HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

February 2011: Vol. 19, No. 2
Pages 17-32

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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.

AHC Media

Don't leave money on the table: Take proactive approach to denials

Avoid denials whenever possible; if that doesn't work, appeal

As reimbursement shrinks and health care providers tighten their belts, hospitals need to take a proactive approach to denials to make sure they get paid appropriately for the care they provide, experts say.

"Hospitals have got to be able to plug all the gaps and prevent as many denials as possible, then appeal those that do occur," says **Deborah Hale**, CCS, president of Administrative Consultant Services LLC, a health care consulting firm based in Shawnee, OK.

Many hospitals don't work their denials, but they should be doing so, adds **Joanna Malcolm**, RN, CCM, BSN, consulting manager, clinical advisory services for Pershing, Yoakley & Associates in Atlanta.

"The payers will often deny clinical information for continued stay, and if hospitals don't know their criteria and pursue their money, they won't get the reimbursement they are due," she adds.

Malcolm tells of one large urban hospital where she reviewed a case that had been denied on the first and second levels of appeal.

"The patient clearly needed to be in a hospital. The denial was ridiculous. The hospital appealed again and got paid for it. It often depends on how persistent you are," she says.

The best way to deal with denials is to make sure they don't happen, says **Ann Kirby**, BA, BSN, MSN, MPAHA, managing director at Wellspring + Stockamp HuronHealthcare, a Chicago-based consulting firm.

"Everyone agrees that avoiding a denial in the first place is best. It's

Special Report: Dealing with Denials

In this issue, we cover managing denials both concurrently and retrospectively, with tips on appealing denials and saving money.

always extra work and uses additional resources if a care manager has to conduct a review for a patient who wasn't put in the right level of care on admission. It's hard to have to research the case and find documentation to support the claim once the patient is gone," Kirby says.

If hospitals have a process in place to look at admissions and get the status and level of care right in the beginning, the likelihood of a denial is greatly reduced, adds **Rachel Hayashi**, RN, MPAH, clinical consultant for Wellspring + Stockamp HuronHealthcare.

Many organizations don't have good processes in place for getting patient status and documentation correct upfront, Hayashi says. They may not have case managers in the emergency department, or they may not staff case management 24-7 without having a back-up plan for a clinician who understands the criteria to ensure that patients are in the right level of care, she adds.

"If you don't have a good process set up at the front end, you're probably setting yourself up to be denied. When there's a denial, if you don't have the appropriate documentation in place, there's not much you can do," Kirby says.

Although hospital staff typically look to the case managers to make sure claims don't get denied, it needs to be a team effort, starting with the admissions staff before the day the patient goes into the hospital, Kirby points out.

For instance, if the admissions staff determine the number of days authorized and put that in the system, it saves case managers time because they don't need to call the payer until the authorization is close to expiring, Hayashi adds.

If a patient is scheduled for a surgical procedure, the case should be evaluated not just for the hospital stay but for the insurer's requirements to make sure all the details are correct. For instance, some insurers want to be notified within a certain time frame after a patient is admitted.

"Even though it is obvious that almost all commercial payers require preauthorization for a hospital stay, others also have rules to follow on admission," she says.

For instance, commercial insurers sometimes deny a claim because they didn't receive notification of the hospitalization or the need for an extended stay in a timely manner, Hayashi points out.

At Medical City Dallas Hospital, the case managers take a proactive approach to avoiding denials and double-check with the insurer to make sure all of the patient days designated in the medical record have been authorized by the insurer.

"We try to close all the loops by documenting every conversation with a payer, then faxing them a confirmation of the approved days and the level of care. This saves us a lot of work on the back end," says **Pat Wilson**, RN, BSN, MBA, director of case management.

When you do get a denial despite your best efforts,

Hospital Case Management™ (ISSN# 1087-0652), including Critical Path Network™, is published monthly by AHC Media, a division of Thompson Media Group 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.

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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.)

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

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.

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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go through the appeals process, Hale recommends.

Make sure that your hospital isn't agreeing with the insurer just for the sake of agreeing, Hale says.

"If you can show that a claim clearly meets inpatient criteria but the insurance company wants to pay the claim as outpatient with observation services, it is up to the individual hospital to decide whether to appeal. I believe that if an insurance company gives you an inappropriate denial, you should fight it," she says.

Start the appeals process right upfront while you have the insurance company on the telephone or as soon as you receive electronic notification, Malcolm suggests.

"If a care manager is talking to a payer and is getting an indication that something is going to be denied, he or she should start the appeal right then. With electronic communication, case managers can still pick up the phone and talk to their payers or send additional information," she says.

It's important for case managers to develop close relationships with the insurance reviewers, Malcolm says.

"When you have a relationship with someone, they're not as fast to deny a case and get off the phone. If they know you, they respect your opinion and are more willing to listen," she says.

Ask what the payer is looking for, look at the chart and get more information, then call the payer back, she suggests.

"A lot of times, case managers think the payer has all the information needed but they are looking for something else. Case managers should ask if they can provide more information rather than just accepting the denial and moving right along," Malcolm says.

If an insurer indicates that something is likely to be denied, the staff at Medical City Dallas Hospital ask for an expedited appeal, Wilson says.

For instance, the payer reviewer may say that the insurer's medical director did not approve part of a stay, Wilson says.

"At this point, we get our medical director involved, and at that point, 90% of the denials are overturned. Physicians understand the nuances of how to treat a particular condition, unlike the payer's reviewer who is using Milliman or InterQual, which don't have any gray areas," she says.

If the denials aren't overturned during the expedited appeal process, the care manager analyzes the case and talks to the physician to find out what the hospital is providing and to determine why the stay is being denied.

"In some cases, we could get a denial for a day because the physician didn't want to send a patient home when he made rounds at 7 p.m. and told him he could stay. We acknowledge these incidents and assign an avoidable day. We look on it as a patient satisfier or a physician satisfier," she says.

The case management team at Medical City works with the appeals nurses on large denials. For instance, when the payer carves out a high-cost drug, the case managers review the medical record for information that could prove medical necessity.

"We get letters from physicians about why the treatment is needed and do whatever is necessary to get the denials overturned," she says.

As case managers work with insurance companies to get approval for additional days or conduct medical necessity reviews, they also should pay attention to what a denial is going to mean to the patient and act as the advocate for the patient, Malcolm says.

"We're all nurses and we want to take care of our patients, to be an advocate for them, and to be sure they get what they need. Case managers need to remember that they're also an advocate for a patient's financial well-being," she says.

For instance, if a Medicare patient is treated as an outpatient with observation services for several days, the copay is likely to be expensive. If a commercial insurer decides that an inpatient stay is not appropriate, the patient could get a huge bill, Malcolm points out.

"A lot of the time, nurses have no idea how hospital finances work. They should become aware of how a denial affects the hospital's bottom line as well as the patient's pocketbook," she says.

Nurses who review denials must have access to information about the contract that the hospital has with each insurer, Hale says.

It's not necessary for the nurses to have all the details, but they should have basic information, such how the insurer defines an inpatient stay versus observation along with the payment arrangement, such as the percentage of charges, for each, she adds.

"I've been in very few hospitals where case managers have a clue about insurance contracts, but if they are going to appeal denials from commercial payers, they need to know what is in the contract as related to inpatient versus outpatient and associated payment rates," she says.

Case managers need this information in order to decide whether it's advisable to appeal, Hale adds.

For instance, in some cases, because of the percentage of charges specified in the contract, the insurer will pay more for a stay that is outpatient with observation services than if the patient is an inpatient.

"I have found situations where hospitals are arguing with the insurer over whether the stay was outpatient with observation services or inpatient when they would get paid more if the patient were on the outpatient side. If the insurer will pay the same percent of charges for either stay, hospitals shouldn't spend their energy appealing," she says.

Manage your denials on an individual basis, then step back and examine the bigger picture, looking for patterns, Hale suggests.

Make sure the appropriate parties know what is being denied and can determine whether each denial was appropriate or not. If it is an appropriate denial, look for trends and identify areas where improvements can be made.

Analyze your data to determine if the greatest number of denials are for patients treated by a particular physician, if their care is being coordinated by a particular case manager, if the denial claims are for patients who come through a particular entry point such as the catheterization lab or the emergency department, and what diagnosis is most often being denied.

Use the information you glean from your data to develop a performance improvement plan, Hale suggests.

At Medical City Dallas Hospital, an interdisciplinary team that includes representatives from all hospital departments meets monthly and drills down to find out why cases are denied.

"Sometimes all of the days had been approved, but the case goes for medical review after the patient is discharged. The insurer may deny a level of care, but we don't find out until the bill has dropped," Wilson says.

The case management team works closely with the appeals nurses to review trends for payers, for individual case managers, or for physicians.

"Sometimes the days are authorized but we lose days on level of care or on the last day. We trend on both ends," she says.

For instance, Wilson is responsible for analyzing the cases denied for medical necessity. She determines if they're coded properly, if the patient should have been outpatient with observation services rather than an inpatient, if the stay wasn't authorized, or if other issues that arose were the responsibility of case management.

In one example, the team discovered that a significant percentage of denied days were cases managed by one care manager who was not counting the days the insurer had approved correctly. For instance, the insurer approved a four-day stay and the patient was discharged on the fifth day, the care manager didn't realize that she had to call the insurer with clinical information to get the last day covered.

"This was a training opportunity for her and for us. She was a fairly new care manager and there is a huge learning curve, even with all the training we provide to new case managers. This was something she had missed in the training. We identified it pretty quickly and corrected it," Wilson says.

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Real-time management keeps denials rate low

Hospital denials consistently are below 1%

By conducing real-time concurrent denials management, Jewish Hospital and St. Mary's Healthcare, a not-for-profit health care system in Louisville, KY, keeps its average denials rate below 1%, consistently exceeding the hospital's goal of a denials rate of under 2% for commercial patient days, including Medicare managed care patients.

"Our goal is to never let denials happen, but when they do occur retrospectively, we appeal. We try to get the issues resolved before they get to full denials, but if we think a case is appealable in any way, shape, or form, we appeal," says **Bev Beckman**, RN, ACM, CPHQ CHAM, corporate director of care management at the health system, which includes a 442-bed tertiary care regional referral center and a 192-bed community acute care hospital.

Managing denials is a collaborative effort of the hospital system's unit-based case managers and a team of LPN payer specialists, located at the health system's resource center, who provide remote denials management and utilization review services for the two acute care hospitals.

As the patient enters the acute care part of the hospital, the care manager on the unit reviews the

patient chart to ensure that all pertinent clinical information has been entered into the hospital's custom-built case management system, developed by a local consultant.

"The system has been upgraded over the years based on compliance and payer guidelines. It's our tool for communicating among the disciplines on our very large campus," she says.

The LPN payer specialists take the information from the case management system and communicate it to the third-party payer by telephone, fax, or e-mail, whichever is the preference of the payer. The hospital system has a relationship with two payers that allows them limited access to the hospital system and to obtain their own clinical information.

When the payer specialist receives a proposed denial from the payer, he or she sends an electronic message to the case manager. The two clinicians work together to collect all the clinical information necessary to get the denial overturned concurrently when the patient is still in the hospital.

Relationships between the payer specialists and the payers are very important, Beckman says.

"The payers are looking for good clinical information. Our team is well-trained and knows what they need to give the payers upfront. If they don't have the information they need, they call the care manager and assure that all the appropriate documentation is in place before they call the payer," she says.

The LPN payer specialists go through a customized training program that includes instruction on how to use the health system's electronic medical record, how to do an admissions review, how to conduct a continued stay review, how to use the Milliman criteria set, and specialized training based on the specific requirements of payers they're assigned to cover. They also have training with a mentor who helps them develop their own internal processes.

The payer specialists are assigned to specific payers. Each day, their work queue includes information on what cases they need to work. The case managers have the same information so if a review is needed, the care manager knows it.

Beckman and her team monitor productivity and workload balance on a daily basis to make sure nobody is overloaded.

"We look at the number of new admissions, continued stay reviews, and discharges, along with pending cases each day to make sure nobody has more work than they can handle. If one payer specialist is backed up, we assign another one to handle some of his or her caseload," she says.

The hospital contracts with an outside physician advisor organization to conduct second-level medical necessity reviews and for assistance in denials management.

"We use the physician review organization for denials when we feel that the stay was appropriate and we need a physician-to-physician discussion to get it overturned," Beckman says.

If the denial is issued retrospectively, the hospital's data analysis specialists in denials management review the record and determine if the hospital should appeal.

"If they feel they need more physician support, they send it on to the physician, who writes the appeal," she says.

In addition to a robust denials management program, the hospital system has processes in place to avoid denials in the first place, Beckman says.

"As patients enter the system, we work with the physician to determine appropriate status. We try to get everything correct from the moment of admission," she says.

The hospital has care managers who cover the emergency department from 9 a.m. to 7 a.m. seven days a week.

When a patient comes in through the emergency department, the care manager works with the admitting physician to determine appropriate patient status at the point of entry.

"We have multiple other points of entry. Patients come in for outpatient procedures, through the cardiac catheterization laboratory, and from surgical services. We have procedures in place to ensure that the status is correct upfront," she says.

"Every invasive cardiac procedure goes to the outside physician firm for a second-level review," she says.

The unit-based case managers review every patient for medical necessity after they are on the unit.

The hospital uses both InterQual and Milliman to ensure that patients meet medical necessity and continued stay requirements.

"InterQual has been used historically for Medicare patients. At this point, 90% of our commercial payers use Milliman," she says.

InterQual is a useful tool when the care managers work with the physician to discuss appropriate status, she says.

"Milliman provides more information about

actual patient management," she says.

The care managers use the Milliman criteria to set individual goals for the day on their daily unit-based rounds with the nurse manager and nursing staff.

The team makes walking rounds on the unit and involves patients and family members in developing the plan of care and goal setting.

"We use Milliman as a tool for our team to determine what care the patient needs and if they have had all the recommended tests and procedures. It's all about ensuring that medical necessity information is on the chart on the unit and communicated to the remote workers so they can keep medical necessity justified," she says.

Beckman is a member of the management compliance team that worked for several years developing internal policies and procedures for the Recovery Audit Contractor (RAC) program.

The team implemented a data-based tracking system, set up a dedicated post office box for RAC correspondence, and designated a RAC coordinator who handles all communication with the RACs.

When a RAC request comes in, the RAC coordinator logs it into the system and sends it electronically to the appropriate department.

The hospital has contracted with the physician advisor company to handle RAC appeals.

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Checks and balances keep denials low

CMs cover ED 24-7, assess patients in PACU

By taking a proactive approach to patient status and instituting a series of checks and balances, Good Samaritan Hospital in Dayton, OH, keeps denials at a minimum.

The 577-bed hospital has care managers covering the emergency department 24 hours a day, seven days a week; requires an order for patient status before the hospital's electronic medical records system will allow patients to be placed in a bed; and requires physician offices to fill out a pre-admission form that includes patient status before a patient can be scheduled for surgery, according to **Teresa I. Gonzalvo**, RN, MPA, CPHQ, LNC, director of integrated care management.

"We have many access points and have created standardized admissions procedures with a goal of getting patient status right the first time and diminishing the errors. Every patient who is admitted to the hospital is reviewed by a case manager for admission status, regardless of their access point or payer," Gonzalvo says.

Having case managers cover the emergency department 24-7 has been a major factor in reducing denials, Gonzalvo says.

"About 70% of our patients come through the emergency department. By being on site, our case managers are able to accurately capture medical necessity before patients leave the emergency department," she adds.

The case managers have access to a patient tracking board that includes a case management component.

"They are able to intervene as soon as they have the laboratory work, radiology results, or other diagnostic information. Since they are physically in the emergency department, they can talk to the patients and physicians if they need additional information," she says.

If patients are placed in outpatient status with observation services, the case managers give them a brochure explaining what observation means, how it may affect their copay, and their eligibility for a nursing home stay if they are Medicare beneficiaries.

The case management department worked with the surgery schedulers, the director of surgery, and the nurse manager of the post-anesthesia care unit to develop a system for making sure patient status is correct before and after surgical procedures.

The hospital has created a pre-admission form that physician offices must fill out before they can schedule patients for surgery. The form includes a list of the appropriate choices for patient status after surgery including "inpatient," "outpatient," or "post-procedure recovery" along with the CPT codes.

"Physician office staff must fax that form with all the information completed before they can schedule the surgery. When the surgery is scheduled, we know what the patient status will be after the procedure," she says.

Once a patient is transferred to the post-anesthesia care unit (PACU) after surgery, the nurse checks to make sure the status is still accurate. If the patient's stay in the PACU exceeds the expected post-procedure recovery period, the

(Continued on page 27)

CRITICAL PATH NETWORK™

CM beyond hospital walls supports chronically ill

Targets people with diabetes, asthma, HF

Recognizing that chronically ill patients benefit from care management beyond the walls of the hospital or their physician's office, Middlesex Hospital in Middletown, CT, has created The Center for Chronic Care Management, which offers four National Committee for Quality Assurance- (NCQA) accredited disease management programs to help patients manage their conditions.

"Our hospital is committed to benefiting the community. Once a person is stabilized with a chronic illness, the hospital's support doesn't end there. The goal of the program is to connect the hospital to the outside community to reduce emergency department visits for people with chronic diseases, to improve the quality of care, and clinical outcomes," says **Kit McKinnon**, BSN, RN, CDE, CCM, diabetes case manager and manager of diabetes care program and operations.

The hospital's Center for Chronic Care Management provides care management for people with asthma, diabetes, and chronic heart failure, along with childhood obesity and smoking cessation programs. The center, located in an office building on the hospital campus, is staffed by care managers, nurses, counselors, and dieticians. The care managers also see patients once a week in a community health center.

"Many similar programs come out of health centers. This one is unique because it's out of a community hospital. We have all these expert resources here at the hospital and are now deploying them into the community," says **Veronica Mansfield**, APRN, AE-C, CCM, nurse practitioner and manager of disease care and development.

The center was developed as an outgrowth of the hospital's focus on frequently occurring readmissions and how to reduce them, Mansfield says.

"Health care professionals from the community joined representatives from the hospital to develop this program. We know that at least 25% of adults in Middlesex County have a diagnosis of one or more chronic illnesses. Our goal is to improve the clinical, quality of life, and fiscal outcomes of people with a chronic illness," McKinnon says.

The hospital formed an interdisciplinary team, headed by a representative from the hospital quality department. The team included a primary care physician, a nurse, a case manager, and representatives from schools and pharmacies in the area.

The hospital purchased a data tracking system that can track patients at all points along the continuum.

The team began with an asthma program and gradually added the other diagnoses over the years.

"Right from the beginning, we were charged with being an adjunct to the primary care physician and not a substitute for care by a physician. We work with the patients and the primary care physician to make sure that patients are more educated about their chronic condition when they return to the communities they live in," Mansfield says.

Many of the patients are referred to the program from community physicians, most of whom are primary care providers, including internal medicine specialists, pediatricians, and family practice physicians.

"They believe in our services. They know that we are not a center where they send patients and never see them again," McKinnon says.

The case managers typically meet the patients

when they are admitted to the hospital or have an emergency department visit.

"We are responsible for checking every day to see if there are inpatients who qualify for our program. When there are, we visit the patients in the inpatient setting. I used to do a lot of intense teaching when the patients were in the hospital, but now I do it later because they often are too sick to fully benefit from the education," Mansfield says.

The program concentrates on the most vulnerable patients, those who have problems managing their diseases.

"We work with the most complicated patients, such as those who are stratified as persistent asthmatics, who need a high dose of medication every day. Many have been hospitalized numerous times and have been intubated," she says.

Many of the patients in the program are having an inpatient admission because they can't get their medication because they became uninsured, lost their job, or for other reasons.

"We enroll them in the program, give them what they need, and educate them on how to manage their condition long term so they don't wind up back in the hospital," McKinnon says.

When they visit patients in the hospital, the case managers assess their financial status, their home situation, what they know about their medications, and what has happened with their illness in the past.

The physician and the hospitalist use information from the assessment in developing the discharge plan, McKinnon says.

"We follow the patients every day they are here. The goal is to have an appointment with them within seven days after they are discharged. They tend to bounce back to the hospital if they're not seen in a few days," she says.

When patients are in the heart failure program, the care managers see them frequently face to face as inpatients and often refer them to a home care nurse for telemonitoring.

If patients are not eligible for home care or are uninsured, the heart failure case manager works with them closely after discharge, seeing them a couple of times a week in the beginning.

The care managers facilitate getting timely physician appointments for the patients and make sure that they can fill their prescriptions.

They collaborate with community physicians to ensure continuity in care.

Some of the physicians have access to the center's electronic health record, making communication easier. There is a specialty physician group upstairs in the center's building and a family practice group across the parking lot, making it easier for patients to see their physician and visit the center on the same day.

When the patients come into the center after discharge, the case managers make sure they are taking their medication properly and start the education process now that they are feeling better. Sometimes patients bring their spouse, children, or another caregiver with them to the center to participate in the education.

"The goal is to get patients back in to see us after they have seen the primary care physician. We have at least two face-to-face visits and often many more. We also do a lot of trouble-shooting over the telephone," McKinnon says.

The hospital has a long-term relationship with the community health center and has worked over the years on quality improvement projects around chronic care, McKinnon says.

She and another RN case manager work at the community health center one day a week, providing education to patients with diabetes. Providers at the health center schedule appointments for diabetes patients on the day the care managers are present.

"The program works well because we're based here at the hospital, and if a patient who is receiving care at the community health center becomes an inpatient, we are able to see them while they are in the hospital and alert the community health center that the patient needs to be on our schedule next time we are there," McKinnon says.

One of the goals of the program is to educate people about the chronic conditions that they live with for many years.

"We are giving patients the tools to make sure they know the evidence-based standards for their disease," Mansfield says.

For instance, education for diabetics includes what A1C is, why they should check their blood sugar regularly, and how foods and medications will improve their health, she adds.

When people have acute complications of their chronic disease, the care managers work to get them stabilized, but it doesn't end there.

"We encourage the patient to continue to participate because the whole idea of community support is to provide long-term support," McKinnon says.

The care managers advocate for their patients in the community to make sure they get the follow-up care and tests they need.

For instance, one man has participated in the program since 2005, when he was hospitalized with a slight stroke and was newly diagnosed with diabetes. He came to the center with a family member and was educated on using insulin and managing his disease.

The patient owns a small business and is uninsured but doesn't qualify for state or federal assistance. Because of his diabetes, the cost of insurance is prohibitive.

The care managers worked with a primary care physician in an individual practice who agreed to treat the patient. They provide coupons for him to have his hemoglobin A1c exam twice a year and give him the support and encouragement he needs to keep his diabetes under control.

"As care coordinators, we look at ourselves as negotiators who speak for our patients to other health care providers. We were able to get him a reduced rate for his retina exam and negotiated with a dentist to get him in for an exam and to have his teeth cleaned for the first time in many years," McKinnon says.

Today, the man's hemoglobin A1c is under 7% and he is able to pay for his prescriptions for insulin and a statin.

"We get a lot of personal satisfaction from working with patients to get them active and using their medications regularly so they can stay at work and live their lives without continually being in and out of the hospital," Mansfield says.

[For more information, contact: Veronica Mansfield, APRN, AE-C, CCM, nurse practitioner and manager of disease care and development, Middlesex Hospital, e-mail: veronica.mansfield@midhosp.org.] ■

Childbirth at Evergreen seen as family experience

Childbirth at Evergreen Hospital Medical Center in Kirkland, WA, is viewed as a family experience, rather than a medical event.

To make it a positive experience, the family — rather than hospital protocol — determines the choices made for birth, says **Tamara Fitzgerald**, NAC, ICCE, LE, lead facilitator in childbirth education at Evergreen.

"There is this balance in the medical care to ensure the best outcomes possible with a focus on the family in terms of their wishes for the birth," explains Fitzgerald.

The balance is created through a comprehensive education program designed to help families make educated choices, and prepare them for childbirth and parenting. Education begins with prenatal classes, continues throughout the hospital stay, is provided directly after discharge with a postpartum visit, and continues throughout the first year of a child's life.

"It ensures that at every part of the parent's development, they have that base of information specific to their phase and the baby's phase," Fitzgerald explains.

Physicians encourage their patients, especially new parents, to attend three prenatal classes at Evergreen: a labor/birth series, an infant feeding series, and a one-day, hands-on class called "A Day About Baby."

"It is part of our collaborative process, for parents have less stress and greater ease when they know what to expect ahead of time," Fitzgerald says.

During the labor/birth series, parents are educated about labor and delivery choices, such as pain medication and relaxation techniques, and they create a written birth plan.

A Day About Baby is unique and fun, Fitzgerald says. During the day-long class, parents receive a life-like doll that is used for lessons about bathing and changing diapers, as well as how to hold a baby, and to calm and soothe a crying baby. Because the baby goes everywhere with parents, the couple must learn how to go through a lunch line in the cafeteria with a baby or use the restroom.

"It is a great role-play piece, and the parents really enjoy it and come away with a prenatal, hands-on experience," Fitzgerald says.

Parents who have children and who are attending the labor coping skill class, which is part of the labor/birth series, learn about any changes that have occurred since they had their last baby.

Also offered to families with children is a sibling class that parents attend with their children. The parents remain in the background while children age 2 to 6 learn about interacting with their new brother or sister and discuss how things might change at home. They learn how to help wrap a baby, play safe games with him or her, and tour the room where the baby will be born. Also, they draw a picture for the baby to hang on the crib when they come to meet their new sibling for the first time. According to Fitzgerald, the sibling class is very popular with families.

The curriculum is shaped by several factors. Recommendations from the Institute of Patient and Family Centered Care are incorporated, and the teaching follows standards on childbirth education issued by the state of Washington. Fitzgerald coordinates curriculum with a clinical nurse educator, and together, they stay abreast of current information.

"Birth doesn't change very much over the years, but certainly what is available to parents does change, and the research to support it; so we take new information and weave it into our curriculum," says Fitzgerald.

Prenatal education is timed to coincide with the various levels of adjustment that parents go through to the thought of a new baby, she adds.

Education is hands-on and continuous once the baby is delivered, because the Family Maternity Center at Evergreen Hospital has rooms where the labor, delivery, recovery, and postpartum stay occur. The value of having the baby room with the parents is that they are able to do the first diaper changes and give the baby his or her first bath. A postpartum nurse is there to answer questions. Also, a feeding specialist/lactation consultant visits every family to help with feedings based on the family's choices.

The hands-on care for the baby is very different from having the baby in a nursery during the hospital stay, and it gives the parents confidence to take the baby home, Fitzgerald says.

In addition to hands-on education, each family is given a DVD titled "Going Home with Your Baby" that was filmed at the hospital. In the DVD, staff and parents discuss all aspects of postpartum care for both the mother and baby. Parents review the DVD with a nurse before leaving the hospital; then, they use it as a reference at home. It contains answers to all types of questions that might arise, i.e., from when a parent should take the baby to the hospital to what a baby's first bowel movement looks like, says Fitzgerald.

Also during the hospital stay, mothers attend a class in their bathrobes with their newborn baby. It is taught by a registered nurse, who is a lactation consultant, and covers a variety of topics, such as umbilical cord care, eye care, and breast-feeding. The classes are small and take place daily. The curriculum follows guidelines from the American Academy of Pediatrics.

Learning continues after discharge with an appointment at the postpartum care center three to four days after the family takes the baby home. Parents and other family members can attend. "It is a clinical safety net for issues that might arise after the birth of the baby," Fitzgerald says.

Parent/baby classes are offered on a weekly basis for one year following the birth of the baby. Parents meet with a group that has babies of a similar age. Groups are divided as follows: families with babies 0-3 months; 3-6 months; 6-9 months; and 9-12 months. The classes are two hours and consist of an hour-long presentation by a parent educator, followed by a time for questions and discussion.

The 0-3 month baby class is offered to families at no charge, because the first three months is a crucial time for parent and infant development, Fitzgerald says. New moms, especially, are integrating the birth experience into their lives, and babies are still womb-oriented and don't yet perceive themselves as separate from the mother; also, they need warmth from a lot of holding, she adds.

According to Fitzgerald, the 0-3 month baby class helps mothers who might be experiencing postpartum mood disorder or depression work through these issues.

Fathering is recognized as a priority in childbirth education, as well, and the program offers a class called "Conscious Fathering."

The maternity education program is continually evaluated and improved through family input. Parents who participate in the prenatal classes together come to a reunion following the birth of their babies, and at that time they provide input on the program discussing what they would like changed — or if there was anything they would have preferred to know in advance.

Feedback is also obtained through a patient/advisory board that rotates members through. Board members share their birth experience at staff meetings with physicians, midwives, educators, and nurses.

The continuum of education works well, says Fitzgerald. Prenatally, families learn the clinical benefits of breast milk and learn the process of breast-feeding. At the Family Maternity Center, once the baby is born, the mothers learn to latch at the baby care class and also have hands-on lessons with a lactation consultant/feeding specialist in their room — and later at the postpartum care center. During the weekly meetings of the 0-3 month baby classes, mothers get further support and education about breast-feeding. As a result of this education, 90% of mothers who deliver at Evergreen Hospital breast-feed their babies. ■

(Continued from page 23)

nurse brings it to the attention of the surgeon.

The unit-based case managers take turns rotating through the post-anesthesia care unit between 2 p.m. and 4 p.m. to determine admission status for patients who are in recovery following surgery. If the unit case manager who is assigned recovery room responsibility has a big caseload on his or her regular unit for that particular day, another unit case manager or the manager takes over the process, Gonzalvo says.

The case managers assess which patients potentially may stay overnight and whether they are meeting observation or inpatient criteria.

If the patient had a procedure with the option of inpatient, outpatient, or post-procedure recovery, the case manager reviews the record for medical necessity and calls the surgeon or attending physician if he or she feels the order does not place the patient in the appropriate status, Gonzalvo says.

If the case manager and the admitting physician can't agree on a patient status, the medical director for case management intervenes.

"It's more efficient to get these patients admitted in the right status if someone goes to the recovery area, rather than trying to manage the admission status when the patients get to the floor," Gonzalvo says.

The team created a user-friendly manual for Medicare's Inpatient Only list to ensure that patients who receive surgical procedures on the list are admitted to the hospital as inpatients.

Surgery schedulers use the manual as a reference to determine if patients should be admitted as inpatients. The case managers re-evaluate the patient status while they are in the recovery room.

The medical record has patient status as a required field and includes order sets specific to the procedures on the Inpatient Only list.

If a procedure is on the Inpatient Only list, the physician does not have the option to order any other status, Gonzalvo says.

The hospital has established what it calls a QWIK bed procedure for patients who are being directly admitted from a physician office or transferred from another hospital.

When a hospital or a physician office calls to admit a patient, the QWIK bed referral management nurses assess the patient's medical necessity status in advance.

"The referral management nurses in this area have access to medical necessity criteria, but if they aren't sure, they collaborate with the emergency department case manager," she says.

Patients who are transferred from outlying hospitals are likely to meet inpatient admission status, Gonzalvo points out.

However, it's sometimes difficult for the admissions nurse in the QWIK bed office to make an assessment of patients coming in from a physician office since diagnostic test results may not yet be available and often the only information they have is vital signs, activity and diet orders, and some symptoms, she says. Often a status is ordered by the physician as well.

"If the QWIK bed nurses don't have enough information to make an assessment, they secure a status order or make a recommendation as outpatient with observation services since our electronic system won't allow a patient to be placed in a bed without an order for admission and a corresponding status indicated," she adds.

The case managers on the unit review the case and recommend changes in the status, using Condition Code 44, if appropriate.

"This happens only with cases that were initially admitted as inpatients, then after further review and clarification with the physicians and discussions with the medical director, it is determined that they really meet observation status," she says.

On weekends, nights, and holidays, the emergency department case manager has a housewide responsibility for medical necessity reviews. In order to set priorities, she runs a report of observation cases, and then reviews the charts of the new admissions, and ensures that the patient is assigned the right status.

"On occasion, things may fall through the cracks on weekends and at night. Due to a high census and complex discharge planning needs of emergency department patients, sometimes the emergency department case manager is not able to realistically review all observation patients. When that occurs, their priority is to start with patients in observation longer than 24 hours," she says. ■

Model decreases LOS, less revenue lost to denials

Physicians receive monthly reports on LOS

By redefining the roles of case managers and social workers and working with physicians on patient throughput and length of stay, Fauquier Hospital in Warrenton, VA, significantly reduced its Medicare length of stay by almost a day and

decreased the revenue lost because of denials by medical necessity by 70%.

From January 2009 to June 2009, the average Medicare length of stay was 5.82 days. For the same time period in 2010, the Medicare length of stay was 4.86 days. At the same time, readmissions remained stable at 18.7% in the first half of 2009 and 18.5% in the first half of 2010, reports **Pat Gerbracht**, BSN, MA, CRA, director of case management and social work.

The hospital consistently experiences less than a 1% denials rate.

"We had three denials in the first 11 months of 2010. If the RN case manager is minding the store, there's no reason to have denials or for patients to stay longer than necessary. Our case managers work closely with the physicians and the rest of the treatment team and check for medical necessity every day," Gerbracht says.

The case management team also prepares a monthly physician long-stay DRG report, focusing on high-volume Medicare DRGs, which shows each physician how his or her data compare to those of his or her peers.

At Fauquier Hospital, case managers and social workers use a sequential model of care. Each discipline has a defined role that makes maximum use of its training and expertise.

The RN case managers are accountable for everything medical that happens during the actual patient stay, including length of stay and quality of care. The social workers are responsible for patient and family assessments and discharge planning.

The RN case managers coordinate care until the patient is nearing discharge, then hand the case off to the social worker.

"We have divided up the work so each discipline does what they do best," Gerbracht says.

When Gerbracht arrived at the hospital in 2009, the case management model varied from unit to unit.

"If every person in the department had been asked to make a list of the tasks they did each day, almost every list probably would have been different. There was no clarity about who was responsible for what, which means there was no accountability," she says.

On many units, both the case managers and the social workers were doing the same job.

Before redesigning the model, the case management team brainstormed to determine what was working well in the department and what wasn't. They spent six weeks developing role definitions and determining how the model would work.

"The meetings resulted in a clear statement from each discipline on what tasks they wanted to own," Gerbracht says.

At Fauquier, case managers review every case every day, making sure that all tests and procedures that have been ordered have occurred, that consultants have seen the patient, and that the treatment team is aware of the results.

The case managers coordinate care for between 18 and 20 patients.

"That's a doable number. We are very detail oriented and look at labs, diet, projected outcomes, and the treatment plan, and we do our own insurance reviews. If the caseload was above 20, it would be very difficult to take care of all the details as thoroughly as we do," says **Annette McVicker**, RN, BSN, CPUR, case manager for the intensive care and step-down unit.

Case managers can tackle a lot of tasks if they don't have to conduct discharge planning, Gerbracht says.

"When you ask the same person to do discharge planning on a busy unit, they're lucky if they can put a review into the system at the end of the day to meet Medicare and insurance company requirements. They know it should happen, but discharge planning is demanding and can over-run the day," Gerbracht says.

The department has a clinical documentation specialist who handles documentation improvement and physician education. The case managers are responsible for insurance reviews.

"When a case manager takes ownership of the case, he or she is the best person to interface with the insurance company. When the insurance company is teetering about approving another day and I tell them I've spoken with the primary care physician and the consultant and here is what they said, it lends credibility to what I am saying because the reviewer on the other end knows me," McVicker says.

The case managers and social workers meet daily to go over the unit census and plan the patient's stay. Social workers have a caseload of 30 to 35 active cases and work with more than one case manager.

"We review the cases where we are anticipating discharge and determine when the social worker will step in. We want to plan as much as we possibly can so we won't have any delays at the end of the stay," McVicker says.

The case manager on each unit holds a daily bed huddle with the unit director, clinical coordinator, and social worker, McVicker says.

"We plan for discharges, transfers to nursing homes, acute rehab facilities, or long-term acute

care hospitals. We look at our bed situation and determine if we can downgrade any patients from the ICU or the step-down unit to a lower level of care," she says.

McVicker typically hands off the case to the social worker 48 hours before the anticipated discharge.

"With complex discharges, we put a lot of preparation on the front end and anticipate a time line," McVicker says.

When a patient is likely to need post-acute care, the social worker collaborates with other clinicians to educate the family. The first person who explains the situation is the doctor.

"The physician's word has the most credibility. They sit down with the family and explain why the level of care is necessary," McVicker says.

The social worker communicates with the patient, the family, and the physician about anticipated discharges. He or she alerts the patient and family as to what time the physician is likely to round and gives them an estimated time that they'll be ready to leave the hospital so the family will be ready to pick the patient up. If the patient doesn't have transportation, the social worker will arrange it.

The new model is extremely popular with the staff, McVicker says.

"As a nurse, I am very clinically minded and clinically focused. I like getting my hands on a case and having the time to make sure the patient has the right medication and consultations early in the stay, that they get the education they need and are ready for discharge in a timely manner. I like to see the progression of the case so that when I hand the patient to the social worker, it's neatly wound up," she says.

The case managers concentrate on ensuring that the patient's care is "front-loaded," that the intensive treatment, consultations, exams, and tests occur during the first one or two days of the stay, resulting in a compact and efficient length of stay.

"Outcomes data and readmissions data show that patients with high-intensity, high-acuity treatment in the early part of the stay have shorter stays, fewer readmissions, and do far better overall than those when they had consultations and treatments gradually," Gerbracht says.

The case managers are on such good terms with the physicians that they feel comfortable suggesting, for example, that the physician order a cardiology consultation early in the stay, she says.

Most of the suggestions are accepted, McVicker says.

"That's the beauty of being floor-based. The physicians know that we are monitoring the case

CNE questions

5. According to Deborah Hale, in some cases, depending on a hospital's contract with a commercial insurer, reimbursement may be higher for a patient who is in outpatient status with observation services than for a patient who is admitted as an inpatient.

A. True
B. False

6. Jewish Hospital and St. Mary's Healthcare consistently exceeds its goal for denials rates for commercially insured and Medicare managed care patients. What is the goal?

A. 1%
B. 2%
C. 3%
D. 4%

7. What percentage of patients come in through the emergency department at Good Samaritan Hospital in Dayton, OH?

A. 70%
B. 75%
D. 80%
D. 90%

8. What was the Medicare length of stay for Fauquier Hospital in the first six months of 2010?

A. 5.82 days
B. 5.69 days
C. 4.86 days
D. 4.52 days

Answer key: 5. A; 6. B; 7. A; 8. 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 June issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

clinically and know what is going on. We're on the floor talking to nursing, dieticians, staff from ancillary departments, and the family, and we are seeing what's going on and the dynamics when the physician is not here," McVicker says.

The department creates a monthly physician long-stay DRG report that includes data on the top 10 to 12 highest-volume DRGs with lengths of stay that exceed the Medicare average length of stay by a full day.

"We also use average length of stay when providing coaching for physicians because the number reflects actual clinical stays across the country," Gerbracht says.

Each physician receives a report of DRGs for which they admit patients. The charts show how the individual physician's length of stay compares to that of every other doctor who admitted patients in that DRG.

The charts are coded with the comparative data blinded so each doctor knows his own statistics but doesn't know which other physician has which data.

The reports are confidential and are mailed monthly to each physician's office. Only Gerbracht and the case management specialist who pull the data know what's in the reports.

After the physicians started receiving the report card, the length of stay slowly began to come down, Gerbracht says.

"Physicians are extremely bright and competitive. There's a significant body of research that indicates that the technique of using blinded data is highly successful. This reporting technique allows a sensitive topic to be discussed respectfully," she adds.

[For more information, contact: Pat Gerbracht, BSN, MA, CRA, director of case management and social work, Fauquier Hospital, e-mail: gerbrachtp@fauquierhealth.org.] ■

'No-wait' ED a five-year success

Wait time to see practitioner cut in half

A true test of the success of a process improvement initiative is whether the results can be sustained, and the ED at Hudson Valley Hospital Center in Cortlandt Manor, NY, has just celebrated the fifth anniversary of its "no wait" process. Most patients skip the waiting room entirely and go right to registration, and then to triage.

"We've cut the wait time to be seen by a practitioner by 50%," says **Ron Nutovits**, MD, FAAEM, chair of the ED. "Most patients are now triaged within five minutes and seen by a practitioner within 20. Within the first month, our rate of patients who left without being seen went from .7% to .33%, and our Press Ganey scores went to the mid-90s." Nuvovits says the 35,000-visit ED was also recognized by Press Ganey for its high staff satisfaction scores.

Maryanne Maffei, RN, MS, director of nursing, explains the process. "When the patient comes in, they sign in at the registration desk. We do a quick registration — name and date of birth — so we can give them a medical record number, and then they have a seat. Their name then appears on our computerized system, and the triage nurse takes them from the waiting room to the triage room." When triage is finished, the patient is taken immediately into the care area, where labs and X-rays can be ordered and treatment begun, Maffei says.

Nuvovits says, "It became a one-way system. Instead of coming in, registering, and going back to the waiting room, now they come in and the greeter gets them into our tracking system, alerts the triage nurse; they go to triage and come directly from triage to the main ED." The department has two triage areas, so patients can be treated simultaneously, he adds.

Maffei says, "We really focused on triage in training. If more than two people are in the waiting room, the staff will go there, bring them to a room, and triage them."

It was emphasized to staff that this change would benefit patient safety. "We needed to change the thought process of some of the nurses in the department, so they could see how much safer it was going to be to bring patients immediately into the department for treatment," says Maffei.

Eventually, this approach became "part of the norm," she says. In fact, Maffei shares, there's another hospital nearby that is trying to implement a similar approach. "They were discussing it with one of our nurses, and she told them, 'Don't worry, it's hard at the beginning, but you get used to it,'" she says. (The transition was also made easier through the use of simulations, which helped ensure that staffing levels matched demand fluctuation.)

[For more information on reducing wait times, contact:

Maryanne Maffei, RN, MS, Director of Nursing, Ron Nutovits, MD, FAAEM, Chairman of the ED, Hudson Valley Hospital Center, Cortlandt Manor, NY. Phone: (914) 734-3247.] ■

Improved flow aids patient safety

Cut wait times, LWBS, boost compliance

If there are any doubts that improving patient flow also enhances patient safety, the recent experience of the ED at Enumclaw (WA) Regional Hospital should dispel them. A new triage and treatment process has dramatically improved flow performance, but it has also garnered the ED the Washington State Medical Association's 2010 William O. Robertson Patient Safety Award.

Richard Dickson, RN, the ED manager, explains why. "Our rate of patients who left without being seen had been 5%, and we dropped it to between .8% and 1.1%," Dickson says. "When we examined the records of the patients who had left before being seen, we discovered that on average they were level three patients." The ED uses a five-level triage classification, with level 1 being the most serious.

A level 3 patient "is someone that needs to be seen," Dickson says. An example is a patient with abdominal pain. "I like to think they went to another hospital, but they also could have gone home and bled out," Dickson notes.

In addition, he says, the department's AMAs (Against Medical Advice) also have dropped, from 1.5% a month to less than .5%. "Patients used to think that what the doctor ordered was either too costly or too time-consuming," Dickson notes. "Since they're being seen much earlier, they tend not to run out before the doctor finishes treating them."

They certainly are being seen more quickly. The door-to-doc time has dropped from an average of 52 minutes to an average of 16 minutes, Dickson reports.

The new process was "borrowed" from a sister hospital, St. Anthony Hospital in Gig Harbor, WA, which implemented its process in March 2009. Enumclaw went live with theirs in early 2010. "It was a brand-new hospital, and we wanted to develop a process that was very patient-centered and designed to meet their needs and expectations," explains **Paul Hildebrand**, MD, regional medical director for emergency services in the Franciscan Health System, which is based in Gig Harbor, WA.

In seeking models, Hildebrand discovered that his group's parent organization, TeamHealth, had developed an effective process for Banner Good Samaritan Medical Center in Phoenix and for Memorial Hermann Hospital in Houston. "We went to Phoenix and observed," he says.

When patients present, says Hildebrand, they are greeted and "brought right back," where they are seen by a physician/nurse team. "They do not spend a lot of time out front or go through the redundant exams you see in a lot of places," he says. Once a treatment plan is created, it is discussed with the patient.

At St. Anthony, says Hildebrand, door-to-doc time is about 10 minutes and LWBS is "essentially zero." If a patient needs to be admitted, a nurse from the inpatient area comes down and takes the patient upstairs. "So our staff is able to continue seeing new patients," Hildebrand says.

One difference between St. Anthony and Enumclaw, notes Dickson, is that his staff is too small to allow a dedicated triage nurse. "We have two RNs 12 hours a day and three the other 12 hours," says Dickson, adding that they basically take turns as the triage nurse.

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

- Recruiting, training effective case managers
- How ED case managers can make a difference
- Improving communication among the multidisciplinary team
- What your peers are doing to prevent readmissions

When patients present at Enumclaw, one of two registration clerks take down the chief complaint and "quick-reg" the patient to give them an account number. "They then call the team intake [triage], and they come and take them either straight back to a patient room or to a triage room, depending on their triage level," says Dickson.

Level 4 or level 5 patients, who are seen in the triage area, then wait outside the X-ray and lab areas (which are not in the ED), sitting on waiting benches provided for them until their results are back. ■

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