HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

September 2010: Vol. 18, No. 9
Pages 129-144

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Financial Disclosure: Managing Editor Jill Robbins, Executive Editor Russ Underwood, and Editor Mary Booth Thomas report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Toni Cesta discloses that she is principal of Case Management Concepts LLC.

Hospitals must reduce readmissions as CMS moves to cut reimbursement

Penalty will be a reduction in reimbursement for every discharge

In just a few years, your hospital could lose a significant amount of money if its 30-day readmission rate is higher for Medicare patients with certain diagnoses than the rate at other hospitals.

Beginning with admissions on or after Oct. 1, 2012, under the Patient Protection and Affordable Care Act, hospitals with risk-adjusted readmission rates in the highest 25% will face a 1% reduction in reimbursement for every discharge in fiscal year 2013, not just the conditions on which they report data.

The penalties, part of the Centers for Medicare & Medicaid Services' (CMS') value-based purchasing initiative, will rise to 2% the following year and to 3% for admissions after that.

CMS has announced its intention to expand the conditions monitored for readmissions and is considering adding chronic obstructive pulmonary disease, coronary artery bypass graft surgery, percutaneous transluminal coronary angioplasty, and other vascular surgery procedures.

The penalties won't be imposed for three years, but hospitals need to start now to analyze their 30-day readmissions and develop initiatives to reduce them, says **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY, and health care consultant and partner in Case Management Concepts LLC.

"Up until now, there was no penalty for readmission from a financial perspective, so there's been no financial incentive for hospitals to reduce readmissions. That's all changed, and the penalties for having a high rate of readmissions will be significant. How hospitals perform now will determine how much they're likely to lose in the future," Cesta says.

Evidence from pilot projects and research studies suggests that rehospitalization can be reduced with better discharge planning, enhanced transitions between health care settings, and additional coaching and education

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to help patients learn to manage their condition and adhere to their treatment plan, according to a 2009 report by the Institute for Healthcare Improvement. (**For a look at some of the interventions to reduce rehospitalizations, see page 121.**)

But so far, many of the promising interventions have been adapted by and funded by health plans, not health care providers.

For instance, several large health plans have saved money and readmissions by adapting the Transitional Care Model developed by Mary Naylor, PHD, RN, and colleagues at the University of Pennsylvania School of Nursing, according to **Kathryn H. Bowles**, PhD, RN, FAAN, associate professor of nursing, University of Pennsylvania School of Nursing.

The insurers use advanced practice nurses employed by home care agencies to coordinate care throughout the continuum.

"At this point, hospitals don't face any penalties if patients are readmitted," adds **Brian Jack**, MD, associate professor of family medicine at Boston University Medical Center, who led the team that developed Project RED (Re-Engineered Discharge).

The hospitals that are implementing Project RED are mostly working with case managers or nurses who are hired by a health plan, Jack says.

Reducing readmissions is important not just from a financial standpoint but from a patient safety and quality standpoint, he adds.

"When the patient safety movement began, we identified transitions in care as an opportunity to improve safety and quality. We focused on hospital discharges as an important transition because they are low-hanging fruit. There are 38 million hospital discharges a year, and it's very clear that there are enormous opportunities for improvement," Jack says.

The hospital stay is just part of the overall continuum of care, points out **Daniel D. Dressler**, MD, MSc, SFHM, associate professor of medicine, associate director, medical education, section of hospital medicine at Emory University School of Medicine in Atlanta and a mentor to hospitals implementing the Society of Hospital Medicine's Project BOOST.

"With the new reimbursement rules from CMS, hospitals are going to have to work with providers across the continuum to make sure that patients have the best possible outcomes after discharge," Dressler says.

Hospitals need to work with post-acute providers such as home care agencies and nursing homes to ensure that patients get the care they need so they don't need to be readmitted, Cesta adds.

"Many patients who are readmitted within 30 days haven't seen a doctor and are not taking their medication properly or managing their diet correctly," Cesta says.

CMS posted updated 30-day readmission rates

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.
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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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on the Hospital Compare website in July. The new data encompass three full years of claims data from July 1, 2006, to June 30, 2009.

The new data showed that national 30-day readmission rates for heart attack, heart failure, and pneumonia did not change remarkably from the 2005-2008 rates. The rates were 19.9% for heart attack patients, 24.7% for heart failure patients, and 18.3% for pneumonia patients.

Programs that provide beefed-up discharge education and support for patients after discharge have demonstrated decreases in readmissions and emergency department visits. Here's a look at some of them:

Care Transitions Program:

In the Care Transitions Intervention, a transition coach, who is a nurse or a nurse practitioner, facilitates care for a month after hospital discharge for patients 65 or older who return to the community.

The transition coach visits patients in their home within 72 hours of discharge and speaks to the patient by phone on post-discharge days one, seven, and 14.

The Care Transitions Program team at the University of Colorado developed the Care Transitions Intervention 12 years ago after interviewing patients with complex medical needs and their family members to learn about their experiences with care transitions.

"We learned that even when people have terrific primary care physicians, case managers, and home care nurses, they still do a significant amount of their own care coordination. In many care coordination models, well-trained professionals identify the problems and fix them. That takes you only so far. We wanted the patients to be able to manage their care on their own when the professional isn't there," says **Eric A. Coleman**, MD, MPH, a geriatrician who is director of the Care Transitions Program and a professor of medicine at the University of Colorado School of Medicine.

The main components of the program, called the Four Pillars, include teaching patients medication self-management, educating them to recognize warning signs and symptoms and what to do when they occur, ensuring follow-up care with a primary care physician, and facilitating patient ownership of their personal health record.

"The program is truly patient-centered. We teach the patients self-care by practicing and role playing," Coleman says.

When the transitions coach visits the home, he or she asks the patient to identify health-related goals, identifies any barriers, and works with them to develop strategies to meet the goals.

"Often when patients with chronic diseases aren't doing what we tell them to, we label them as noncompliant without looking at the broader barriers," he says.

The coach goes over the patient's medication list, asks him or her to describe the medications and how to take them, then compares the medication the patient was taking before hospitalization to the discharge medication list.

"Inevitably, there is a discrepancy. Instead of fixing the problem, the coach discusses what steps the patient should take to eliminate the discrepancy so the patient will be able to do that on his own when another question arises," Coleman says.

The coach assumes the role of the physician, pharmacist, or home care nurse and lets the patient practice how he or she will resolve the problem.

"Patients often feel reluctant to interrupt the doctor. This gives them a chance to practice and build confidence," Coleman says.

The coach takes the patient through a similar scenario when it comes to getting a timely follow-up visit with a physician.

The Care Transitions Program has fostered the adoption of the Care Transitions Intervention by more than 300 organizations including hospitals, home care agencies, large physician groups, and home care agencies.

It provides materials and training, but the organizations make their own decisions on how to determine which patients are eligible for the program.

Studies have shown that patients who participate in the Care Transitions Intervention were significantly less likely to be rehospitalized and more likely to achieve personal self-care and medication management goals.

Investigators in one study estimated the cost savings associated with the Care Transitions Intervention would be $296,000 over 12 months for 350 patients.

[For more information on the Care Transitions Program, contact: Eric Coleman, MD, MPH, director of the Care Transitions Program, e-mail: Eric.Coleman@ucdenver.edu or visit http://www.caretransitions.org.]

PROJECT BOOST:

Project BOOST (Better Outcomes for Older adults through Safe Transitions) was created by the Society of Hospital Medicine with grant support from the John A. Hartford Foundation. The pro-

gram was piloted at six hospitals and now provides training and support for a total of 47 sites where the project has been rolled out.

With Project BOOST, mentors work with hospitals and provide resources that enable the hospitals to identify patients at high risk for readmission and take steps before and after discharge to prevent the readmission.

"This started as a project that focused on the elderly but has been piloted addressing all adult patients," says Dressler. Project BOOST aims to reduce the 30-day readmission rates for general medicine patients, with a particular focus on older adults, improve patient satisfaction and HCAHPS scores, improve the flow of information between hospitals and community physicians, identify high-risk patients and target specific interventions to mitigate their risks for adverse events, and ensure that patients and family members are prepared for discharge.

The process has four key elements:

- a comprehensive intervention;
- a BOOST implementation guide that provides step-by-step instructions and tools to help multidisciplinary teams plan, implement, and evaluate the intervention;
- a mentoring program that includes face-to-face training and a year of mentoring and coaching;
- and the BOOST collaborative, through which sites communicate with each other and share ideas.

Hospitals participating in the process use Project BOOST screening tools to identify and manage patients at risk for readmission and tools that address whether patients are prepared to care for themselves after discharge, if they can identify when and who to call if problems arise, and if they have appointments for follow-up physician visits and tests.

"The project is institution-specific as to who performs the interventions. In some hospitals, I've worked with nurses, case managers, social workers, and physicians to perform some of the interventions, depending on how the facility breaks it down. Case managers play a critical role in the implementation of a BOOST project," Dressler says.

The project includes a teach-back training video for case managers, nurses, and physicians to help them learn to use the teach-back methodology to ensure that patients understand their diagnoses, medications, and follow-up.

"One of the key components within the BOOST project is assurance of adequate and timely transfer of information from one provider to another," Dressler says.

The project calls for transmittal of a discharge summary immediately to the clinicians providing follow-up care and follow-up telephone calls to patients within 48 to 72 hours to make sure they understand their plan of care and to answer any questions and concerns.

Depending on the facility, the follow-up calls are made by nurses, case managers, or pharmacists.

Preliminary data from pilot project sites demonstrate that readmissions in BOOST units fell from 13% to 11% in six months, while similar non-BOOST units experienced a rise in readmission rates from 11% to 13% over the same interval.

[For more information, contact Lauren Valentino at (267) 702-2672 or visit www.hospitalmedicine.org/BOOST.]

Project RED:

In Project RED (Re-Engineered Discharge), a nurse or case manager called a discharge advocate works with patients to educate them during their stay, organize post-discharge services, and expedite the flow of information to caregivers after discharge.

Boston University Medical Center's research team developed the Re-Engineered Hospital Discharge Program, over a five-year period with a grant from the Agency for Health Research and Quality (AHRQ) and the National Heart, Lung and Blood Institute.

The program is designed to educate patients about their post-discharge care plans, ensure that patients receive the recommended follow-up care, and increase communication between the hospital and the patients' primary care physicians.

The discharge advocate educates the patient about his or her diagnosis throughout the hospital stay; makes follow-up appointments with clinicians and for post-discharge tests; sets up post-discharge services and makes sure the patient understands the importance of the services; reconciles the patient's medications and makes sure the patient and family understand the medication regimen; educates the family and patient on what to do if a problem arises; and ensures that outpatient providers receive a discharge summary in a timely manner.

The nurses, who work full-time on discharges, can facilitate four to six discharges every day, says Jack. The RED process calls for patients to receive phone calls two to three days after discharge to reinforce the discharge plan and answer questions

and concerns.

"Half the people who go home are doing something that's not quite right. The follow-up calls are designed to fix the problems," Jack says.

Follow-up calls may be made by a nurse, a pharmacist, or another clinician.

"The follow-up phone call is part of the package. The hospital component is important, but it's not sufficient," he says.

One of the principal features of Project RED is a personalized after-hospital care plan, a spiral-bound color booklet that includes individual information for each patient, depending on his or her condition, medication, and discharge instructions.

The discharge advocate uses special computer software to create the booklet and assess the patients' understanding of the plan by asking them to describe the plan in their own words.

The team at Boston University Medical Center has developed a virtual discharge advocate, named "Louise" — an animated character that educates the patient via computer and tests them on how well they understand their discharge plan. When the discharge advocates print out the test results, they can see where gaps in the patient's understanding occur and can reinforce the teaching.

"Patients have said they prefer 'Louise' to a human teacher because the virtual advocate allows them to go at their own pace," Jack says.

A pilot study using the Re-engineered Discharge concept shows that people enrolled in the study had fewer readmissions and emergency department visits and that their post-acute care cost an average of $412 less when compared to people with similar diagnoses in a control group.

[For more information, contact Brian W. Jack, MD, Boston University Medical Center Department of Family Medicine, e-mail: Brian.Jack@bmc.org or visit: http://www.bu.edu/fammed/projectred.]

Transforming Care at the Bedside:

Transforming Care at the Bedside (TCAB), a program launched in 2003 by the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement, aims to improve transitions of care for patients discharged from medical and surgical units within hospitals.

"It takes a whole community to improve transitions and create continuity in care so patients avoid coming back to the hospital unnecessarily. The aim is not to keep people out of the hospital who want to be there, but we want to prevent rehospitalizations that are avoidable. Avoidable rehospitalizations can occur because of pool care processes, lack of timely communications, and inadequate care coordination in the health care system," says **Pat Rutherford**, RN, MS, vice president at the Institute for Healthcare Improvement.

Ensuring a smooth transition is not just the responsibility of hospital discharge planners, but is a responsibility of the entire care team within the hospital and in collaboration with community partners, Rutherford points out.

"Community clinicians and post-acute providers of care must work hand-in-hand with hospital personnel to design processes that improve communication and hand-off," she says.

"Whoever is going to provide care for patients after discharge, whether it's family members or post-acute facilities or agencies, should have all the information they need to ensure that the patient follows the treatment plan and receives the necessary follow-up care," Rutherford says.

"TCAB's goal is to improve transitions of care within the health care system by promoting better discharge preparation while patients are in the hospital, providing timely information to help community physicians provide follow-up care, and improving transfers to skilled nursing facilities, rehabilitation facilities, and home care agencies," she says.

The Transforming Care at the Bedside process focuses on enhanced admission assessment for post-discharge needs; enhanced teaching and learning during the hospital stay; patient- and family-centered hand-off communication; and early post-acute care follow up.

Rutherford recommends that hospitals apply the standards of care to all patients, not just those who are at risk for readmission.

A comprehensive assessment for post-discharge needs is a major component of the TCAB process, Rutherford says.

"Most case managers and nurses say they are currently assessing patients to determine their needs after discharge, but we recommend that family caregivers and community providers contribute to a more comprehensive needs assessment," Rutherford says.

For instance, the assessments don't always include information about whether the patients have the money to buy their medication, if they have transportation, or their living situation.

"Case managers and discharge planners need a better understanding of the social and health care needs that patients face at home. Using this information, they can make referrals to organizations

that can help the patients get the help they need," she says.

People who are at high risk need additional services to help them stay well at home or in a long-term care hospital or skilled nursing facility, Rutherford adds.

If patients are going home, family members should be involved in the educational process while patients are still in the hospital, she says.

Patients at risk for readmissions should have a visit by a home care nurse or see a physician within two days. Those at lower risk should receive a follow-up phone call within 48 hours and see a physician within five days, Rutherford says.

TCAB calls for customizing education to the patient and using the teach-back method to ensure that the patients understand.

Clinicians can get a good idea of patients' understanding of their condition and treatment plan by asking just three questions, Rutherford says:

- Do you understand what your problem is?
- Do you know what you need to do to take care of yourself at home?
- Do you know what signs and symptoms to look for and who to call if they occur?

St. Luke's Hospital in Cedar Rapids, IA, documented a 50% reduction in rehospitalizations for heart failure patients when it adapted the approach. *(For details, see* Hospital Case Management*, May 2010.)*

[For more information about the Institute for Healthcare Improvement, visit: http://www.ihi.org/ihi; for more information about TCAB, visit: http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/EmergingContent/ProjectOverview.htm.]

Transitional Care Model:

In the Transitional Care Model, master's prepared nurses, skilled in working with older adults, coordinate care for high-risk, elderly patients with chronic illnesses throughout the continuum of care.

The original program was created by Naylor and her colleagues at the University of Pennsylvania School of Nursing as a way of helping chronically ill older adults transition from the hospital to home with follow-up phone calls, says Bowles.

"The team recognized that the telephone calls were helpful but not enough in the long term. We created a transitional care model led by advanced practice nurses who meet the patients during their hospital stay, meet the providers, coordinate the discharge plan with the hospital treatment team, and follow the patients back into the community," she says.

In the model, the advanced practice nurses typically are employed by home care agencies and reimbursed by private insurance.

The nurses visit the patients daily while they are in the hospital, complete an assessment, and collaborate with other members of the treatment team to develop a plan of care. They visit patients in the home, helping them learn how to manage their disease and adhere to their plan of care, and contact them by telephone regularly for an average of two months after discharge.

"The nurses go into the home within 24 hours of discharge, complete a comprehensive assessment, educate the patients about their disease and their plan of care, and coordinate the care between multiple providers," Bowles says.

The nurses accompany patients to the doctor's office, particularly during the first post-discharge visit, to ensure that the transition between hospital and home goes smoothly.

As the time approaches for patients to be discharged from the program, the nurse sets up the hand-off to the primary care physician or other provider.

"We have a recruiter at a hospital who uses a risk screening tool to identify people for the program. When someone is eligible and agrees to participate, the advanced practice nurse gets involved immediately, becomes part of the treatment team, and begins to build a rapport with the patient and family," she says.

The nurses typically coordinate care for 10 to 20 patients at a time. If they are working with newly transitioned patients, their case load is lower because the needs of the patient at hospital discharge are more intense.

The University of Pennsylvania School of Nursing team has formed partnerships with several health plans to assist them in setting up the model in association with home care agencies. Naylor and her staff provide materials and tools, train the nurses, and assist in getting the programs up and running, she says.

Several randomized clinical trials have documented that the Transitional Care Model results in fewer rehospitalizations, lower overall health care costs, and improved patient satisfaction, Bowles says.

In one study, 10% of patients in the Transitional Care Model were readmitted within six weeks after discharge while 23% of similar patients in a control group were readmitted. In another study, total health

(Continued on page 139)

CRITICAL PATH NETWORK™

Project to reduce costs for Medicare beneficiaries

Hospital places CMs in primary care offices

After three years, Massachusetts General Hospital's Medicare demonstration project to manage the care of high-risk, high-cost Medicare patients appears to be making a difference for many medically complex patients, according to **Joanne Kaufman**, RN, MPA, A-CCC, nurse manager for the care management program at Massachusetts General.

The Centers for Medicare & Medicaid Services (CMS) has approved expanding the program to include two affiliated Boston-area hospitals and has extended it for another three years. CMS has contracted with RTI International to conduct an independent evaluation of the program's effectiveness in improving quality of care and reducing Medicare expenditures.

The MassGeneral care management program, which started in 2006, is a primary care-based model designed to coordinate care and improve transitions as patients move through the continuum of care.

When the program began, CMS provided the hospital with a group of 2,600 patients and selected a comparison group of patients with similar medical risk and utilization, says **Mary Neagle**, project manager, MassGeneral care management program.

"The overall goal of the project is to improve care in a variety of ways by working closely with patients in a primary care practice and by helping patients navigate the complicated health care system," Kaufman says.

The hospital receives a monthly fee for each participant in the program and must achieve a savings target that includes their fees.

"The program is a financial risk for the hospital and Massachusetts General Physicians' Organization, but everyone from the CEO on down supports the initiative to help improve care for Medicare beneficiaries," Kaufman says.

The case managers in the program are assigned to primary care practices and work in the practice setting. They collaborate closely with the physicians and the care team to ensure that the patients' health care and psychosocial needs are met.

Patients in the program live in the Greater Boston area and are being treated by a primary care physician who is in the hospital's health system.

"These are the sickest of the sick patients, and the physicians know them very well. We work with the patient and his or her primary care physician to develop a plan of care. We facilitate referrals to community and home-based services such as skilled home care and transportation to appointments that can help the patients stay as safe and healthy as possible," Kaufman says.

Depending on the number of patients in a practice, some physician groups have more than one case manager assigned to them and others share a case manager with another practice.

"Prior to the start of the program, we piloted a similar model in one primary care practice. This provided tremendous insight and helped form the model we now are using," Neagle says.

Before the program began, the project team visited the physician practices to learn about the needs of their patients and how the program could best collaborate with the practices to address the patients' needs.

"We negotiated with them to provide space for our case managers and worked on building relationships with the physician, nursing staff, and other employees of the practice," she adds.

Most of the patients in the program have several chronic diseases and may have either a mental health diagnosis or psychosocial needs, or both, Kaufman says.

"We knew up front that we needed a mental health component and a social worker on the team. In the fourth year, we have three social workers whom the case managers can call on to co-manage patients with a mental health diagnosis or a psychosocial need," she adds.

The social workers are assigned by primary care practice so each case manager has a "go-to" social worker. They receive referrals when patients need psychosocial support or make "friendly phone calls" to the patients to remind them of appointments and check in to make sure they're doing well.

So the case managers could concentrate on the clinical needs of the patients and handle a larger case load, the Massachusetts General team created the position of community resources specialist , a nonclinical person who helps with transportation, housing assistance, access to community services, and other non-medical issues.

When patients are chosen for the program, CMS sends a letter introducing the program.

The case managers review the medical records of their assigned patients, then meet with the primary care physicians to get additional information and to prioritize the patients as high, medium, or low risk.

They call each patient, enrolling those who are willing to participate, and conducting an assessment to identify their needs. Areas covered by the assessment include functionality, psychosocial needs, transportation needs, and medication.

As part of the assessment, the case managers identify caregivers and family members so they can communicate and collaborate with them if any issues arise.

"It may be that they haven't been in to see the physician in a while and need an appointment or need transportation. If a patient is coming into the emergency department frequently with shortness of breath related to heart failure, the case manager may set up skilled nursing visits to monitor the patient or may arrange for telemonitoring," she says.

They work with the patients to set goals and look at what resources patients need to meet the goals.

For instance, they may make a referral to a social worker for follow-up if a patient is experiencing depression or contact the community resource specialist to set up transportation to a physician visit, or ask a pharmacist to evaluate the patient's medication.

"When all those pieces are put into place, the case manager follows the patient through the continuum and bases the frequency of the follow-up interventions on patient needs," Kaufman says.

The case managers get a list every week of patients who have appointments with the primary care physicians. They also get a list of patients who have canceled or missed their appointments and follow up to find out the reason the patient missed the appointment and reschedule a visit with the physician. They frequently meet with the patients when they come in to see their primary care provider.

The case managers work with patients in the program to ensure that they have advance directives in place and can provide copies to the inpatient team.

When patients visit the emergency department or are hospitalized, the case managers are automatically notified.

"We rely heavily on our electronic system to help us coordinate the care of these patients and to communicate with providers," Kaufman says.

For instance, when a patient in the program is admitted to Massachusetts General Hospital, the case manager sends an electronic note to the hospital case manager with information about what has been going on with the patient in the primary care setting.

"Some of our patients and family members have challenging psychosocial issues and complex family dynamics, and it helps when the primary care-based case managers can provide the hospital team with information on the patient's medical history, social support, and how to best approach issues with them," she says.

The MassGeneral care management case managers meet with patients in the hospital when possible and often attend family meetings with the hospital team if critical decisions about the patient's care are being made. Sometimes they participate by telephone so they will be available to give input and answer any questions the team may have, Kaufman says.

When a patient is discharged from the hospital, the case manager makes a follow-up call within 24 to 72 hours and completes a post-discharge assessment to make sure the patient is settled back into the community, has filled his or her prescriptions, and has a follow-up visit with a primary care physician. The case manager also makes sure that any durable medical equipment has been delivered, and that a home health practitioner has visited if the physician has ordered it.

The post-discharge assessment includes ques-

tions about whether the patients know why they were in the hospital and if they called their primary care physician before going to the emergency department, Kaufman says.

"We try to reconnect the patient with their primary care provider and gather any critical information the primary care physician needs. We make sure that the patient's follow-up appointment is timely. If the date is more than a week away, the case manager makes sure the patient gets an appointment sooner. If a patient is having problems with medications, the case manager works with the primary care physician to clarify the medication regimen," she says.

The team members have developed close relationships with community organizations, home care agencies, skilled nursing facilities, and hospice care agencies.

"Our patients often have needs for community and home-based services. We want the providers to have an understanding of our program and what our goals are so we can collaborate with them on care," Kaufman says.

The case managers reach out to skilled nursing facilities, rehabilitation hospitals, and other post-acute providers to let them know that their patients are part of the program and to make sure they received the appropriate paper work. They get an estimate of when the patient is likely to be discharged from post-acute care and they help facilitate the transition back to the community.

If a patient goes home with home care services or is receiving hospice care, the case manager shares this information with the physician and other members of the patient's care team.

"We follow the patients throughout the continuum and try to help coordinate their care. As advocates for our patients, we want to make sure their needs are met at every level of care," she says.

This year, CMS has expanded the program to Brigham and Women's/Faulkner Hospital and Northshore Medical Center.

As the program has progressed, the team has analyzed data and made operational changes.

"This is not a stagnant program. We review data and talk with staff every step of the way to determine what is working well and to identify opportunities for improving the model. The program is ever-changing, and as a result, in the future it probably will look somewhat different from today's model," Neagle says.

[For more information, contact: Mary Neagle, project manager MassGeneral Care Management program, e-mail: mneagle@partners.org.] ■

Medical home model helps DP process with care

Point person or EMR keeps all providers informed

Here's a common hospital discharge scenario: the patient is ready to be discharged home, and the hospital has a discharge planner or case manager who is prepared to call the patient's primary care physician (PCP) to discuss the patient's post-discharge care. But who does the discharge planner call? And will anyone respond to the call?

"Everyone in a typical doctor's practice is busy; and they might be a little annoyed, because they don't have time for this; and they don't have a system in place to handle it," says **Marjie Harbrecht**, MD, CEO of Health TeamWorks, formerly the Colorado Clinical Guidelines Collaborative (CCGC) of Lakewood, CO.

This is where the patient-centered medical home model can greatly benefit discharge planning. With this model, there is a person to call — a primary care case manager or care coordinator. And chances are that the care coordinator might even call the hospital discharge planner first.

"The medical home sets up a specific contact system, so each person has been assigned to someone who can check this log to see who has been in the hospital and emergency room," Harbrecht says.

The hospital discharge planner can tell the medical home coordinator about the patient's discharge, the hospital team's chief concerns, and the need to have the patient seen by a provider soon after he or she returns home, she adds.

Harbrecht and other experts discuss these ways the medical home model can enhance care transition and the hospital discharge process, and how hospitals can make the most of these transitions with or without assistance from medical home providers:

• **Create tools to improve communication between the hospital and medical home/PCP.**

Physicians sending patients to the hospital will want to communicate some specific details about the patient's case, but it's often unclear how they might do so, Harbrecht notes.

"Who is the patient, his or her demographics, histories, medications, allergies, etc.?" she says. "And how do you contact me and send information back?"

Also, there might be times when the PCP doesn't know the patient has entered the hospital, and the hospital doesn't know where to send results.

TeamWorks created some tools to help with these communication issues.

One is a wallet card for medical home patients. They receive a handout that says, "You're now part of a medical home, and here's what it means; here's how to reach us after hours, and if you do have to go to the ER, call us first to see if we can help you through that," Harbrecht says.

Patients keep these cards in their wallets or purses, so they'll have it to show hospital staff their PCP's name and their health coordinator's name and contact information.

Another tool is a fax referral form that is available for these care transitions:

- PCP to hospital - direct admit;
- hospital to PCP;
- PCP to ED;
- ED to PCP.

These one-page fax forms have spaces for all essential communication about the patient, including the following information:

- patient name;
- patient date of birth;
- dates of hospitalization;
- hospital name;
- attending physician/hospitalist;
- reasons for hospitalization;
- discharge diagnoses;
- key lab/imaging results;
- new medications/immunizations;
- procedures done;
- pending lab/imaging results;
- recommended follow-up (including specialists contacted);
- comments;
- provide discharge summary if available.

• Provide electronic communication processes.

"One challenge is how to get succinct communication back and forth between the busy emergency department and the primary care physician and back," says **Tina M. Snapp**, RN, BSN, CCM, continental division director of case management of Hospital Corporation of America of Denver.

One method is to provide PCPs with access to the hospital's computer system and electronic medical records for their patients.

This way they can check their patient's lab test results at the time they have the patient sitting in the exam room waiting for them.

"Through our information system, we set up a remote access for the physician group, so they can go online for information," Snapp says. "We have a website called healthonecares.com, and doctors can go online with access codes, and if these are tagged to their patient, they can see the test results."

Insurance company nurses also can access this system when they're primary payers, she adds.

• Work with medical home care coordinators.

Medical home care managers provide complex case management for patients, Snapp says.

"From the discharge perspective, we know the primary care office, and we can call different care coordinators in the offices, and information will go over to them," she says.

"It's set up in our system that discharge summaries and information is faxed over to the primary care office too," Snapp says. "So, they know what happens in the course of hospitalization."

It can be a relief to hospital discharge planners to have a point person to call about a patient.

"It's still our responsibility, but the difference is we have somebody to call and say, 'This person is very high risk and has been here several times, so would you please make sure you get the patient in your office right away,'" Snapp explains.

"Before, you might call the doctor's office and leave a message that goes into oblivion," she adds. "But now, there's someone at the doctor's office who's responsible for this call, and that's a huge difference."

Case managers and social workers have a tremendous opportunity to be a positive force in care transition through the medical home model, notes **Robyn Golden**, MA, LCSW, co-founder of the National Coalition on Care Coordination in New York City and director of older adult programs at Rush University Medical Center in Chicago.

Medical home care coordinators regularly call patients to make certain they are adherent to their medication and doctor visits and to see if they have any symptoms that might lead to an ED visit.

"They talk to patients all the time, making sure things are going okay," Golden says. "They're the contact person."

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(Continued from page 134)

care costs for Transitional Care Model patients (readmissions, emergency department visits, unscheduled acute care visits, and care provided by visiting nurses or other health care professionals) was an average of $5,000 less over a one-year period.

"Based on these studies, we know that the Transitional Care Model not only provides higher quality care, but saves money even after accounting for the cost of the nurse," Bowles says.

[For more information contact NewCourtlandCenter@nursing.upenn.edu or visit-www.transitionalcare.info.] ■

CMS adds outpatient data to website

Aim to help patients compare health care quality

As part of its efforts to increase transparency in health care and to help consumers make informed decisions about which hospital to choose, the Centers for Medicare & Medicaid Services (CMS) expanded the information on the Hospital Compare website, adding 10 new outpatient measures and updated information on 30-day mortality and readmission rates for heart failure, acute myocardial infarction, and pneumonia.

The revision to the website in July marks the first time that CMS has posted outpatient measures online.

CMS has launched a new website, HealthCare.gov, which includes information on insurance options, preventive care, the new health care reform laws, and a link to the Hospital Compare site.

"The more information consumers and patients have, the better the options and choices are for them when it comes to their health care. HealthCare.gov is designed to put the power of information at the fingertips of Americans, and quality compare tools are a critical part of this new website," said Health and Human Services Secretary Kathleen Sebelius in a statement.

The change will help patients and their families better compare quality at America's hospitals, according to Sebelius.

The outpatient measures include four heart attack-related measures, two surgery-related measures, and four imaging efficiency measures.

Outpatient measures for heart attack include fibrinolytic therapy administered to patients with a suspected heart attack within 30 minutes of arrival at the emergency department; aspirin on arrival for heart attack and chest pain; median number of minutes for chest pain or heart attack patients to receive an EKG; and the median number of minutes that heart attack patients who needed specialized care were in the emergency department before being transferred to another facility.

Outpatient surgical measures include the percentage of patients who were given an antibiotic within an hour before surgery to prevent infection and percentage of patients who were given the right kind of antibiotics.

"Now that the outpatient data are being made public, hospitals without good compliance should be looking at what they can do to improve their ratings," says **Deborah Hale**, CCS, president of Administrative Consultant Services LLC, a health care consulting firm based in Shawnee, OK.

Depending on the hospital's case management model, the appropriate person to monitor compliance may be a case manager, a utilization review nurse, or someone else, Hale adds.

"Hospitals need to look at whether it is appropriate to ask case managers in the outpatient setting to monitor this data. It goes back to whether case management departments are adequately staffed. If you add another duty to the case manager's role, something is going to fall by the wayside," Hale adds.

The imaging data tracks the percentage of outpatients who had an MRI procedure performed without trying recommended treatments such as physical therapy; the percentage of outpatients who had a follow-up mammogram or ultrasound within 45 days after a screening mammogram; and how often hospitals gave outpatients "double computer tomography" (CT) scans when a single scan may have been all that was needed.

The imaging measures were designed to reduce unnecessary exposure to contrast materials and/or radiation and to encourage hospitals to follow evidence-based guidelines about how and when to use imaging services and to reduce overuse and waste, according to a statement issued by CMS.

The imaging measures allow Medicare patients to see how efficiently facilities use imaging equipment and keep them safe from exposure to potentially harmful radiation that may not be necessary, Sebelius added.

Patients and their families can use the information to understand the risks associated with imaging technologies and talk with their doctors about

which hospitals are most likely to help patients reduce those risks, according to acting CMS Administrator Marilyn Tavenner.

According to CMS, one in three Medicare beneficiaries receives MRI of his or her lower back after complaining of pain, rather than first receiving more recommended and potentially safer treatment, such as physical therapy.

"While most practitioners use imaging technology such as MRIs safely and effectively to diagnose or treat disease, studies show that overusing MRIs for lower-back pain could cause patients unnecessary stress, risk, and cost," the agency said in a statement.

In other cases, such as CT scans, the imaging technology exposes patients to the radiation used to produce the images, which means that overuse could harm their health, the statement adds.

"Adding outpatient quality measures to Hospital Compare will give consumers a more complete picture of the quality of care available at local hospitals. In particular, the heart attack and surgical care outpatient measures can be viewed alongside the inpatient data we already report for these conditions, providing a comprehensive look at what facilities in [a patient's] area are doing to provide high-quality, high-value care," says **Barry M. Straube**, MD, chief medical officer for CMS and directory of the agency's Office of Clinical Standards and Quality.

Hospital Compare now includes updated data for outcomes of patient care, including the new 30-day mortality rates and 30-day readmission rates for inpatients admitted for heart attack, heart failure, and pneumonia. The new data encompass three full years of claims data from July 1, 2006, to June 30, 2009.

[For more information, contact: Deborah Hale, president of Administrative Consultant Services, LLC, e-mail: dhale@acsteam.net.] ■

Collaboration on capacity management

Helps with discharge delays, waits for beds

When a hospital in downtown Knoxville, TN, closed and volume soared at other nearby hospitals, two hospitals in the Covenant Health System joined forces to develop a systematic approach to capacity management that allows each hospital to create variances in the process to meet its individual needs.

The process reduced discharge delays, increased discharges early in the day, and reduced waiting time in the two hospitals. *(For details on how the process was developed, see* Hospital Case Management*, July 2010.)*

"Patient flow is a huge process that needs to be managed every day in real time. We developed a process for ensuring good patient flow, but it's also about relationships and communication. The success of the process depends on a 'trifecta for patient flow'— the physicians, the nursing leadership, and the case managers," says **Sheila Gordon**, RN, MS, director clinical effectiveness/ nursing administration at Fort Sanders Regional Hospital.

The volume at Fort Sanders Regional spiked to 1998 levels last year after the downtown hospital closed.

"All of a sudden, we were having 90% census days. ParkWest Hospital took some of the volume we couldn't handle, but we knew that we had to improve on our capacity management process," Gordon says.

The hospitals replicated a best practice in patient flow from the Institute for Healthcare Improvement, according to **Lori Myers**, RN, MSN, capacity management manager at ParkWest Hospital.

"To achieve good patient flow, hospitals need an open conduit that goes from the administration down to the person who sees the patient first, and spreads out across the hospital from the charge nurse, to the primary nurse, to the case manager, to the ancillary units, and everyone else who touches the patient," Myers says.

Representatives from both hospitals formed a multidisciplinary team and developed a systematic approach to capacity management that allows for each hospital to create variances to meet its individual needs.

For instance, the process they developed calls for daily huddles between the nursing manager and the case managers on each unit and a daily hospitalwide capacity management meeting, but each hospital handles the practice a little differently.

At Fort Sanders Regional the first meeting of the day is the huddle during which the nurses and case managers identify what should happen with the patients during the day. That meeting is followed by the hospitalwide capacity meeting to discuss patient flow, any potential new patients, and which patients are expected to leave.

ParkWest holds the hospitalwide meeting first, followed by the huddle.

At Regional, if the hospital is approaching

capacity, the team meets again, in the emergency department at 3 p.m.

"We look at how many patients have moved in the past six hours. At 3 p.m., most of the patients waiting for a bed are in the emergency department. We collaborate with the staff there to help us think through what we need to do to get those patients in a bed," Gordon says.

Fort Sanders Regional has designated specific overflow areas when patients need a bed, such as the catheterization lab recovery area. The hospital can shift critical care staff to the step-down unit if critical care beds are needed.

"When we are approaching capacity, there is a lot of creative thinking and critical thinking and a lot of dialogue between the physicians and the rest of the staff," Gordon says.

For instance, if the emergency department is full and holding acute care patients and the hospital is being called to accept transfers from outlying hospitals, the team looks for ways to accommodate the new patients.

"We look at how many patients we have on a unit that have not been discharged, and the staff concentrate on getting them moved so the hospital can put patients holding in the emergency department in a bed on the unit and receive patients from the outlying hospitals," she says.

The staff at ParkWest have three daily bed capacity huddles regardless of census, Myers says.

The shift leaders and case managers from throughout the hospital meet at 8:30 p.m. and 4 p.m., and the shift leaders meet again at 4 a.m. when the day crew starts work.

Then each unit holds a daily huddle at 9 a.m.

If it appears that the census is going to be high, a 7 a.m. bed alert goes out all over the hospital.

"The administration, nursing managers, hospitalists, emergency department staff, charge nurses, and case managers all receive the bed alert and they know that they need to start looking at their part of capacity management first thing," Myers says.

For instance, when the bed shortage is significant, the 7 a.m. alert cancels all meetings for administration and management to free up their time to concentrate on the flow. It alerts surgeons to go to the floor and discharge patients before they start their surgery.

When Regional has a high census, the team is alerted at the original bed huddle and meets again at 12:30 p.m., 3 p.m., and 8:30 p.m., depending on the capacity issues.

"We call down to the areas that are having a high census and try to involve them in improving patient

CNE questions

9. CMS has announced that hospitals in the top 25 percentile for readmission rates will have reimbursement for every admission cut by 1%, the first year, 2% the second year and 3% after that. When does this take effect?

A. Beginning with admissions on or after Oct. 1, 2012
B. Beginning with admissions on or after Oct. 1, 2011
C. Beginning with admissions on or after Oct. 1, 2010
D. Beginning with admissions on or after July 1, 2011

10. A pilot study using the Re-Engineered Discharge concept show that people enrolled in the study had fewer readmissions and emergency department visits. What was the average savings when compared to a control group?

A. $252
B. $377
C. $412
D. $421

11. What is the typical caseload for nurses in the Transitional Care Model?

A. 10 to 20
B. 10 to 15
C. 15 to 20
D. 20 to 25

12. How many outpatient measures is CMS posting on its Hospital Compare website?

A. 8
B. 10
C. 12
D. 5

Answer key: 9. A; 10. C; 11. A; 12. B.

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. ■

flow. At Regional, we tend to have bottlenecks in critical care and cardiology, and less frequently, the pulmonary floor and oncology," she says.

"We identify areas where there are flow issues and call the nurse manager, shift leader, and case manager to the extra bed-control meeting," she says.

Keys to the success of the process are a discharge flow board that tracks all of the regulatory requirements for patients, as well as procedures that have to occur before the patient can leave, and a computerized case management system that allows management to track glitches in the patient flow, Myers says.

For instance, Myers can determine if a patient was late leaving because the physician was rounding late in the day or if the insurance company took a long time to precertify post-acute services.

Case management drives the flow board process that informs the entire multidisciplinary team about what is going on with patients, Gordon says.

When a case manager believes a patient is likely to be discharged the next day, she lists him or her as an "intent to discharge" and enters it on the flow board.

Each morning the case manager and nurse manager on the unit use the flow board to determine which patients are labeled "intent to discharge," who can be discharged that day, who cannot be discharged, and the plan of the day for each patient.

"The intent-to-discharge list is what case managers look at first thing in the morning and work on throughout the day. They work to make sure that these patients get everything they need for discharge," Gordon says.

The team discusses any obstacles to discharge and assigns someone to take responsibility for overcoming them. For instance, if a patient's discharge depends on the results of an X-ray, the charge nurse alerts the primary nurse to let radiology know that the test is a high priority. The case manager makes sure that home health is ordered for patients who will need it.

The nursing and case management staff start holding conversations with post-acute facilities earlier in the day. If discharges depend on home health, they call the agency to let them know the hospital is on bed alert and they need to process the referral quickly.

Gordon and Myers track the reliability of the process to determine how many patients designated as "intent to discharge" are actually discharged and what kept them in the hospital if they are not discharged.

The hospitals track time frames at essential points, such as how long it takes from the time the patient arrives until the patient is in a bed, and use the information to develop targets for getting patients admitted and for housekeeping turnaround times.

"If we are efficient in our admission process and get patients admitted and the beds turned around in a timely manner, we can focus on discharge issues, such as physician orders and referrals for post-acute services," Gordon says.

The hospitals have collaborated on process changes that one or the other hospital piloted before the other rolled it out.

For instance, ParkWest added environmental services milestones to its flow board. These include adding when housekeeping arrives and when the bed is ready for the next patient to its flow board. Following the success of the project, Fort Sanders Regional is adding environmental services to its flow board.

The increased communication and awareness of patient flow needs has cut 20 minutes off the time between when a bed is empty and the room is clean, Myers says.

"We took two solid processes and combined them. Environmental services had their benchmarks and processes, and we had ours. By having conversations between the two areas and combining the benchmarks, we were able to improve efficiency," Myers says.

[For more information, contact: Sheila Gordon, RN MS, director clinical effectiveness/ nursing administration at Fort Sanders Regional Hospital, Knoxville, TN, e-mail: sgordon1@CovHlth.com or Lori Myers, RN, MSN, capacity management manager at ParkWest Hospital, e-mail: LMyers2@CovHlth.com.] ■

AMBULATORY CARE
QUARTERLY

Is 'boarded' care viewed as substandard?

Your ED patient's bad outcome might have nothing to do with the fact that he or she was held in the hallway while awaiting an inpatient

bed. However, it could impact the outcome of subsequent litigation against the ED.

"I know that patients and families think that 'boarded' care is substandard to inpatient care. I would think the jury may think the same," says **Matthew Rice**, MD, JD, FACEP, an ED physician with Northwest Emergency Physicians of TEAMHealth in Federal Way, WA.

Sandra Schneider, MD, professor of emergency medicine at University of Rochester (NY) Medical Center, says that the best way to reduce liability is to "get the admissions out of the ED as soon as possible. We know that boarding is the number one patient safety concern of emergency physicians." She believes risk increases with very prolonged boarding times as the patient is handed off to subsequent providers who often are not aware of the details of the patient's case.

According to the Centers from Disease Control and Prevention report "Estimates of Emergency Department Capacity: United States, 2007," there are 500,000 ambulance diversions annually in the United States, and 62.5% of EDs board admitted patients for more than two hours. **Andrew Garlisi**, MD, MPH, MBA, VAQSF, medical director for Geauga County (OH) EMS and co-director of University Hospitals Geauga Medical Center's Chest Pain Center in Chardon, OH, says the report contains "few, if any, surprises to nurses and emergency physicians who regularly work in the trenches."

Stop dangerous practices

S. Allan Adelman, JD, a health law attorney with Adelman, Sheff, & Smith in Annapolis, MD, says the most dangerous practices regarding ED boarding involve "anything that makes continuous supervision and monitoring of the patients more difficult."

Adelman isn't not aware of any specific evidence, such as studies or literature, showing that holding patients increases an ED's legal risks. "But you cannot ignore the fact that being left in a hallway is not going to create an impression of well-organized health care," says Adelman. "That alone may make patients much more willing to believe they were not properly cared for."

Adelman says that he firmly believes "that an unanticipated bad outcome coupled with dissatisfaction with some aspect of the care provided are the primary ingredients of a malpractice claim." He recommends the following:

• Be sure that sicker patients whose condition

CNE OBJECTIVES

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

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

COMING IN FUTURE MONTHS

- What health care reform will mean for you
- How to improve efficiency in the ED
- Reducing hospital-acquired infections
- Identifying and addressing atrial fibrillation

could deteriorate more rapidly are kept in locations where they can be more readily and regularly observed.

• Be clear regarding who is responsible for the boarded patient, both with regard to the nursing staff and physicians.

• Make regular contact with the patients and their families, and explain to them why the patient is being boarded.

• Make an effort to provide privacy.

• Have a good explanation of why boarding was necessary readily available. ■

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