HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

AHC Media LLC

IN THIS ISSUE

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NOVEMBER 2009
VOL. 17, NO. 11 • (pages 161-176)

Struggling to find post-acute care for undocumented and uninsured immigrants

Patients without payers are challenging to place

When a Florida hospital transferred a seriously disabled, undocumented immigrant back to his native Guatemala for care and won a subsequent lawsuit filed by the man's American guardians, the case made national headlines.

And all over the country, the dilemma the hospital faced resonated with case managers who deal with the challenge of finding post-acute care for patients with no funding and no family in this country to care for them after discharge.

When patients no longer have acute care needs but cannot be safely discharged and have no means to pay for post-acute care, they often stay in hospitals for months or even years.

"Hospitals don't have unlimited resources and can't provide millions of dollars of care for one individual. For instance, quadriplegics ordinarily would go to a rehabilitation center after acute care, but if these patients are undocumented or uninsured, the hospital social worker rarely can identify a place that will take them. It's an ongoing problem," points out **Deborah Cruze**, JD, MA, program associate, health sciences and ethics at Emory University's Center for Ethics in Atlanta.

Before taking her current position, Cruze was a clinical ethicist at Grady Memorial Hospital, Atlanta's 953-bed public hospital, which houses the only Level 1 trauma center in the region.

Because of the Emergency Medical Treatment and Labor Act (EMTALA), hospitals have to take care of every patient who has an emergency and comes in the door. No other provider has to meet that requirement, Cruze points out.

"Every other provider — nursing homes, rehabilitation centers, and long-term care facilities — can say no. That leaves the care for those patients up to the hospital," she says.

In the Florida case, the patient was treated at the hospital for a traumatic

brain injury he received in an automobile accident, but no post-acute facility would take him because he had no funding. After providing care for several years at a cost exceeding $1.5 million, the hospital chartered an air ambulance and transported the man to a Guatemalan hospital, which eventually discharged him to the care of his mother, who lives in a remote village.

When the man's cousin filed a lawsuit challenging the hospital's decision, a jury decided that the hospital did not act unreasonably when it transferred the patient back to his home country.

"Hospitals struggle with both undocumented and indigent patients with conditions that make them difficult to place in post-acute care. The laws concerning each are different; but when they need complex medical care after discharge, both groups are difficult to place," Cruze says.

It's not unusual for Lutheran Medical Center in New York City to have patients in the emergency department who require acute care beds that are being taken up by patients who could be in a nursing home if they had funding, says **Fred Nenner**, LCSW, director of social work.

Lutheran Medical Center is located in an urban setting in New York City in an area that traditionally has had a large immigrant population.

"We are a Level 1 trauma center and care for severely injured patients. Put that together with an immigrant population that is likely to be ineligible for post-hospital care, and we are at risk for treating patients who cannot be safely discharged to the community," he says.

The 479-bed hospital's mission statement says that its objective is to serve its neighbors.

"We try to serve that mission; but when the hospital treats those patients who need a skilled level of care in a nursing home facility and for whom we cannot access Medicaid coverage, we are basically stuck with those patients," Nenner says.

Only about 1% of the charity patients at Medical City Dallas Medical Center are undocumented, but the percentage is trending up, says **Pat Wilson**, RN, BSN, MBA, director of case management.

"Providing health care for undocumented immigrants is becoming more challenging every day, especially in Texas and California. When patients are unfunded, the chances of finding a post-acute facility to take them are slim," Wilson says.

Having patients who aren't in need of an acute care bed but can't be safely discharged poses more than just a financial problem, says **Regina Hasan**, LMSW, executive director of social services at WellStar Health System in Marietta, GA.

"Kennestone Hospital often runs an 80% to 90% census. If a patient who isn't in need of acute care is taking up a bed, and we have patients holding in the emergency department while waiting for a bed, that doesn't provide the best-quality care we can for our community," Hasan says.

The 633-bed Kennestone Hospital is the flagship facility for the five-hospital WellStar Health System.

"We're a not-for-profit public hospital, and we

Hospital Case Management™ (ISSN# 1087-0652), including **Critical Path Network**™, is published monthly by AHC Media LLC, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to ***Hospital Case Management***™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

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

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $78 each. (GST registration number R128870672.)

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This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This activity has been approved by the Commission for Case Manager Certification for 18 clock hours.

This program was approved by the National Association of Social Workers (provider # 886399925) for 18 continuing education contact 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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treat anybody who presents for treatment the same way, whether they have insurance or not. But when patients don't need acute care and have no place to go after discharge, we have no choice but to keep them," she says.

At Grady Memorial Hospital, at one time, nearly half of the beds in the step-down unit were occupied by people who no longer needed acute care but had no place to go, Cruze says.

"Hospitals have only so many ventilators and only so many providers to take care of all these patients," she adds.

"If you believe that all individuals have the right to access health care, that means that the health care system should take care of anyone who needs care for as long as he or she needs care," Cruze says.

On the other hand, when a hospital provides an intense level of care to one person for the rest of his or her life, an intensive care unit bed will be taken up for years, and the hospital may not be able to take someone who could recover and return to society as a contributing member, she adds.

"Hospitals don't have unlimited resources. If they have to continue to treat people without reimbursement, they may have to close their doors," Cruze points out.

When Cruze worked in Arizona, some hospitals there closed their emergency departments because they were providing long-term care for so many catastrophically ill patients who had no other place to go after discharge and for whom the hospitals received no reimbursement.

"When this happens, the rest of society has no access to emergency care," she says.

There are several different categories of undocumented workers, Cruze points out. One group comes to the United States to work and sends money back home. They may be the easiest to return to their country of origin because they have family there to care for them.

But there are other undocumented patients who may have immigrated with their families at an early age but never became citizens. They aren't eligible for Medicaid, and they may not know anyone in their native countries, so sending them back isn't a viable option.

"The problem becomes more difficult when you look at the facts of individual cases," Cruze says.

The 1996 federal welfare reform act (the Personal Responsibility and Work Opportunity Reconciliation Act) says people admitted to the United States after August 1996 cannot receive coverage except in emergencies until they have been residents for 10 years.

"If a patient has an entitlement benefit that we can access, we can usually see the light at the end of the tunnel," Nenner says.

In the case of patients who may have been in this country for five years or longer, Lutheran's social work staff work with them to establish residency so they can receive benefits.

However, they aren't always successful. Lutheran Medical Center has been caring for a Mexican quadriplegic who has lived in New York for more than 10 years but has used so many different names that the hospital can't establish his identify so he can get Medicaid. His elderly parents in Mexico don't want him to come back, leaving the hospital no choice but to keep him since he cannot be safely discharged.

Under current law, undocumented immigrants may not receive anything but emergency Medicaid; but under EMTALA, the hospital must provide emergency care for them.

"People protest that illegal immigrants should not get benefits, but if they go to the hospital, under current laws, they get care but the hospital doesn't get paid," Cruze points out.

Grady provided care for a patient in his 80s who came to Atlanta from another country. He was in the United States legally but he hadn't been here the five years necessary to qualify for Medicaid. He didn't qualify for Medicare because he hadn't paid into the system. The patient was on a ventilator and required too much care for his family to take care of him. Instead, he lived in the hospital for the rest of his life.

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Finding discharge options for uninsured immigrants

Paying for a lower level of care an option

"When faced with an increasing number of immigrants who don't have funding for post-acute care, hospital case managers and

social workers must use their ingenuity to come up with creative options that lessen the financial burden of care," says **Deborah Cruze**, JD, MA, program associate, health sciences and ethics at Emory University's Center for Ethics in Atlanta.

If patients have someone to care for them in their native land, it may be a good option for hospitals to pay for an air ambulance to return them home, Cruze points out. **(For more information on transferring patients back to their native countries for care, see related article on p. 165.)**

"The dilemma arises when patients are not going to be able to receive anything close to the kind of care they need in their home country," she adds.

In those cases, look for less expensive ways to provide care for patients in a less acute setting, Cruze suggests.

For instance, when Cruze was a clinical ethicist at Grady Memorial Hospital in Atlanta, the hospital looked at the feasibility of renting an apartment for patients to live in while they received outpatient care, depending on how complex their clinical needs were.

"In some cases, it was a cost-effective option to bring family members here to take care of them for a certain length of time," she says.

When the staff at WellStar Kennestone Hospital identify undocumented immigrants who are likely to have post-discharge needs, the care coordinators meet with them and talk about what kind of options may or may not be available to them, says **Regina Hasan**, LMSW, executive director of social services for the WellStar Health System.

"If they will be able to go back to the community, the staff identify clinics or other services that can meet their needs. If they need long-term care, like vent-dependent patients, or those who have end-stage renal disease, we have to work on alternatives. We meet with the family and let them know that if the patients are in need of long-term care like skilled nursing or long-term chronic care, there are no options available in this country at this point, unless they are willing to pay for them," Hasan says.

At Medical City Dallas Hospital, case managers and social workers work as a team to look at potential options for discharging undocumented patients who have serious injuries or illnesses, says **Pat Wilson**, RN, BSN, MBA, director of case management at the 598-bed hospital.

"We try to understand the realistic outcome for the patient and that may be that the patient is never able to care for himself. We get the family involved immediately and talk to them about the likelihood of the patient recovering, what it means, and what kind of care he will need," she says.

Knowing realistic outcome

The physicians, case managers, social workers, physical therapists, occupational therapists, and others on the treatment team frequently meet to make sure that they all have an understanding of the goal of treatment and the patient's realistic outcome.

The case managers and social workers find out what kind of resources the family has, if they have someone who can stay home with the patient, and look at all the possibilities for post-acute care.

"If a patient is unfunded, the likelihood that he or she can get into charity rehab is slim. In those cases, we provide as much of a rehab program as we can to get those patients to the best level of functionality we can," Wilson says.

This means patients stay in acute care and have physical therapy, occupational therapy, and/or speech therapy several times a day — whatever will have the biggest impact to get the patient further along the road to recovery without being in the rehab setting, she adds.

"We tell the family member up front that the patient ultimately is their responsibility. We get them involved in the beginning and make them part of the team. That way, they know the expectation," Wilson says.

When the family is willing to care for the patient at home, the case managers usually can partner with a home care agency to provide two or three visits to help the family adjust at home.

Many undocumented Hispanic patients, particularly those who immigrated many years ago, do not have a family in the traditional sense but do have strong bonds in the community, Wilson says.

"Members in the Hispanic community tend to cherish and protect each other and are willing to do what they can. Sometimes, they want to do more than we think is in the patient's best interest and, in those cases, we try for charity rehabilitation or home health," she says.

"We give all our patients the facts and information about their condition, and if they choose to go home, we send them home," she says.

When a patient has a catastrophic illness or injury and doesn't have a family member who can be a decision maker, the case managers get the hospital's ethics committee to review the case.

Grady has made arrangements to pay post-acute

providers to care for patients a certain length of time and agreed to take them back if they don't progress, Cruze says.

"These agreements tend to be difficult for the hospitals because the patients often return to acute care. It is a temporary solution that lessened the cost, but ultimately the hospital didn't become absolved of responsibility for the patient," she says.

Dialysis patients with no funding present a special dilemma for hospitals because they are usually stable enough to be discharged to the community, but they don't receive the regular dialysis they need because no dialysis center will take them if they don't have a payer source, Wilson points out.

"Dialysis patients must be aware that when they miss treatments, they are going to get worse and end up in the emergency room. We talk to them about how treating them only in the crisis mode is not the best kind of treatment and isn't a long-term plan," she says.

WellStar Cobb Hospital has kept patients with end-stage renal disease and no funding in the hospital for dialysis, but some have gotten tired of staying in the hospital and left against medical advice, Hasan says.

"Then their condition would get worse, and they would bounce back to the emergency department, often ending up in the intensive care unit, depending on how long they went without dialysis. The hospital was like a revolving door for them," she says.

At Medical City Dallas, the case management staff treat patients without funding "the same way they treat noncompliant patients and educate them that not being on routine dialysis schedule will shorten their life," Wilson says.

In instances when the patient has family in Mexico, the hospital's social workers bring up the subject of going back to Mexico for treatment.

"We have sent patients back to Mexico when they are stable enough to make the trip and we have 100% family support. They are grateful to go home to their loved ones to die or receive medical care," Wilson says.

The key to success in finding post-acute accommodations for unfunded patients is to take a proactive approach to discharge and involve the family members up front, keeping them informed on the goals of treatment and the realistic expectation for the patient's recovery.

"When we know what we think the patient's outcome will be, it gives us a place to start working with the family and looking at what resources they have and what we call pull together. If we wait until the last minute, the plan would never come together," she says. ■

Transporting patients to native country for care

Win-win situation for patient, family, and hospital

For **Fred Nenner**, MSW, and the rest of the staff at Lutheran Medical Center in New York City, successfully returning injured immigrant patients to their family in their native country is one of the most challenging and rewarding jobs they tackle.

"The rewards are astounding. It becomes a triumph for our mission. Everybody on the staff knows when we're returning a patient to his family, right up to the CEO. When we get it done, we feel like we are on the top of the world," says Nenner, director of social work.

Certain conditions have to be met for the hospital to send people back to their country of origin, he says.

Patients must have no other possible alternative for care and are likely to physically reside in the hospital for as long as they live. The hospital must get in touch with the patient's family in the country of origin, and they must want the patient back. A facility in the patient's country of origin must be able to provide adequate care for the patient.

"We do not send people back to their home countries unless there is a safe plan for their care and they have a family who wants them. We have people in this building that we have no way of discharging because they need skilled nursing," Nenner reports.

The hospital has picked up the tab for sending seriously injured patients back to Mexico, Poland, and China via commercial flights or air ambulances. The patients typically are accompanied by medical personnel from the hospital who take care of their in-flight needs.

Arranging those discharges takes a lot of staff time over a period of weeks to work out, Nenner adds.

"It is expensive; but if you do the math, it all makes sense. You have to weigh the cost of the transportation vs. the cost of providing care for the patient for an indeterminate amount of time. When you factor in the fact that you will be able to turn over the bed, the economic benefits are clear," he says. ■

Hospital returns immigrant to his family in Poland

Case study illustrates a complicated discharge

Returning an immigrant to his or her native country for post-acute care is a long and complicated process but one that produces great rewards, says **Fred Nenner**, MSW, director of social services at Lutheran Medical Center in New York City.

Here's one success story:

Mr. J, a native of Poland, was in America with his daughter visiting his sister-in-law when he was hit by an automobile, suffering a C-3 fracture that severed his spinal cord and left him with neurological damage and a compromised mental status.

He was separated from his wife and other children by 8,000 miles and wanted to go home.

"His family wanted him back. They lived in the northwest corner of Poland, about four hours from Warsaw. We worked with the Polish Consulate to identify a hospital in that area that could provide the care he needed. After talking back and forth on the telephone, we got him admitted," Nenner recalls.

When the patient came into Lutheran Medical Center, he was in serious condition and on a ventilator.

"We had to get him off the ventilator because we can't transport a ventilator patient by airplane. That took at least four weeks," Nenner says.

Then came the challenge of transferring the patient to Poland. An air ambulance would cost $35,000.

It took about two months to arrange the transfer, Nenner says. There was an eight-hour time difference between New York and Poland that made it challenging to contact the hospital and physicians to share information about the patient.

Working with an airline, the hospital found a way to accommodate the patient's stretcher but needed to purchase nine airplane seats, as well as airfare for two doctors who attended him during the flight. The cost: $12,000.

Providing the continuous oxygen the patient needed was another challenge, since the airline wouldn't allow oxygen tanks on board. The solution: A respiratory therapist worked with the airline to find fittings from the plane's oxygen system that would fit his tracheometer.

"The respiratory therapy department worked with the hospital in Poland to get appropriate fittings that were compatible with their equipment so he could receive oxygen when he got home," Nenner says.

The medical staff traveled with medical kits and portable suction.

Because of security concerns, the hospital had to get permission for the ambulance to drive onto the tarmac, right up to the airplane.

"And we always pray that the patient is still stable the day of the flight," Nenner says.

The flight went smoothly and the hospital in Poland sent an ambulance to transport the patient from the airport in Warsaw to the hospital — a four-hour trip.

"The patient was happy. The family was happy. We felt good about the positive outcome. It was a win-win situation for everybody," Nenner says. ■

Preceptors, mentors help CMs learn the way around

Program has increased satisfaction, less turnover

A program that pairs new case managers with a preceptor for eight weeks and a mentor for a year has increased staff satisfaction and reduced turnover for the case management department at Carolinas Medical Center in Charlotte, NC.

"Case managers can't learn everything they need to know in just a few weeks. We believe that training needed to be an ongoing process for about a year," says **Chris Walsh**, RN, CCM, director, clinical care management.

Carolinas Medical Center's case management department was named winner of the 2009 Franklin Award of Distinction by The Joint Commission and the American Case Management Association.

The department began its preceptor and mentoring program after the medical center's first employee satisfaction survey showed that case managers felt that the orientation process could be better.

"The training piece and educational piece was always there. What was missing was making it personal and welcoming. What happens with new employees now represents a tremendous improvement from when I joined the department," says **Debbie Wright**, BSN, who has been a case manager at Carolinas Medical Center for about 18 months.

(Continued on page 171)

CRITICAL PATH NETWORK™

Interdisciplinary initiative reduces LOS by 2%

Staff learn it's not just case management's responsibility

Following a systemwide initiative, Catholic Healthcare Partners has reduced its average length of stay by 2%, potentially avoiding 18,000 hospital days in the multistate hospital system with headquarters in Cincinnati.

"We started our length of stay initiative in 2008 as we looked for opportunities to decrease waste in the system. The overall goal of the project is to reduce our observed length of stay to the expected length of stay, based on the Centers for Medicare & Medicaid Services [CMS] geometric mean length of stay," says **Cathy Follmer**, RN, BSN, MBA/HCM, CHCE, CRNI, corporate director of continuum of care services for Catholic Healthcare Partners.

As Follmer visited facilities throughout the health system in the beginning of the initiative, asking them to identify opportunities for improving length of stay, she heard the same thing at every facility — that it was a case management problem.

"We quickly realized that the first challenge would be changing that mindset. Case management plays a big role, but length of stay is a multifaceted problem," she says.

Length of stay affects the hospital's bottom line but also is a patient safety issue, Follmer points out.

"Patients are more likely to develop pressure ulcers if they stay in the hospital longer. They have a higher chance to develop infections and have more opportunities to fall," she adds.

The health system set up multidisciplinary tasks forces in each hospital to develop projects for improving length of stay, based on the organization of each hospital and the population it serves.

The length-of-stay task force at each hospital includes the chief executive officers or designee, chief operating officers, chief nursing officers, directors of case management, directors of quality, directors of patient safety, chief medical officers, and ancillary and post-acute services directors.

"This isn't a one-department project. It has to be hospitalwide. We looked at what processes are in place to improve patient-centered care and move patients safely through the system in a timely manner," Follmer says.

The hospitals used the Lean Six Sigma process as a foundation for efficiency, analyzing roadblocks in patient throughput and looking for ways to remove the obstacles for discharge.

Each hospital's task force looked at how the case management and nursing department worked, how the facilities were set up, and what processes were in place that could be done more efficiently to come up with individual projects for their particular facility.

"Everything that happens when patients come in the door until they are discharged affects the length of stay. For instance, if the correct information isn't collected at registration, that can hold up the discharge," Follmer explains.

One of the areas the task forces tackled was ancillary services. At some hospitals, the cardiac lab didn't do stress tests after noon and only in case of an emergency on weekends.

"That means that if a doctor decided on Thursday afternoon that a patient needs a stress test, he might not get it until Monday if the lab is booked on Friday," Follmer says.

The team looked at how many patients stayed over the weekend because they had a test on Monday that could have been done on Friday.

"We looked at the cost of keeping patients compared to having someone on call or opening

the department on the weekends," Follmer says.

The team looked at what the cost savings might be if staffing was increased in some departments to handle tests and procedures and avoid keeping patients who otherwise were ready for discharge.

"We challenged the CFOs to look at return on investment. If it happened only a few times a year, it might not be worth it to add staff; but if patients were staying longer regularly, it might be financially viable," Follmer says.

Physicians told the team that many times, when they made rounds, the labs were not on the charts.

"Patients were being kept an extra day while waiting for laboratory and test results. This was an area of opportunity for many hospitals," Follmer recalls.

In some facilities, it was easy to find out what was holding up the lab results. In others, the team had to drill down to determine what was holding up the process and what needed to be put in place to expedite it.

"Sometimes it was changing the layout or upgrading the computer system to make the flow easier. At other facilities, labs weren't being drawn until 7 a.m. when they used to be drawn at 5:30 a.m.," Follmer says.

The team analyzed how many patients were admitted on Wednesday and Thursday but not discharged until Monday because the test results were not back when the physician made rounds on Friday. They used the information to determine if the ancillary departments needed to revise their procedures.

In some facilities, the primary care physicians routinely made rounds before the consulting physician came in to see the patient. As a result, even though the consulting physician said the patient could go home, the patient stayed until the next day, when the primary care physician wrote the discharge orders.

"We advised the medical staff to work with their physicians to put a method in place to get the patient discharged when the consulting physician says it's OK," Follmer says.

The teams looked at how tests and procedures were scheduled and how the process could be improved.

"If patients need an X-ray and a CT scan, the procedures can be scheduled back to back so the patient doesn't have to be shuttled back and forth between radiology and the room," Follmer says.

In many facilities, the physical therapy department is closed on Sunday and provides therapy to a limited number of patients on Saturday. This also caused holdups in discharge and problems for the patients, Follmer says.

"When a patient who is going to a skilled facility after discharge starts physical therapy on Thursday and doesn't receive it on the weekends, the three days of therapy that enables them to qualify for a skilled nursing stay goes out the window. We had to change the mindset of the physical therapists to solve this problem," she says.

Another initiative was to make sure that discharge planning starts on Day 1 in all facilities.

"In some facilities, the case managers did the initial review and went back to the chart to authorize the days, but they didn't look at the chart again until the physician wrote the order in the chart. This led to the case manager scrambling to try to set up the discharge. It was especially problematic if the patient was going to a long-term care facility and many times added two or more days to the length of stay while the case manager was getting the paperwork filled out and finding a facility," Follmer says.

The team challenged the case managers and nurses to work closer together and share information that helps with the discharge and to bring the entire multidisciplinary team into the loop.

"It's not a case management model or a nursing model but a care management model that involves collaboration among everyone in the multidisciplinary team," Follmer says.

For instance, the nursing aides spend a lot of time with patients and many times know a lot about the patient's home environment.

"They may know that a patient's bathroom is on a different floor from the bedroom or that the family is dysfunctional, information that can be important for early identification with choosing the appropriate level of care on discharge," says Follmer.

Levering technology, such as bed tracking, has been instrumental in many of the facilities as it alerts staff and physicians visually at a glance where the patient is, what the time is on the present length of stay, and who is pending discharge.

"Used correctly, technology can greatly enhance throughput. Choosing the right care model, utilizing available technology, and collaborating with all the players is key to reducing length of stay," Follmer says.

(For more information, contact: ***Cathy Follmer****, RN, BSN, MBA/HCM, CHCE, CRNI, corporate director of continuum of care services for Catholic Healthcare Partners, cxfollmer@health-partners.org.)* ■

Multidisciplinary meetings lower LOS, excess days

Mandatory meetings involve all disciplines

Within 45 days after daily multidisciplinary patient care conferences were instituted at North Fulton Regional Hospital, the hospital's average length of stay dropped by more than a day and excess days decreased by more than 300 days within the first quarter of implementation.

The initiative has increased the hospital's compliance with core measures and allowed the case management department to better identify and track patients in observation status, says **Kamela Sooknanan**, RN, administrator of clinical quality improvement and case management services for the 202-bed hospital in Roswell, GA.

"The greatest asset to impacting quality of care has been the early identification of the need to involve additional disciplines in the patient's care and assigning accountability for meeting the patient's needs. All of the disciplines are there from the get-go to share information about the patients," she says.

Staff members make up for the time they spend attending the morning meetings later in the day because they don't have to track down individual disciplines for questions, Sooknanan adds.

When the hospital began the conferences in August 2006, Tenet Healthcare had begun a corporatewide initiative to have all the hospitals in the system implement daily patient care conferences to manage length of stay and improve overall patient outcomes.

"As case managers, we know how significant the multidisciplinary approach is to managing and coordinating patient care. In addition, at the time of the corporate roll out, our length of stay had been trending up. Therefore, this was the perfect opportunity to institute a daily care conference approach and meet both needs at once," Sooknanan says.

At the time, the hospital was holding weekly patient care conferences on the units, but they were poorly attended. The charge nurse presented the cases, and the team focused on the discharge plan and information sharing.

"The meeting structures were lacking in the care plan development process. Many people thought of them as being case management meetings and they just didn't attend," Sooknanan explains.

Now, the directors of every department make sure their staff attend the meetings, and directors also attend the meetings.

Staff initially complained

When the mandatory meetings were instituted, many staff members complained about the time commitment and competing priorities.

Hospital management created a policy for daily patient care conferences, and the management team continually showed its support for the conferences.

For several months before the conferences were implemented, the team conducted focused housewide education, putting up posters on all the nursing units and introducing the concept of nursing and ancillary staff meetings. All directors received weekly e-mail updates. One-on-one education was conducted with key physician groups, and newsletters were sent to the entire medical staff.

The support of the hospital's leadership team was instrumental in getting the meetings off the ground, Sooknanan recalls.

"We let everyone know that these meetings were necessary to improve quality of care and length of stay. The way we approached it is that nobody gets a pass for not coming to the meetings on any day. It's ingrained as part of our operations," says **Ilona Wozniak**, chief operating officer.

In the beginning, Wozniak or someone else from senior management attended the daily meetings.

"This reinforced the expectation that we would see all of the multidisciplinary team members and directors at the meetings. If someone wasn't present, we would follow up with his or her supervisor. Directors are kept informed, and they know that a team is committed to this project and that it is mandatory for everybody to participate," she says.

Disciplines attending the meeting include case management; nursing; hospitalists on the medical units; physical, occupational, and speech therapy; pharmacy; respiratory therapy; nutrition; unit directors; ancillary directors; and the director of case management.

The meetings are held in the mornings at staggered times so that no two units are meeting at the same time, allowing staff who cover multiple areas to participate. Each meeting covers 20-30 patients.

The team discusses every new admission on the morning after admission and discusses every patient with a length of stay of four days or longer.

"Each patient is discussed each day with the

exception of Day 3 of their admission. Many patients are discharged on Day 3 of their hospital stay," Sooknanan says.

The meetings are very formal and have strict ground rules, which include no side conversations, and are redirected as needed to keep the focus on the patients and the issues affecting the progression of care.

The team is committed to starting and ending the meetings on time and limiting the time to 30 minutes, Sooknanan adds.

"Whenever a case is complex, we off-line it and the people most closely involved finish the conversation after the meeting," she says.

For instance, if a patient has significant social issues, instead of spending time at the meeting coming up with solutions, the case manager would consult with the other team members after the meeting.

The case managers lead the meeting. They introduce the patients and the diagnosis and turn it over to the nurse to present the patient's clinical status.

The team focuses on what is keeping the patient in the hospital and potential barriers to discharge. These include diagnosis and current status, home/social situation, invasive devices, respiratory status, physical therapy and occupational therapy needs, diet and intake, wound care, and pertinent tests and procedures and tests that are pending.

(For more information, contact: ***Kamela Sooknanan****, RN, administrator of clinical quality improvement and case management, North Fulton Regional Hospital, e-mail: Kamela.Sooknanan@ tenethealth.com.)* ■

Patient satisfaction upon discharge improved

Hospitalists, PCPs use communication software

When hospitalists use discharge communication software, patients and the outpatient doctors who carry out the care have better perceptions of the quality of the discharge process, according to new research published in the August issue of the *Journal of Hospital Medicine.*[1]

Compared to standard systems, computerized physician order entry (CPOE) software:

• increased discharge preparedness scores from 17.2 to 17.7 for patients — a small, but statistically significant increase;

• increased discharge quality scores from 16.5 to 17.2 for outpatient physicians — a small but statistically significant increase, but;

• decreased the "easiness" of the discharge workflow from 7.9 to 6.5 for hospitalists — a significant decrease.

James Graumlich, MD, associate professor of medicine and clinical pharmacology, chair in the department of medicine, University of Illinois College of Medicine, is lead author of the study. Graumlich and his colleagues designed the software and studied the experience of 631 patients and 70 hospitalists who had used it between November 2004 and January 2007 in a teaching hospital in Illinois.

Overcoming barriers

"We knew from studies that had been published before and a review done by AHRQ [Agency for Healthcare Research and Quality] that there was a problem with communication between hospitalists and primary care physicians [PCPs]," says Graumlich, explaining the rationale for creating the software. "It was suggested that these barriers to communication were causing adverse events and/or readmissions to occur within one month."

The current study, he continues, was specifically designed to see if the CPOE software would improve communications. "It was designed to include what were thought to be the ideal components of the discharge process as far as communication is concerned — medication reconciliation; letting the PCP know what tests were pending at the time of discharge; what tests were required as part of follow-up; and letting the patient know what the follow-up appointment date was," Graumlich says. "All of this had been previously published in guidelines, but they had not been studied to see if it made a difference."

In the study, he notes, half of the patients received the usual paper discharge instructions, while the other received them using the CPOE software.

Reference

1. Graumlich JF, Novotny NL, Nace GS, et al. Patient and physician perceptions after software-assisted hospital AQ1 discharge: Cluster randomized trial. *J Hosp Med* 2009; 4(6): DOI: 10.1002/jhm.565.

[For more information, contact: ***James Graumlich****, MD, at (309) 655-7730.]* ■

(Continued from page 166)

The department formed a recruitment and retention council made up of nurses and social workers to come up with an orientation process based on feedback from the satisfaction survey and from staff at their 90-day evaluations. The team includes recent employees and seasoned employees in order to get feedback from both.

Under the new recruitment and retention program, potential employees are interviewed by management and a committee of peers. In addition to going through the hospital's week-long orientation program, they work with a preceptor for six to eight weeks during the case manager training process and have a mentor who meets with them regularly for a year. **(For details on the interview process, see related article on p. 172.)**

"The retention process goes hand in hand with the mentor and preceptor program. Our turnover rate was lower than the hospital, but the staff's perception was that we had a lot of people leaving. The mentorship program helps to foster retention," Walsh says.

Program creates more unity

The program has brought more unity to the department, Walsh says.

"Employees see having a preceptor and a mentor as an effort to meet their needs. They become immersed in the department from the beginning and they never feel isolated," she says.

Carolinas Medical Center has more than 800 beds and is a Level 1 Trauma Center. The case management department is staffed by 25 social workers and 45 nurse case managers and uses a combined staffing model.

"The nurses and case managers are unit-based, but many units are disease-specific populations, such as those on the cardiac floor, the renal failure and orthopedic units," Walsh says.

The hospital's nurses operate under a shared governance model, and the case management department uses a similar shared governance model specifically designed for its own operations.

"Before we started this program, we asked the newer people what would have made those first weeks better. They all said that you can't perform your job as well if you're not comfortable with your surroundings. The preceptors now spend a lot of time helping the new employees get to know their co-workers and learning their way around," says **Kim Blok**, BSN, CCM, case manager who is a member of the department's orientation council, as well as serving as a preceptor and a mentor.

As a fairly new member of the case management team, Wright has made a lot of suggestions on how to improve the new process, Walsh says. Those suggestions, along with input from other new employees, help guide the development of the program, she adds.

"When I came to work here about a year and a half ago, I would have liked for somebody to introduce me to the rest of the staff and to have spent time showing me around. The preceptor and mentor program fills a gap and is a big improvement over the orientation I received," Wright says.

On their first day in the department, the new case managers receive a welcome bag with a card signed by their new co-workers, meal tickets, a lunchbox, orientation material, and an orientation calendar that blocks out time for them to spend with their assigned preceptor and various interdepartmental disciplines.

"Their desk, computer, and pager are available on Day 1. The feedback we got was that new employees didn't feel welcome if all of that wasn't lined up," Walsh says.

The preceptors meet with the new employees the first morning, take them on a hospital tour, and go over some of the hospital policies.

The preceptors are experienced case managers and social workers who, in addition to training new employees, carry a daily assignment. When staffing allows, the preceptor's assignment is reduced, allowing them to spend time with the new employee, Walsh says.

Case management orientation includes a total of 16 hours of classroom sessions in addition to time spent with the preceptor. The initial orientation lasts six to eight weeks, depending on the individual needs of the new employee. The classes include information about the philosophy and culture of the hospital, and sessions on being a responsible person who is accountable for his or her actions.

The department tries to assign a preceptor who works as closely as possible to the unit where the new hire is going to work, Walsh says.

"If the employee is going to work on a cardiac unit, we try to assign a preceptor who works on the cardiac floor so they'll at least be familiar with the population and the physicians, if not the individual unit," she adds.

The new employee shadows the preceptor on the preceptor's unit in the beginning.

The new employees' computers are next to the preceptors so they can start learning the hospital's computer system before they go to computer training.

"They have told us it's helpful to be familiar with the computer system before they go to training because they know what questions to ask," Blok says.

After the orientation is officially over, the new employees are assigned a mentor who may or may not be the preceptor.

The department takes past work history, level of experience, and personality into account when assigning mentors so the new employee will feel comfortable.

During the yearlong mentorship program, the mentors meet with the employee at least once a month and are available at all times as a resource when the employee has a question or a concern.

"Effective mentoring can occur in as little as one of two hours of contact a month. Managers oversee the program and are available to provide guidance and feedback as needed," Walsh says.

At the end of the orientation program, the new employees meet with their mentors and review the program. Their feedback is used to make revisions in the process to improve the overall quality and success of the program, Walsh says.

"The mentorship program is designed to connect experienced case managers and social workers with new employees or those new to case management, to provide both personal and professional guidance and to empower them to achieve their potential," Walsh says.

(For more information, contact: ***Chris Walsh****, RN, CCM, director, clinical care management. E-mail: Chris. Walsh@carolinashealthcare.org.)* ■

Management, staff collaborate on hiring

Peer interviewing team includes CMs, SWs

At Carolinas Medical Center, the management team and a panel of case managers and social workers interview all potential employees and collaborate on who will fit best in the department.

"The staff has a big part in the hiring process. We value their input and usually end up hiring the people they recommend," says **Chris Walsh**, RN, CCM, director, clinical care management.

When the hospital's human resources department forwards information about a potential employee to the management team, the team identifies candidates for an interview, looking at education, past experience, and any certifications.

The candidates meet with the management team first and then the peer interviewing team.

Peer interview team

The three-member peer interview team is a combination of case managers and social workers, part of a group of six employees who have attended classes to learn interview techniques.

The team has come up with a series of seven questions that describe a situation and ask the employees for examples of how they have responded to the situation.

"We use the behavioral interviewing technique and ask them to give us an example of situations that would help us identify characteristics and qualities that would make a successful case manager," says **Kim Blok**, BSN, CCM, case manager and member of the peer interviewing team.

For example, one question asks employees if they have assisted their team in becoming more productive. Another asks how the employee handled it when a customer had goals and beliefs that differered from his or her own.

After the team asks questions, the potential employee has an opportunity to ask questions. One of the first questions that everyone asks is what a typical day is like, Blok says.

"When they talk with us, the candidates get a good feel for what the department is like. As their peers, we can tell them first hand because we are on the patient care units day in and day out. We tell them what the job entails so they don't come to work and find out that they may have to work holidays or something else that would make them unhappy with the job," Blok says.

After the interview, each member of the interviewing team rates the prospective employee on a scale of 1 to 5 for each question and adds up the points.

Using the tool, the team makes recommendations to the management team on which people seem to be the best fit for the job.

"Peer interviewing provides insight within the hospital's shared governance model, promoting retention and success of case managers and social workers who are new to the department," Walsh says. ■

Reduce one-day stays when observation is better

Transitions were not optimal

Hospitals sometimes fail to transition patients to the optimal level of care, which can create issues with quality of care and reimbursement.

A recent quality improvement project found that most one-day stays in a hospital were related to patients having chest pain symptoms. And many of these one-day stays originated in the emergency department and were unnecessary, an expert says.

The project found that patients were transitioned inappropriately, leading to higher costs and Medicare claims denials.

"We worked with 17 hospitals in a process improvement effort," says **Mary Helderman**, RN, CPUM, an oncology nurse in Terre Haute, IN. Helderman wrote a quality improvement report on one-day stays when she was the project coordinator for the Hospital Payment Monitoring Program (HPMP). HPMP, which had the goal of measuring, monitoring, and reducing the incidence of improper fee-for-service inpatient acute care Medicare payments, was disbanded in August 2008.

"We took a sampling of patients from the 17 hospitals and found that 79.9% didn't meet admission criteria," she recalls.

"So that's a large percentage, and the estimated overpayment for those amounted to over $600,000," Helderman adds. "When we looked at charts at three different intervals for 17 hospitals, there was an estimated overpayment of $1.5 million over a two-year period."

The baseline sampling was retrospective, and the other two samples were done before the claims were submitted, she says.

The idea was to have physicians clearly write whether they wanted a patient to have an observation stay or to be admitted to the inpatient acute area, she says.

"We found that maybe when the physician would write an admit to outpatient care, the person registering the patient would see the word 'admit' and interpret it as an inpatient stay," Helderman explains.

The problem could be the forms made the patient's transition unclear, or that people were not looking as closely at the forms as they should, she says.

Some hospitals seeing this report decided to implement a case management team in their emergency departments, Helderman says. Other smaller hospitals implemented weekend coverage of case management to catch inappropriate inpatient stays before Monday morning, she adds.

CNE *questions*

17. The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to treat anyone who walks in the door but the same is not true of any other provider.
A. True
B. False

18. A Florida hospital transferred a disabled undocumented immigrant back to his native Guatemala for care after spending how much on his care?
A. More than $2 million
B. More than $5 million
C. More than $1.5 million
D. More than $3.5 million

19. Lutheran Medical Center in New York City transferred a severely disabled man to a hospital near his family in Poland. How much did the hospital pay for the nine airline seats it took to accommodate his stretcher and the medical personnel who accompanied him?
A. $12,000
B. $15,000
C. $20,000
D. $35,000

20. Carolinas Medical Center has a preceptor and mentoring program for new case managers that lasts how long?
A. Nine months
B. 18 months
C. One year
D. Six months

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

CNE 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. ■

"Others focused on education, educating staff on the difference between an inpatient stay and an observation stay, and they gave staff information about payment and denials," Helderman says. "Some started focused monitoring on inpatient stays to see where the gaps were in the process and to implement some changes there."

And some hospitals did concurrent chart reviews, rather than wait until patients were discharged to review their charts, she adds.

[For more information, contact: ***Mary Helderman****, RN, CPUM, oncology nurse, Terre Haute, IN. Phone: (765) 505-0102.]* ■

ACCESS MANAGEMENT
QUARTERLY

Revamp process for sudden surges in registrations

Cross-training is key

This spring during the H1N1 epidemic, registrations through EDs increased dramatically nationwide. The processes of virtually every patient access department were put to the test.

Cross-training is the key for any unexpected surge in patient volume, according to **Catherine M. Pallozzi**, CHAM, CCS, director of patient access at Albany (NY) Medical Center Hospital. "Patient access has spent a great deal of time cross-training for all units within the department," she reports. "As a leadership team, if the need arises — and it does often — the manager is on the front line, the associate director is on the front line, and I am on the front line."

Pallozzi says that as a patient access professional, she deals with staffing shortages "on a regular basis."

"When there is an influx of patients due to H1N1 or just another day of high census, we have learned to manage with the staff we have," she says. "Our secret is being able to flex staff by bringing staff from other areas. Also, having managers with the ability to work the front line in not only their unit, but in multiple units."

Due to the cross-training effort and the team approach, Pallozzi's patient access department was able to appeal to other units to assist in the emergency department during a particularly high-volume period. "We were able to pull six to eight staff members," says Pallozzi. "Their willingness, our need, and the cross-training effort resulted in coverage being achieved."

"Volume surges, including flu epidemics, can certainly present challenges to patient flow," says **Bridget D. Puryear**, director of patient access at The George Washington University Hospital in Washington, DC. "Flexibility, including allocating staff to other areas, is critical when facing fluctuations in patient volume."

Staff are cross-trained to complete all types of registration. Training for the registrar position entails an admit, discharge, transfer (ADT) system review, a review of department policies and procedures, and hands-on training, including an actual patient registration in the emergency department. Staff need to obtain proper identification of the patient, complete a full registration, verify insurance, and collect the copayment.

"Having a good, quick registration process is key," says Puryear. "There are many challenges. However, proper patient identification is important. And ensuring that the full registration is completed prior to the patient's departure from the emergency department is critical."

Either prior to triage or during the triage process, staff obtain the patient's name and date of birth, primary care physician, and reason for the visit. This allows them to create an account number for their emergency department visit, while allowing the clinical staff to move forward with the patient's care.

"Facilities want to be sure that their patient access representatives know their quick registration process," says Puryear. "You need a strong process in place to complete the registration process prior to the patient's departure from the emergency department. Having good communication between the patient access team and the emergency department is also very important."

If staffing shortages should occur due to H1N1 or seasonal flu, Puryear says her department's contingency plan is to utilize part-time and per diem employees to meet the increased workload. "The part-time and per diem employees have completed all of the competencies required for the job and have been fully trained in the positions," she says.

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Number of patients leaving against advice increasing

Would it surprise you that the number of patients leaving a hospital against medical advice (AMA) increased 39% between 1997 and 2007? The number totaled 368,000 in 2007, says a new report from the Agency for Healthcare Research and Quality.[1]

According to the report, the top five diagnoses for patients leaving AMA in 2007 were: nonspecific chest pain (7%); alcohol-related disorders (6.9%); substance-related disorders (5.7%); mood disorders (3.8%); and diabetes with complications (3.4%).

"Tracking AMAs by diagnosis is interesting," says **Peter Kraus**, CHAM, CPAR, business analyst with patient financial services at Emory University Hospital in Atlanta. "For three of the top five, the patient's mental state may be a contributing factor. The other two are diagnoses the patient may be living and coping with over a period of time. Symptoms fade, the patient feels better and doesn't want to stay, even though it might be more sound medically to do additional testing or treatments."

A significant percentage (22%) of the patients who left AMA were uninsured. In light of this, Kraus says one concern is that if an emergency department patient leaves AMA, access could be suspected of screening patients financially prior to triage in violation of the Emergency Medical Treatment and Labor Act. Another possibility is that some of the AMA patients might have chosen to stay and be treated if they had qualified for financial assistance or public programs. "If self-pay patients know that the hospital will help them qualify for financial assistance, they may be less fearful of running up a bill they can't pay," she says.

Reference

1. Stranges E, Wier L, Merrill CT, et al. Hospitalizations in which patients leave the hospital against medical advice (AMA), 2007. Statistical Brief #78. Healthcare Cost and Utilization Project (HCUP). Rockville, MD: Agency for Healthcare Research and Quality; August 2009. ■

CNE 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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- Survivors of RAC pilot project offer advice
- Would 24-7 case management work in your facility?
- How one facility reduced its incidence of pressure ulcers
- Tips for preventing readmissions within 30 days

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1. Publication Title	2. Publication No.	3. Filing Date
Hospital Case Management	1 0 8 7 – 0 6 5 2	10/1/09
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$499.00

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

Contact Person: Robin Salet
Telephone: 404/262-5489

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

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

Publisher *(Name and Complete Mailing Address)*
Robert Mate, President and CEO
AHC Media LLC, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*
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Russ Underwood, same as above

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Full Name	Complete Mailing Address
AHC Media LLC	3525 Piedmont Road, Bldg. 6, Ste 400
	Atlanta, GA 30305

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

Full Name	Complete Mailing Address
Thompson Publishing Group Inc.	805 15th Street, N.W., 3rd Floor
	Washington, DC 20005

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
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PS Form **3526**, September 1998 *See instructions on Reverse)*

13. Publication Name: Hospital Case Management

14. Issue Date for Circulation Data Below: September 2009

15. Extent and Nature of Circulation			Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*			1001	1163
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	624	595
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	0	0
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	8	5
	(4)	Other Classes Mailed Through the USPS	44	51
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			676	651
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	12	12
	(2)	In-County as Stated on Form 3541	0	0
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e. Free Distribution Outside the Mail *(Carriers or Other Means)*			20	20
f. Total Free Distribution *(Sum of 15d and 15e)*			32	32
g. Total Distribution *(Sum of 15c and 15f)*			708	683
h. Copies Not Distributed			293	480
i. Total *(Sum of 15g, and h.*			1001	1163
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			95%	95%

16. Publication of Statement of Ownership
Publication required. Will be printed in the November 2009 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: President and CEO — Date: 9/27/09

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