitals have a fighting chance of avoiding denials," she says.

In this new environment, it is even more important for hospitals to get patient status right up front, adds **Steven Greenspan**, JD, LLM, vice president of regulatory affairs for Executive Health Resources, a Newtown Square, PA, healthcare consulting firm.

"Right now, the quality improvement organizations [QIOs] are looking at a small sample of cases and they can refer hospitals with a pattern of denials to the Recovery Auditors [RAs]. When the RAs get a referral, they can review many more claims than the QIO, subject only to the hospital's limit for additional documentation requests, but the RA also can ask for permission from CMS to raise the limits," Greenspan says.

Hospitals need to have adequate case management staff that can review patients at every point of access and guide physicians on what their status should be, Lamkin says.

In addition to reviewing the cases of Medicare patients, case managers also need to make sure that the hospital meets the requirements of private payers. "A lot of Medicare Advantage payers are not necessarily adhering to CMS rules. Now case managers have an additional burden to ensure that utilization review is completed for patients covered by private payers and that all payers are following appropriate rules and adhering to their contracts," Lamkin says.

Lamkin recommends caseloads of 18 or fewer patients so case managers can have the time to complete all their tasks and do them well. She recommends that case management directors track case manager screenings and continued stay reviews compared to rates of denials and financial penalties to demonstrate the case manager effect on the reduction in denials and use the data when making the case for more staff.

Since many patients come in from the emergency department, it is essential for hospitals to have case managers stationed there, she says.

Hospitals don't necessarily have to have case managers dedicated to other points of access, but instead could create the position of admissions case manager who does nothing but review admissions, she adds. Set up a system so the admissions case manager is alerted when admissions come from the surgical department, catheterization lab, and other procedural areas, she suggests.

Lamkin also recommends putting a review nurse in the admissions department to make sure the documentation in the record supports an inpatient admission. "One of the steps in the admission process should be to make sure the record contains the information necessary to meet medical necessity criteria," she says.

The main reason for denials so far has been lack of adequate documentation, Greenspan says.

"The documentation should tell the story of why this particular patient is receiving this particular treatment, and why it's appropriate for the patient to receive these services in an acute care hospital," he says.

"There is still a lot of misunderstanding out there regarding appropriate use of observation as compared to inpatient admissions, and clinical documentation pertinent to the need for acute services never has been more essential to the justification," says **Donna Hopkins**, MS, RN, CMAC, vice president at Novia Strategies, a national healthcare consulting firm.

Hospital case managers have to stay on top of every patient — particularly those who have short stays — and patients in observation, Hopkins says. "For those who are admitted, the question at the second midnight is the need for services that can be delivered only in a hospital setting. That need has to be documented and cannot be

due to system, provider, or patient convenience," she adds.

In the 2016 Outpatient Prospective Payment System (OPPS) final rule, CMS modified the controversial two-midnight rule to allow shorter stays to be billed as inpatient stays based on the physician judgment, but they did not cite any examples to give guidance to hospitals, leaving a lot of providers confused, Lamkin says.

Many hospitals are still erring on the side of observation due to the lack of clarity and interpretations of the two-midnight rule and the possibility of audits, Hopkins says. "Until hospitals are able to provide services — such as cardiac and gastrointestinal procedures — seven days a week and until providers document accordingly, observation rates are still going to be high," she says. ■

CMS gives the RA program a makeover with more changes in store

Legislation also addresses audit problems

CMS has cranked up the Recovery Audit program again, but changes are in the works.

The new scope of work for the auditors, which went into effect Jan. 1, changes both the timeframe for review and the numbers of records that can be requested, says **Deborah K. Hale**, CCS, CCDS, president of Administrative Consultant Services, a Shawnee, OK, healthcare consulting firm.

CMS made what it calls "enhancements" to the current contract and has announced changes that will be included when new Recovery Auditor contracts are issued.

In addition, a bill pending in Congress makes changes in the audit program and especially in the appeals process.

The current RA contracts were set to expire in 2014 but have been extended several times due to lawsuits challenging the contracts, and other technical issues. CMS has issued a request for proposals from potential RA participants and has extended the current RA contracts until July 31.

"CMS is trying to link the new contract with the end of the current contract July 31, but has postponed the date that proposals from potential RAs were due from Dec. 18 to Jan. 21. The date that the new RA contracts take effect will depend on how quickly CMS can evaluate the new proposals and if there are any legal challenges," says **Steven Greenspan**, JD, LLM, vice president of regulatory affairs for Executive Health Resources, a Newtown Square, PA, healthcare consulting firm.

A major change that went into effect Jan. 1 restricts a RA's additional documentation requests (ADR) to 0.5% of a provider's total number of paid bills for all types of claims in the previous year. The RAs have to wait 45 days between ADR letters and can send requests only eight times a year, Hale says.

Hale gives the following example of how the change would work: If a provider had 22,530 Medicare claims paid in 2014, the RAs would

EXECUTIVE SUMMARY

CMS has made changes in the scope of work for the Recovery Auditor program and has proposed a number of other changes to be implemented when new RA contracts are issued.

- CMS has restricted the number of additional documentation requests, has shortened the "look-back" period for patient status reviews, and announced penalties for RAs with high error rates.
- The new contracts shorten the time RAs have to complete complex reviews, requires RAs to wait 30 days before referring cases to the Medicare Administrative Contractors, and postpones contingency payments to RAs until after the second level of appeals.
- The Audit and Appeal Fairness, Integrity, and Reforms in Medicare (AFIRM) bill, introduced in the Senate in December, revamps the appeals process, adding an Ombudsman for Medicare Reviews to assist in resolving complaints by hospitals that have appealed and those considering appeals, and establishes an Appeals Medicare Magistrate program with attorneys who will handle appeals of denials for $1,500 or less.

be limited to a total of 112.65 (0.5%) letters requesting additional documentation, or 14 records in each 45-day cycle.

The limits could be increased or lowered, depending on the hospital's rate of denials, Hale says. "Providers with low denial rates will have ADR limits decreased, while providers with high denial rates will have their ADR limits increase," she says.

"To address hospitals' concerns that they do not have the opportunity to rebill for medically necessary Medicare Part B services by the time a medical review contractor has denied a Medicare Part A claim, CMS is changing the Recovery Auditor 'look-back period' for patient status reviews to six months from the date of services in cases where the hospital submitted the claim within three months of the date it provided the service," Hale says.

Through its enhancements to the program, CMS now requires Recovery Auditors to maintain an overturn rate of less than 10% at the first level of appeal. If their overturn rate is higher, CMS could decrease the additional documentation requests the RA could issue or cease some reviews until the problem is corrected. CMS is also requiring recovery auditors to maintain an accuracy rate of at least 95% or face a reduction in ADR limits.

Recovery Auditors now are required to have a contractor medical director and to give physicians at providers the opportunity to discuss cases with the contractor medical director. CMS also encourages the RAs to have a panel of specialists available for consultation.

When the new contracts are issued, the Recovery Auditors will have 30 days to complete complex reviews and notify providers of their findings. Currently, they have 60 days. The RAs will not receive contingency fees for complex reviews that aren't completed within 30 days, Hale says.

The new contracts also will require the Recovery Auditors to wait 30 days before sending a claim to the MAC for adjustment. "The 30-day period will allow the provider to submit a discussion period request before the MAC makes any payment adjustment," Hale says.

In the new contract, RAs will not receive their pay until a case has been affirmed at the second level of appeal. The new contract will require RAs to confirm receipt of providers' request for discussion or other written correspondence within three business days.

Meanwhile, a bill is pending before Congress aimed at reducing the estimated backlog of appeals of nearly 1 million Medicare claims.

The Audit and Appeal Fairness, Integrity, and Reforms in Medicare (AFIRM) bill was introduced by Senate Finance Committee Chairman Orrin Hatch (R-UT) and Sen. Ron Wyden (D-OR) with a goal of improving the Medicare audit and appeals process.

The bill (S.2368) proposes to give the Office of Medicare Hearings and Appeals more money for appeals and establishes the position of an independent Ombudsman for Medicare Reviews to assist in resolving complaints by hospitals that have appealed and those considering appeals. It also establishes an Appeals Medicare Magistrate program in which attorneys handle appeal requests for cases when the amount in question is between $150 and $1,500, Greenspan says.

The bill would establish a voluntary alternate dispute resolution process to allow multiple pending claims with similar issue of law or fact to be settled together.

The bill was introduced Dec. 8, 2015, and referred to the Senate Finance Committee, which sent it on to the full Senate. ■

Safety net hospital, community providers collaborate to improve transitions

Transitional care nurses target at-risk patients

A multi-pronged, cross-continuum program to improve care transitions at San Francisco General Hospital has reduced readmissions and increased the percentage of patients who see a primary care provider within seven days of discharge.

When CMS announced its readmission reduction program in 2012, the hospital appointed a multidisciplinary Care Transitions Task Force to develop initiatives to improve care transitions, says **Michelle Schneidermann**, MD, clinical professor of medicine at the University of California San Francisco/San Francisco General

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

Thinking of Separating Utilization Management and Case Management? Think Again!

By Toni Cesta, Ph.D., RN, FAAN

Introduction

Case management is a malleable and easily adapted model that applies to a variety of care delivery locations and systems. These traits have enabled organizations applying the model to design and implement the model to meet their specific needs. Although case management has been used in the community setting for the longest period, it is now commonly seen as an integrated care delivery model in the acute care setting and other sites along the continuum of care (e.g., skilled nursing facilities and long-term care facilities). More and more organizations are recognizing the model's ability to manage resources while maintaining or improving quality. Most recently, case management has been identified as a strategic tool to be used in accountable care organizations, healthcare systems, and other care delivery models that coordinate patient care across the continuum.

MORE AND MORE ORGANIZATIONS ARE RECOGNIZING THE MODEL'S ABILITY TO MANAGE RESOURCES WHILE MAINTAINING OR IMPROVING QUALITY.

Since case management moved into hospitals in the mid-1980s, a variety of models have been tested and tried across the country. Variation in models usually depends on the level of integration between disciplines, roles, and functions. Each hospital thinking of changing its model must do so based on factors that affect the ability of the model to work in its organization.

The more siloed your department, the more likely that the staff will resort to tasks rather than looking at all of the elements and data associated with the patient in an integrated fashion. This is the danger associated with separating utilization review from the other roles of the case manager. This month, we will talk about the pros and cons of separating utilization management out from the role of the case manager.

Contemporary Roles

As we look at the roles assumed by a hospital case manager in a model that adapts to the changes in healthcare reimbursement, value-based purchasing, readmission reduction, or care along the continuum, we quickly see how these roles are dependent on each other to work most effectively.

When siloed from each other, these roles simply become tasks rather than an integrated set of functions that are dependent on each other.

- Patient flow — clinical coordination/facilitation
- Utilization and resource management
- Denial management
- Variance tracking
- Transitional and discharge planning
- Quality management
- Core measures
- Readmissions
- Adverse events
- Psychosocial assessments and interventions

Stages of Model Development

1. Simple with no integration. These models focused on one core activity, either discharge planning or utilization management. These were the first and traditional models. They were fragmented and expensive as the discharge planning and utilization review functions were separated from each other.

2. Moderate with partial integration. These models, still in use today, focus on the core roles of case managers but typically integrate only two of the roles as listed above. They provide more of a contemporary approach to case

management and are more efficient, but do not combine all of the roles of case management that are considered contemporary today. Because these models begin to integrate previously disconnected roles, they tend to be more cost-effective than the simpler models. The collaborative case management model is an example of this.

3. Complex or full integration. The fully integrated models combine all the roles of today's case management departments as they are listed above. These models are the most forward-thinking, as they allow for fewer handoffs of information as well as more efficient use of RNs and social workers. As with all case management models, they must be combined with appropriate staffing ratios. If these models are understaffed, they will not produce the desired outcomes. The integrated case management model is an example of a fully integrated model.

Main Differences Between the Models

The two most commonly used models today are the integrated model and the collaborative model. There are fewer differences between these models as there are similarities. Clearly, the most effective models are those that provide a mechanism for managing patients across the continuum of care, thereby providing a seamless, integrated care process. In a managed care environment this is most easily done because of the integrated services inherent in a managed care system. The notion of managing patients in a variety of care settings is more difficult in payer systems in which there are no incentives for various settings to communicate and/or share resources. With the advent of the medical home and health home concepts, as well as the accountable care organization, Medicare has provided new incentives that reach beyond commercial payers and deeply into the government payer arena. While managed care had traditionally been viewed as the system that provided the generalized structure and focus when managing the use, cost, quality, and effectiveness of healthcare services, it is no longer the only payer interested in managing cost.

Many healthcare organizations have opted to first implement case management in the acute care setting. This accomplishes a number of things. First, it allows the organization to design, implement, and perfect its case management system in a more easily controlled environment, the hospital. Although it provides greater challenges in terms of the clinical management of patients in the acute care setting, it is still a place where team members are part of a team that is within the walls. In fact, the term "within the walls" has been used to aggregate those case management models that manage patients' care during the acute care portion of the illness. Among the many applications of the within-the-walls models is a host of types using the members of the team in various role functions. In most cases, the RN is used as the case manager. It is the placement of the RN in the organizational structure and the associated role functions that differentiate the various models.

Integrated Model

In the integrated model, all roles are performed by a single RN case manager. This model integrates previously disconnected roles and functions. Included in the integrated model are all the roles listed above. The nurse case manager integrates the roles of patient flow, utilization management, and discharge planning into one role that applies to all patients asigned to her. The nurse case manager is responsible for referring any psychosocially complex patients to the social worker as they are identified.

The integrated model requires that all patients are seen by a nurse case manager. For some patients that are considered "high risk," they may also be followed by a social worker.

The Collaborative Model

In this model, a third team member is added. The third member, called the Utilization/DRG Manager or business associate, is responsible for the "business" aspects of case management such as conducting clinical reviews for the purpose of transferring information to a third-party payer. They are also responsible for clinical documentation improvement. As such, the staffing ratios are different in the collaborative model. The case manager is responsible for assessing, planning, coordinating care, and outcomes management.

Principle Differences

Each model brings pros and cons. The key differences between the two models are the integration of utilization management into the role of the case manager versus the separation of the role through the addition of a third team member. Some hospitals have separated out the functions in an attempt to lower overall costs. They accomplish this by reducing the staffing within the department of case management.

Others believe that utilization management is a "task" that can be done by anyone, either inside the hospital or in an office somewhere else. It is within this logic that the problem lies. If the organization views the role of utilization management as an isolated set of tasks or functions, then this important role becomes separated from the other roles of the case

manager in a contemporary case management model.

Factors to Consider When Picking a Model

Picking a model is an individual hospital's decision. The journey toward making this decision depends on a number of factors that need to be considered. These factors include the following:

- Model design
- Roles and functions of RN case managers and social workers
- Payer mix
- Intensity of services provided
- Complexity of patients
- Length of stay
- CM assignments
  - -Unit-based
  - -Physician-centric
  - -Product line
  - -Hybrid

Pricing Out a Model: Getting the Biggest Bang for your Buck

If your hospital is struggling with the decision of which model to pick, you may want to consider the following exercise. The purpose of the exercise is to cost out each type of model and determine which one will work best from a model perspective as well as a cost perspective. Getting started will require that you collect demographic data on your hospital and that you use this data to test out each model. The following is a format that you might want to consider when performing this exercise with your case management steering committee or executive staff. Ultimately the decision will need to be multi-factorial, but this information will give you an additional tool with which to make a determination as to which model is best for your hospital.

Case Study: Determining Case Loads and Cost of Two Case Management Models

St. Elsewhere Hospital and Medical Center Demographics

Payer Mix:
40% Medicare
20% Medicaid
30% Managed Care
7% Self-Pay
3% Other

Admissions per year: 18,000

Emergency Department Visits per Year: 30,000

Patient Care Units

Specialty	Occupied Beds
2 Surgical	40
2 Medical	60
2 Step-Down	20
2 ICU	30
1 Obstetrics	20
1 NICU	10
1 Pediatrics	20
Total Beds	200

Other Factors to Consider:

- Physician Advisor
- Clerical Support Staff
- Unit-Based Design/Other

Based on the hospital's structure as described above, a staffing analysis for a contemporary case management department was created.

Integrated Model

Total Personnel:
Director: 1
Social Work Assistant Director: 1
Physician Advisor: 1
Audit & Appeals: 2
Total RN Case Managers: 13
Float Case Manager: 1
Total Social Workers: 5
Secretary: 1
Clerical Support: 3
Total FTEs: 28

Clinical Areas Covered

Case Managers Caseload 1:15 (unit-based):
Surgery: 2
Medicine: 3
Step-Down: 1
ICU: 1
Obstetrics: 1
NICU: 1
Pediatrics: 1
Emergency Department: 2
Admitting Department: 1
Float: 1

Social Workers Caseload: 1:17(more than one unit):
Surgery: 1
Medicine/Step Down/ICU: 2
OB/NICU/Peds: 1
ED: 1

Design: Unit-Based

Patients receiving CM coverage: All

Patients receiving SW coverage: 40%

Physician Advisor: Available to all staff; responds to all clinical areas

Roles and Functions of Case Managers: Patient flow, including coordination/facilitation of care; utilization management; discharge planning; variance identification; resource management.

Roles and Functions of Social Workers: Psychosocial assessments and interventions on 40% of patients meeting social work referral criteria. May perform some discharge planning.

Roles and Functions of Utilization/DRG Manager: Not applicable.

Collaborative Model:

Total Personnel:
Director: 1
Social Work Assistant Director: 1
Physician Advisor: 1
Utilization/DRG Managers: 7

- 2 Surgical (Floors + Units)
- 2 Medical (Floors + Units)

• 1 OB/NICU/Pediatrics
• 1 Supervisor/Denials Mgmt
• 1 Relief

Case Managers: 9.5
• 1.5 ED (Days)
• 2.0 Surgical (Floors + Units)
• 3.0 Medical (Floors + Units)
• 1.0 OB/NICU
• 1.0 Pediatrics
• 1.0 Relief

Social Workers: 8
• 2.0 ED (Evenings)
• 2.0 Medicine
• 2.0 Surgery
• 1.0 OB/NICU
• 0.0 Supervisor/Pediatrics
• 1.0 Relief

Central Placement Office: 1

Clerical: 1

TOTAL FTE: 28.5

Caseload:

UM/DRG Management Caseload:

Adults 1:30 beds

OB/NICU/Pediatrics 1:40

CM Caseload:

Adult Med/Surg 1:25 (includes relief)

Note: With screening, should see caseloads of about 1:16.

Pediatrics 1:20

Note: With screening should see about 1:14; can backup Med/Surg as needed.

OB/NICU 1:30

Note: Can generally tolerate higher caseloads in this population.

SW Caseload:

Adult Med/Surg 1:30 (includes relief)

OB/NICU 1:30

Peds 1:20 + Supervisor

Note: SWs cover ED during days for crisis intervention on a rotating basis.

Design: Population-based

Patients receiving CM coverage:

• Assume 50-75% post screening for medical, social, financial risk.

• Every patient needs to be managed; not every patient needs a case manager.

Patients receiving UM coverage: 100%

• Medical necessity screening
• Certification/Recertification
• Observation patient management
• DRG Assurance
• Denials Management

Patients receiving SW coverage: 40%

Physician Advisor: Available to all staff; responds to all clinical areas; relates to the physician community.

Roles and Functions of Case Managers: Screening; assessment/planning; continuum of care coordination; resource management; outcome management/evaluation.

Roles and Functions of Social Workers: Psychosocial assessments and interventions on 40% of patients meeting social work referral criteria; may perform some discharge planning.

Roles and Functions of Utilization/DRG Manager: Clinical reviews; clinical documentation improvement.

Keeping your Model Patient-Centric

Each model requires about the same number of positions with one main difference: In the collaborative model, not every patient is seen by a case manager. In addition, the separation of utilization management from discharge planning in the collaborative model requires that there is constant and consistent communication between the case management team members so that redundancy, duplication, or missed work does not take place. This can add time and complexity to the process that does not occur in the integrated model. It also moves discharge planning and utilization apart, which can often result in these roles being performed as tasks rather than as an integrated part of all the case management needs of the patient. In addition, the social worker caseloads are much smaller in the integrated model, and because of this more patients can be seen by a social worker during their hospital stay.

It is also clear that many patients in today's healthcare environment need psychosocial assistance while they are in the hospital as well as referrals to community resources after discharge. It is now commonly understood that psychosocial issues such as poverty, chemical and alcohol dependence, and health illiteracy can greatly contribute to readmissions and poor outcomes after discharge. These issues need to be addressed while patients are in the acute care setting and then followed up in the community. To accomplish this work, strong social work staffing ratios are needed so that social workers have the time to spend with patients, families, and family caregivers.

Summary

Case management should be designed as a fully patient-centric model with all the roles and functions of the case manager and social worker performed as part of a package of services provided to the patient, not as a series of tasks that are disjointed and performed in isolation of each other. When case management models separate these roles, they create an environment in which these roles no longer interface and no longer are applied with the patient's current and long-term care needs in mind. Be very cautious when implementing such models and as you can see above, the argument that the collaborative model is less expensive simply does not hold true. Whenever possible, try to keep your case management roles and functions as integrated as possible for the greatest success and achievement of outcomes! ■

Hospital and medical director of the San Francisco Department of Public Health Medical Respite and Sobering Center. In addition to clinicians and staff from the hospital's inpatient and outpatient settings, the task force included representatives from primary care clinics and skilled nursing facilities.

When the task force started, 34% of patients were seen in the primary care clinic within seven days. Now, it's upward of 50%. About 70% to 80% of patients leave the hospital with a primary care appointment, Schneidermann says. "Shortly after the push for timely post-acute follow-up, the hospital's all-cause 30-day readmission rate decreased from 13% to 10.5% and has remained there. Patients seen within seven days of discharge have a readmission rate of about 6%," Schneidermann says.

San Francisco General Hospital is a trauma center and the only public safety net hospital in the city and serves a diverse, young, and underinsured population. About 30% of patients are uninsured, 40% are covered by MediCal, California's Medicaid program, and 8% to 10% are homeless.

"As a safety net hospital, we have limited resources and we need to be smart about how we deploy resources, whether it is personnel or financial resources. That was our challenge as we worked on ways to improve transitions and reduce readmissions," Schneidermann says.

The goal of the task force is to improve transitions for all patients, regardless of risk. The team developed a basic bundle of interventions for all patients. It includes appropriate communication between inpatient and outpatient providers, appropriate transfers including information needed by the next level of providers, and the right level of education for patients and caregivers.

"Whenever possible, we use materials that target patients with lower health literacy and limited proficiency in English," she says.

All patients, regardless of risk, get the basic bundle. Patients identified as high risk are referred to the SFGH transitional care nurses, the task force initiative staffed by three nurses whose backgrounds correspond with the racial, cultural, and language identities of many patients served by the hospital.

One nurse is African American, was born at the hospital, and has ties to the community served by San Francisco General. The others are a bicultural and bilingual Latino nurse and a bicultural and bilingual Chinese nurse.

The nurses work with heart failure patients of any age, and patients over 55 with chronic obstructive pulmonary disease, diabetes, or renal failure, or who are recovering from a myocardial infarction.

When they see patients in the hospital, the nurses use motivational interviewing to determine how to focus their bedside teaching with the patient and caregiver. They conduct extensive medication reconciliation and education about the patient's medication regimen and print out an enhanced post-discharge care plan. The nurses use software purchased with grant funding to create medication instructions at a fifth-grade reading level that can be translated into 18 different languages.

The nurses make sure patients have a follow-up appointment with a primary care provider and coordinate with outpatient and community providers. They call patients within 72 hours of discharge to reinforce the education and answer questions and concerns. Then they make follow-up calls to the patients every week for a month.

At-risk patients who receive the transitional care nursing intermissions have a readmission rate of 10% compared with 18% for similar patients who aren't able to receive the interventions for various reasons, Schneidermann reports.

"It's been a very effective program for a relatively small number of patients," she says. "We are trying to figure out how to scale this up and develop similar interventions. We are also still learning how to best identify patients at risk for readmission. We know that

EXECUTIVE SUMMARY

A Care Transitional Task Force at San Francisco General Hospital created a cross-continuum program that has reduced readmissions and increased timely primary care visits for discharged patients.

- A basic bundle of services includes communication between inpatient and outpatient providers, providing the right information to the next level of providers, and giving patients and family members the right level of education.
- Transitional care nurses work with heart failure patients of any age and patients over 55 with chronic obstructive pulmonary disease, diabetes, renal failure, or who are recovering from a myocardial infarction.
- The nurses work closely with patients and family members during the hospital stay and follow up weekly for 30 days after discharge.

readmission risk is more than just a diagnosis and that psychosocial issues contribute a lot to the risk. We want to develop a standardized, systematic approach to identifying which patients have both medical and non-medical issues that put them at risk."

The team is concentrating much of its efforts on transitions from the hospital to the community and a primary care provider.

"We learned early on from our analysis that our hospital is different from many. Only 6% of total discharges and 9% of Medicare patients go to a skilled nursing facility. Most of our patients receive their immediate post-acute care in outpatient clinics. We also found that there were gaps in communication between the inpatient team and outpatient providers, so we are focusing our energy on improving transitions to outpatient care," she says.

Getting patients to see a primary care provider for post-acute follow-up is a struggle for many hospitals and it's particularly difficult at San Francisco General, Schneidermann says. "Most of our patients live in poverty and have a lot of stressors and competing priorities, and making their clinic appointment may not be at the top of their list. We have to meet patients where they are and work from there," she says.

The team analyzed data from the 12 public health clinics in the hospital's network to determine the proportion of patients who went to follow-up appointments in the clinic within seven days of discharge. They are partnering with the leadership in the clinics to increase the number of patients who are able to get timely follow-up appointments and set performance goals to increase the number of patients who are seen in the clinic within seven days.

When representatives from the primary care clinics reported that they often didn't have the information they needed about their patients' hospital stay, the task force developed a discharge database that everyone in the network can access.

They began a pilot project to determine if it is feasible to have a health worker or medical assistant in the clinics make post-discharge follow-up calls and created a program to educate patients to see their primary care provider if they have post-discharge problems rather than coming back to the hospital.

"WHAT IS MORE COMPELLING IS IMPROVING THE WAY WE PROVIDE BOTH ACUTE AND POST-ACUTE CARE AND TO ENSURE THAT PATIENTS AND CAREGIVERS HAVE A POSITIVE EXPERIENCE AND A SAFE TRANSITION."

Members of the task force are working with the leadership of local skilled nursing facilities to improve transitions and to standardize the handoff between the hospital and the skilled facility.

"Reducing readmissions and improving care transitions is a priority for the hospital. We are beginning to understand the problem and share the information to providers in the health network," she says.

The multidisciplinary task force, which meets bi-weekly, includes clinicians and staff across the health services including the inpatient team, representatives from the hospital's primary care and ambulatory clinic, and skilled nursing facility. It includes representatives from the physician and nursing staffs in inpatient and outpatient settings, case management, social services, utilization management, physical therapy, palliative care, and the hospital and primary care administration. The team added a data analyst who routinely collects metrics related to care transitions.

"We wanted to be able to tell the story of care transitions and readmissions with data as well as anecdotal experiences and chart review," Schneidermann says.

The first year the team developed its mission and vision, set goals, and identified metrics to follow, then began to address the gaps that occurred when patients transition from one level of care to another. The team created three subgroups who were charged with developing initiatives in the inpatient setting, the primary and ambulatory care settings, and pharmacy-related initiatives.

"When we started, we didn't have an approach to assessing risk for poor transitions of care and we didn't have information on the types of patients that were being readmitted. We now have an ongoing process to help us understand which patients are at highest risk. From a human perspective, just focusing reducing readmissions is not compelling. What is more compelling is improving the way we provide both acute and post-acute care and to ensure that patients and caregivers have a positive experience and a safe transition," she says. ■

Transitional coordinator nurses focus on at-risk patients with chronic diseases

Initiative frees unit case managers to see other patients

As part of its readmission reduction program, Tucson (AZ) Medical Center developed the role of transition coordinator to work closely with patients with chronic diseases who are at risk for readmissions.

The hospital has reduced its penalties for readmissions in the first three years of the CMS readmission reduction program and expects no penalties for 2016, says **Elizabeth Maish**, RN, MSN, CPHQ, chief nursing officer at the 641-bed hospital.

"Tucson is a small city with a population of about one million. We are a big hospital and have a strong, long-term relationship with the post-acute providers. All of this contributes to our success in reducing readmissions," Maish says.

The hospital has a stable and experienced case management department that experiences little turnover, Maish says. "The case management department is very important and is essential to our bottom line and to our patient flow. Coordination of care is so pivotal to readmissions and management of patients, and our case managers are very involved and get good results," Maish says.

The hospital has an average census of more than 400 patient a day and a high Medicare acuity index. "This tells us that our population is older and more chronically ill," Maish says.

When the case management department began focusing on readmission rates, they analyzed patient populations, diagnoses, and demographics and determined that many of the patients who were being readmitted were elderly with chronic diseases.

"We found that there were commonalities among the patients who were impacting our readmission rates. Every patient is a little different but many at-risk patients have chronic diseases, such as diabetes and heart disease, that contribute to readmissions," she says.

The team also found that behavioral health issues were another factor in readmissions, she says. "We know that depression is very prevalent in older adults with chronic conditions. These patients are very difficult to place. They aren't difficult to treat, but you can't treat somebody over a four-day hospital stay and expect that they will be completely stable from a medical, spiritual, and mental health standpoint. They need follow-up after discharge," Maish says.

The hospital created the role of transition coordinator to work with at-risk patients who have chronic conditions, and filled the slots with three experienced RNs who were knowledgeable about chronic diseases. Two of the nurses were case managers and the third was an intensive care nurse.

"These nurses know the clinical piece and treatment protocols for managing chronic diseases and they also know the best environment in which to place these patients after discharge," she says.

The transition care coordinators focus on the at-risk patients with chronic diseases, leaving the unit-based case managers free to work with other patients on the unit, Maish says. They access the electronic medical record each day for a report that identifies potential patients based on primary and secondary diagnoses and their healthcare utilization for the last five years. "Our average length of stay is 4.4 days, so it's essential that we identify these patients early in the stay," Maish says.

The transition coordinators typically coordinate care for 7 to 12 patients at a time, depending on the hospital census, Maish says. They work

EXECUTIVE SUMMARY

Tucson Medical Center keeps its readmission rates low by having transitional coordinators work closely for patients with chronic disease who are at risk for readmissions.

- An analysis of readmitted patients determined that many who were rehospitalized were elderly with chronic diseases.
- The transitional coordinators are three experienced nurses with knowledge of chronic disease who work closely with the care team and follow patients for up to 30 days after discharge.
- The hospital arranges for post-acute providers to come to the hospital to see the patients referred to them for services.

closely with the medical team and help them follow the hospital's best care pathways. They work with the rest of the team to create a disease-specific treatment plan for the patient stay and a discharge plan that provides everything the patient needs for a safe discharge, Maish says.

Education of patients and caregivers is a major component of the chronic disease program.

"Whether patients are going home, to a skilled nursing facility, an assisted living facility, or to live with family, the most important piece of preventing readmissions is preparing patients to transition to the next phase," she says. "The chronic disease care coordinators bring together all the aspects of the patient, including physical status, spiritual and mental health, medication profile, patients' understanding of their disease and medication regimen, and communicate it with the people at wherever the patient is going."

The transition coordinators work as a team with the treating physician and the clinical team to coordinate the transition plan and to make sure that the next provider of care, whether it's the primary care physician, a skilled nursing facility, or a home health agency, has the information they need to take care of the patient's needs.

They follow up with patients and their caregivers as needed for up to 30 days after discharge, she says.

When a patient is ready for discharge to a post-acute facility or has a home health referral, the transition coordinator sends the facility the pertinent parts of the patient record over a secure Internet connection and follows up with a phone call to the nurse who will be caring for the patient.

"We have strong connections and long-term relationships with the post-acute facilities and home health agencies in Tucson and we hold them accountable for the outcomes experienced by our patients. We work closely with them and share quality data and patient feedback with them," Maish says. ■

Readmissions are focus of TJC resources

The Joint Commission has developed two new resources to help healthcare providers in their efforts to reduce patient readmissions and improve the discharge process. The resources are a new Speak Up campaign for providers and organizations to educate patients, including an infographic, animated video, and podcast; and a Quick Safety newsletter for healthcare professionals that includes suggested actions for improving transitions. *(The Speak Up campaign is online at http://tinyurl.com/j6bxdkw, and the Quick Safety newsletter is online at http://tinyurl.com/z6ys4yb.)*

The importance of transitions in improving patient safety is illustrated by The Joint Commission's sentinel event data compiled from January 2014 to October 2015. The data show a total of 197 sentinel events — from suicide to falls to wrong-site surgery — and the root causes included failures in patient communication (127 incidents), patient education (26 incidents), and patient rights (44 incidents). The majority of the patient education failures were related to not assessing the effectiveness of patient education or not providing education. The patient rights failures included absent or incomplete informed consent, and lack of the patient's participation in their care.

The new public service campaign, "Speak Up: Avoid a Return Trip to the Hospital," uses easy-to-understand language to help patients understand the steps they should take after they are discharged to avoid returning to the hospital. The materials are free and available on The Joint Commission's website. They were developed so that healthcare organizations and providers can easily display and distribute them to patients and caregivers in their facilities, online, and in printed materials.

The pre-discharge information in Speak Up includes facts patients need to know about their treatment and diagnosis, medication, follow-up care, and information on where and how to get help if they need it. The post-discharge recommendations explain to patients the steps they may go through depending on their condition and the location they are discharged to. The infographic includes tips and bulleted lists describing the different settings where a patient might receive care following discharge including a doctor visit, home care, community services, therapy, hospice, and a nursing care center.

The Quick Safety newsletter, "Transitions of Care: Engaging Patients and Families," focuses on ways to improve transitions and involve patients and their families in the process. The publication includes suggested actions to consider for positively affecting patient transitions, such as organizational policies that enable families to visit around the clock, conducting physician and interdisciplinary rounds at the patient's bedside, having nurses give their change of shift report at the patient's bedside, patient-centered discharge planning, and EHRs that patients can access and edit. ■

Hospital safety scores show some improvements

The Hospital Safety Scores released recently by The Leapfrog Group show key shifts among many hospitals on the letter grades rating them on errors, injuries, accidents, and infections. While overall progress remains elusive, the data showed encouraging signs, with hospitals taking steps to make safety a priority by consistently maintaining an "A" score or by raising a lower score to an "A" over time. The following are key findings:

• Of the 2,530 hospitals issued a Hospital Safety Score, 773 earned an A, 724 earned a B, 866 earned a C, 133 earned a D, and 34 earned an F.

• One hundred thirty-three hospitals earned the "Straight A" designation, which calls attention to hospitals that have consistently received an A grade for safety since the Hospital Safety Score launched in 2012.

• Zero hospitals in the District of Columbia, Alaska, North Dakota, New Mexico, Vermont, or Wyoming received an A grade.

• Due to a considerable data update, 46% of hospitals changed at least one letter grade.

The Hospital Safety Score assigns letter grades to more than 2,500 U.S. hospitals twice per year. For more information and to view the list of state rankings, visit www.hospitalsafetyscore.org. ■

A burnout barometer to assess your work culture

Tools available at AACN website

The American Association of Critical-Care Nurses (AACN) has created tools to address issues associated with a healthy work environment, including burnout and "compassion fatigue," available at http://www.aacn.org/.

For example, the following is used as a work environment assessment where healthcare workers give a range of answers from "strongly agree" to "strongly disagree." Obviously, the more of the latter you have on this list the more concern is warranted about the work culture.

• Administrators, nurse managers, physicians, nurses, and other staff maintain frequent communication to prevent each other from being surprised or caught off guard by decisions.

• Administrators, nurse managers, and physicians involve nurses and other staff to an appropriate degree when making important decisions.

• Administrators and nurse managers work with nurses and other staff to make sure there are enough staff to maintain patient safety.

• The formal reward and recognition systems work to make nurses and other staff feel valued.

• Most nurses and other staff here have a positive relationship with their nurse leaders (managers, directors, advanced practice nurses, etc.).

• Administrators, nurse managers, physicians, nurses, and other staff make sure their actions match their words — they "walk their talk."

• The right departments, professions, and groups are involved in important decisions.

• Support services are provided at a level that allows nurses and other staff to spend their time on the priorities and requirements of patient and family care.

• Nurse leaders (managers, directors, advanced practice nurses, etc.) demonstrate an understanding of the requirements and dynamics at the point of care, and use this knowledge to work for a healthy work environment.

• Administrators, nurse managers, physicians, nurses, and other staff have zero-tolerance for disrespect and abuse. If they see or hear someone being disrespectful, they hold them accountable regardless of the person's role or position. ■

COMING IN FUTURE MONTHS

- Inpatient vs. observation: Will it ever be easy?
- Tips for providing patient-centered care
- How to handle ethical dilemmas
- Having the difficult end-of-life conversation

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CE QUESTIONS

1. Under current CMS regulations, which organization will review hospitals' records for compliance with the two-midnight rule?

A. The Recovery Auditors
B. The Quality Improvement Organizations
C. The Medicare Administrative Contractors
D. The Zoned Program Integrity Contractors

2. According to Elizabeth Lamkin, MHA, what is the maximum caseload case managers should carry in order to do their job well in the current healthcare environment?

A. No more than 25.
B. No more than 20.
C. No more than 18.
D. No more than 15.

3. When CMS issues new contracts for the Recovery Audit program, it proposes that contractors will not be paid if complex reviews are not completed in 30 days.

A. True
B. False

4. What is the average caseload for the Transition Coordinators at Tucson Medical Center who coordinate care for at-risk elderly patients with chronic conditions?

A. 7 to 12.
B. 8 to 10.
C. 10 to 15.
D. 18 to 25.

CE OBJECTIVES

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

1. identify the particular clinical, administrative or regulatory issues related to the profession of case management
2. describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the healthcare industry at large
3. discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.