HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

December 2011: Vol. 19, No. 12
Pages 177-192

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Financial Disclosure:
Executive Editor **Joy Dickinson**, Managing Editor **Felicia Willis**, Editor **Mary Booth Thomas**, and Consulting Editor **Toni Cesta**, PhD, RN, FAAN, consulting editor of *Hospital Case Management* and author of *Case Management Insider*, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. **Donna Zazworsky**, RN, MS, CCM, FAAN, serves as peer reviewer for *Case Management Insider*. She has no relevant financial disclosures.

AHC Media

Centers for Medicare and Medicaid Services tighten reimbursements

Medicaid RACs add another layer of scrutiny

If you're not paying as much attention to documentation and medical necessity for Medicaid patients as you do for those covered by Medicare, your hospital is likely to suffer when the Medicaid Recovery Audit Contractor (RAC) program starts on Jan. 1, 2012.

"If case managers haven't been focusing on Medicaid patients, they've done their hospital a disservice. CMS is tightening up on Medicaid reimbursement and the rules are different from Medicare rules," says **Charleeda Redman**, RN, MSN, ACM, executive director of corporate care management for the University of Pittsburgh Medical Center, an integrated care delivery system.

Hospital case managers may not be scrutinizing Medicaid patients as closely as they do Medicare patients if their state does not have a process that requires utilization review and authorization, Redman points out. "Case managers need to put processes in place to ensure that Medicaid patients receive the same types of medical necessity reviews as Medicare patients and that it is clearly documented in the record," Redman adds.

Hospitals have been on notice that implementation of the Medicaid RACs was in the works since CMS issued a proposed rule for the program in November, 2010, Redman points out. In January 2011, the agency delayed

EXECUTIVE SUMMARY

Hospitals will suffer when the Medicaid Recovery Audit Contractor (RAC) starts on Jan. 1, 2012, if case managers aren't scrutinizing those patients as closely as those who are covered by Medicare.

- Make sure your documentation is complete to avoid denials and prepare for appeals.
- Work with your state Medicaid provider to determine how the program will work in your state.
- Learn the rules for all states in which your patients reside.
- Be aware that the Medicaid RACs are charged with taking a proactive approach to identify potential fraud.

the proposed April 1, 2010, implementation date to give the states time to prepare for the new program. *(For more information about the rules, see related story, p. 179.)*

Victoria Choate, RN, CCM, RN-BC, CCP, CPHQ, vice president of performance excellence and chief quality officer for Cheyenne (WY) Regional Medical Center, urges case management directors to take a proactive approach to reimbursement changes and be aware of what new initiatives payers are considering. In the past, hospitals have written off denials as the cost of doing business, but with shrinking reimbursement, they can no longer afford to do so, Choate adds.

"Gone are the days when case management directors don't have to be acutely aware of everything that is happening in regards to reimbursement. If they want to avoid being blindsided, case management directors can no longer leave it to the chief financial officer or the chief operating officer to keep up with payer rules and regulations. When we know what payers are considering for the future, we can plan for it," she says.

Brian Flood, managing director for KPMG, the U.S. audit, tax and advisory firm, with headquarters in New York City, points out that historically, hospitals have not given Medicaid programs the same focus as they give Medicare programs when it comes to compliance programs and financial audits. However, provisions in the Patient Protection and Accountable Care Act have caused the Medicaid program to experience historic growth, which translates into more patients on Medicaid and larger pools of funds to be reviewed by the Medicaid RACs, he adds. "Hospitals need to implement oversight and review mechanisms commensurate to the growing risk and catch up from the historical lag within the industry," Flood says.

This change means that case managers have to give the same attention to evidence-based documentation for Medicaid patients as they have been doing for patients covered by Medicare, he says. Because commercial insurers are likely to follow suit and start their own RAC-like audits, case managers also have to carefully scrutinize the medical necessity and documentation for privately insured payers, Flood adds.

Hospital-based case managers should work closely with the Medicaid case managers who come in to review the charts and make sure their documentation is meeting the Medicaid requirements, says **Elizabeth Lamkin**, MHA, chief executive officer and partner in PACE Healthcare Consulting, Hilton Head Island, SC. "Case managers should treat Medicaid patients exactly as they do Medicare patients and review the charts concurrently while the patient is still in the hospital. They need to make sure that medical necessity is documented on the front end and get their physician advisors involved when there is a question," Lamkin says. She also recommends that hospitals have clinical documentation specialists review the documentation in the charts on an ongoing basis.

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 105109, Atlanta, GA 30348.

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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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Editor: **Mary Booth Thomas**, (marybootht@aol.com).

Executive Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).

Managing Editor: **Felicia Willis.**

Production Editor: **Kristen Ramsey.**

Editorial Questions

For questions or comments, call Joy Dickinson at (229) 551-9195.

If you use InterQual or Milliman medical necessity criteria sets, you have set yourself up to mount an appeal if there is a denial, Lamkin says. "If case managers and clinical documentation specialists understand criteria and review the charts concurrently, the hospital should have few take backs," she says.

Redman recommends that hospitals put a process in place to clearly document authorization for admitting patients and how the authorization was obtained. "Our Medicaid provider uses InterQual criteria as a guideline and typically, if a patient meets InterQual criteria, the patient's stay is authorized as an inpatient stay. If the patient doesn't meet InterQual criteria, the case is referred to the Medicaid physician for secondary review/authorization," she says. If after the secondary review, the inpatient stay is denied, the hospital can ask for a peer-to-peer review to authorize the patient stay as inpatient.

The hospital record should be clearly documented to reflect that the reviewing Medicaid physician authorized the patient's stay as inpatient admission in order to avoid a denial from the integrity auditor or the RAC auditor, Redman says. "We have had an opportunity to overturn cases retrospectively denied by an auditor when we could produce documentation that a Medicaid physician approved the stay as an inpatient stay, following a peer review," she says.

Clear documentation is particularly important in the case of Medicaid patients who are admitted because of the absence of care and support in the community, Redman says. "If there is a clinical issue that needs to be addressed, but the patient doesn't meet InterQual criteria, our physician contacts the Medicaid provider's physician to provide additional information as to why the patient should be an inpatient," she says. "If we believe that patients need to be admitted because of a combination of clinical and social reasons, we initiate the peer-to-peer review."

The University of Pittsburgh Medical Center has been undergoing retrospective audits of hospital records by the Pennsylvania Department of Public Welfare, which oversees the Medicaid program for more than five years. The contract that has been used by the Pennsylvania Department of Public Welfare has been awarded the Medicaid RAC contract in Pennsylvania.

Redman is working with the Pennsylvania Department of Public Welfare state department of welfare to get an idea of what the Medicaid RAC program will be like in her state. "Pennsylvania providers have been exposed to the Medicaid audit process through the state audit program but there are still a lot of details for the Medicaid RAC program that CMS has left up to the individual states," she says.

Lamkin points out that hospitals that have successfully managed the Medicare RAC audits have set up RAC committees to develop ways to prepare for the RACs and handle appeals. You don't have to create a different Medicaid RAC committee, but you need to expand the existing committee to include the RACs, she says.

A computerized process for tracking Medicaid RACs is imperative, Lamkin says. "With the Medicaid RACs, each state can define the records limits, the timing of appeals, and other details of the program. Hospitals have to understand and follow the rules of each state where their patients reside," she says. ■

Medicaid RACs — whole new ballgame

States can create their own rules

Just as hospitals are learning to deal with the Medicare Recovery Audit Contractors (RAC), along comes the Medicaid RAC program with a different set of rules and an expanded focus.

"The Medicaid RACs will have the same mission as the Medicare RACs: to take back inappropriate payments," says **Victoria Choate**, RN, CCM, RN-BC, CCP, CPHQ, vice president of performance excellence and chief quality officer for Cheyenne (WY) Regional Medical Center. "But there are differences in the program and case managers need to be aware of them," Choate adds.

Historically, Medicare RACs have focused on inpatient claims. The difference is that the Medicaid RACs are going to take a broader scope and identify inappropriate payments for outpatient services, home care, durable medical equipment, home health, hospice, and behavioral health, Choate says. "The Medicaid RACs are going to expand their audits to the outpatient arena and hospitals need to make sure that all outpatient procedures are medically appropriately and coded correctly," she says.

When the Medicare RAC program was developed, the Centers for Medicare and Medicaid Services (CMS) issued mandates that apply to all the states, and divided the country into four RAC regions. Not so with the Medicaid RACs. States are allowed to contract with one or more RACs to identify overpayments and underpayments and have a lot of leeway in developing the program.

Elizabeth Lamkin, MHA, chief executive officer and partner in PACE Healthcare Consulting in

Hilton Head Island, SC, says: "Instead of a being a regional RAC with one set of rules that applies to everyone in the country, the Medicaid RACs are state-driven and each state will be able to set its own rules. Hospitals that treat patients from multiple states are going to have multiple sets of rules to follow, which could be a logistical nightmare."

Many hospitals are struggling to get ready because the rules for Medicaid RACs are not necessarily clear and they will vary from state to state, says **Charleeda Redman**, RN, MSN, ACM, executive director of corporate care management for the University of Pittsburgh Medical Center, an integrated care delivery system. "Our facilities have patients who come from New York, West Virginia, and Ohio, as well as Pennsylvania," Redman says. "All the rules are different, and each state has a different appeals process. It's important for facilities to partner with their Medicaid providers to get a better sense of how the RAC program will be deployed in that state and to give them suggestions based on their experiences with the Medicare RACs."

Lamkin suggests that case managers and other hospital officials urge their congressional representatives and senators to develop a more standardized approach for the Medicaid RACs and the proposal to limit Medicaid reimbursement for hospital-acquired conditions. "Unless there is a standardized approach by all states, some providers are going to suffer," she says.

When the Centers for Medicare and Medicaid (CMS) issued the final rule for the Medicaid Recovery Audit Contractor program (RAC), the agency made it clear that it wants the Medicaid RACs to be proactive in turning in cases of potential fraud, Lamkin says. "In the demonstration project, the RACs uncovered $1 billion in improper payments and identified only two cases of potential fraud. CMS has upped the ante for the Medicaid RAC program," she says.

Any pattern of errors could be considered a disregard of the law and the hospital could be turned in for fraud and abuse, Lamkin says. "It could be something as simple as not updating the charge master for two years but if the RAC sees a pattern, they could report it," she says.

The final rule states that organizations can be turned into the Health and Human Services Office of the Inspector General, the U. S. Department of Justice, the Federal Bureau of Investigation, state Medicaid fraud control agencies, and state and federal law enforcement agencies.

Brian Flood, managing director for KPMG, the U.S. audit, tax and advisory firm with headquarters in New York City, adds: "The Medicare RACs don't have any incentives to refer cases to law enforcement because they do not receive contingency fees for those referrals. CMS has told the states to design their programs to ensure that the Medicaid RACs are required to refer cases to state and federal law enforcement agencies."

SOURCES

For more information, contact:

• **Victoria Choate**, RN, CCM, RN-BC, CCP, CPHQ, Vice President of Performance Excellence and Chief Quality Officer, Cheyenne (WY) Regional Medical Center. E-mail: vikki.choate@crmcwy.org.
• **Brian Flood**, Managing Director for KPMG, New York, NY. E-mail: bgflood@kpmg.com.
• **Elizabeth Lamkin**, MHA, Chief Executive Officer and Partner, PACE Healthcare Consulting, Hilton Head, SC. E-mail: Elizabeth.Lamkin@pacehcc.com.
• **Charleeda Redman**, RN, MSN, ACM, Executive Director of Corporate Care Management, University of Pittsburgh Medical Center. E-mail: redmanca@upmc.edu. ■

Improving transitions cuts HF readmissions

Post-acute providers, hospital team up

A series of initiatives by Cooley Dickinson Hospital in Northampton, MA, has improved patients transitions, which has resulted in a 50% reduction in readmissions for heart failure patients.

Key components of the initiatives include forging an alliance with post-acute providers, transition coaching for at-risk patients during the hospital stay and after discharge, and teaching patients to use their personal health record to track their care and list questions for providers, according to **Tammy Cole-Poklewski**, RN, MS, director of quality, patient safety, and care management at the 142-bed facility.

The hospital started its readmission reduction program in 2008 by leading the development of the Hampshire County Continuum of Care, an organization of hospital staff, including case managers, social workers, nurses, and physicians; skilled nursing facility administrators; and representatives from the Visiting Nurse Association and elder services agencies. The organization focuses on improving communication between levels of care. *(For details on how the consortium was organized and what it does, see related article on p. 182.)*

"In the fall of 2010, we realized that we were making improvements in heart failure, but the overall

EXECUTIVE SUMMARY

Cooley Dickinson Hospital in Northampton, MA, has cut heart failure readmissions by 50% by collaborating with post-acute providers and improving patient education.

- Coalition focuses on improved communication as patients transition.
- Transition coaches work with at-risk patients.
- Patients use a personal health record to track their progress.

readmission rate wasn't going down as much as we had hoped," Cole-Poklewski says. The team reviewed the charts of a group of patients who had been readmitted, and determined that the majority were readmitted within 24-48 hours of discharge. A large population of patients readmitted within 24 hours had secondary psychological diagnoses, or were uninsured, underinsured, or homeless, she says.

"We knew that if we didn't address the underserved population, we'd never decrease the readmission rate," Cole-Poklewski says. "We also knew that the readmission reduction techniques we used with the rest of the population wouldn't work with this group because there are so many other things going on in their lives."

The hospital received a grant from the Massachusetts attorney general's office to focus on decreasing emergency department visits and readmissions for the high risk population. The hospital adopted the Care Transitions Intervention model, developed by researchers at the University of Colorado in Boulder, CO, led by **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 in Denver, CO. *(To learn more about the Care Transitions, follow the link in the Resource on p. 182.)* In the model, a transitions coach who is a case manager or a social worker follows the patients for a month after discharge. Trainers from the University of Colorado trained case managers and social workers to become transition coaches.

The hospital determined that the patients who were being readmitted shortly after discharge generally fell into two categories. One group had complex psychosocial needs, were uninsured, homeless, and had a secondary psychiatric diagnosis, and other needs that make them appropriate for coaching by a social worker. The other group of patients had multiple chronic diseases, was discharged on eight or more medications, had limited services at home or refused post-acute services, and had limited social support. In addition to heart failure patients, the second group includes patients with coronary artery disease, chronic obstructive pulmonary disease, diabetes, pneumonia, those who have had a stroke, and those who are being coached by RN case managers.

As part of the assessment process, the hospital case managers screen every patient admitted to the hospital if they have one of the diagnoses covered in the coaching program, to identify those who are eligible for the interventions. The care transition coaches pull up a report each morning, divide the list according to patient needs and set priorities on whom to see first, depending on the number of risk categories determined by the screen.

The coaches talk to the staff on the unit to get more details about the patients, then visit the patients, explain the program, and ask the patient to agree to the coaching process. The social worker coach also determines what community resources the patient may need and starts getting the resources in place.

"One of the biggest pieces was to give patients a personal health record and teach them how to fill it out," Cole-Poklewski says. The 24-page booklet has space for the patients to enter basic health information including names and phone number of providers, hospitalizations, allergies, and medications. It has a place for the patient to enter personal goals and list of questions for providers.

The transition coaches visit the patients within 3-4 days after discharge. They work in conjunction with other clinicians providing post-acute care to the patients. "The transition coaching doesn't replace other services, such as the Visiting Nurse Association visits, or follow-up doctor visits," Cole-Poklewski says. "The coaching supplements any other services the patients may get and helps improve the patient's self-management skills."

During the home visit, the coaches typically focus on use of the personal health record and medication review. The coach doesn't conduct the medication reconciliation, but talks the patient through it. Patients bring in all the medications they are taking, explain to the coach what they are for, and write it in their personal health record.

If the patient is experiencing symptoms or problems, the coach has them write down the symptoms, decide what questions to ask, and coaches the patient through calling the doctor.

"A key to the success of the personal health record is to have the patient or family member fill in the information, rather than having the coach do it," Cole-Poklewski says. "The coach is on hand when they fill it out to help them with the information and to help them identify their healthcare goals."

The overall hospital readmission rate has decreased every month since the program began in February 2011. Three patients enrolled in the program have stayed out of the hospital for more than 30 days after previously being admitted every 2-3 weeks, Cole-Poklewski says.

SOURCE/RESOURCE

For more information contact:

• **Tammy Cole-Poklewski**, RN, MS, Director of Quality, Patient Safety, and Care Management, Cooley Dickinson Hospital, Northhampton, MA. E-mail: tammy_cole-poklewski@cooley-dickinson.org.

• For more information on the Care Transitions Program, see http://www.caretransitions.org. ■

Good communication smoothes transitions

Hospitals and SNF collaborate

By getting feedback from its post-acute providers, Cooley Dickinson Hospital in Northampton, MA, is improving communication between facilities and, as a result, facilitating smoother patient transitions.

The hospital led the development of the Hampshire County Continuum of Care Consortium in 2008 by inviting the lead people at local nursing facilities and the Visiting Nurse Association (VNA) to come to a breakfast and discuss how to work together better. **Tammy Cole-Poklewski**, RN, MS, director of quality, patient safety, and care management at the hospital explains: "Early on, we wanted to make sure the organization wasn't just a committee that met periodically but truly was an effort on the part of all participants to improve the way we work together," she says.

The 25-30 members of the Hampshire County Continuum of Care Consortium include hospital case managers, social workers, nurses, and primary care physicians, nurse practitioners who work in the community, nursing home administrators, representatives from the Visiting Nurse Association and elder service agencies, and retired healthcare professionals. Cole-Poklewski and the executive director of the VNA are co-chairs.

The entire group meets monthly and discusses improving patient care across the continuum. Smaller groups meet weekly and discuss specific activities to improve the transition.

"We started the consortium to improve communication between levels of care. We wanted to know how we were doing as a hospital to ensure a smooth transition and what we could do better," she says.

The first suggestion from the post-acute providers was for the hospital to improve the information provided to the receiving providers when a patient is transferred. A committee of hospital discharge staff and representatives from the nursing facilities and VNA worked together for a month to standardize and streamline the information provided by the hospital.

The biggest complaint the post-acute hospitals and agencies had was inconsistency in the information they were receiving through the hospital's electronic discharge product. "At the time, whichever nurse or social worker was handling the discharge pulled together what they thought the nursing home wanted," Cole-Poklewski says. "There were as many different ways the documents were organized as there were clinicians sending them. The nursing facilities told us that sometimes they didn't know where to begin."

The nursing facilities reported that they wanted the discharge summary, laboratory work, and progress notes in an easy-to-read format and for the information to be the same and in the same order for every patient. "We actually reduced the discharge paperwork from hundreds of pages to 8-10 key documents," Cole-Poklewski says.

The following month, the hospital began looking at how other hospitals facilitate transitions between levels of care and decided to hire a non-clinical support person to handle transmission of the discharge information. "The post-acute agencies loved it," Cole-Poklewski says. "In the past, eight or nine individuals were sending them information. This way they knew that every time, they were going to get the same information in the same place."

The consortium also focused on coordination of care and reducing readmissions for heart failure patients, identifying areas that needed improvement, and developing best practices in communication as heart failure patients transitioned through levels of care. For example, the consortium realized that each level of care was giving patients different materials to educate them about heart failure and how to manage it. The consortium developed a one-page educational sheet on heart failure that providers use across the continuum of care.

As a result of her involvement with the consortium, Cole-Poklewski was one of three healthcare professionals in Massachusetts who was trained as

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CASE MANAGEMENT INSIDER
Case manager to case manager

The full scope of case manager and social workers roles, functions, models, and caseloads

Help to determine maximum caseload

(Editor's note: This is a multi-part series where we will explore the most common roles, functions, models, and caseloads in the hospital case management field.)

By **Toni Cesta**, PhD, RN, FAAN
Senior Vice President
Lutheran Medical Center
Brooklyn, NY

The roles of the case manager and social worker encompass a wide range and scope of responsibilities. Over this multi-part series, we will explore the most common roles, functions, and models in the hospital case management field today. Knowing this information will drive the calculations that help to determine a maximum caseload of patients.

The most common roles assigned to case managers and social workers include the following:

- patient flow — coordination and facilitation of care;
- utilization and resource management;
- denial management;
- variance tracking;
- transitional and discharge planning;
- quality management;
- psychosocial assessments and interventions.

Overriding these roles are The Case Management Society of America (CMSA 2010) Standards of Practice that apply to all roles for which a case manager or social worker might be responsible. *(For information on how to get a free copy, see resource, p.183.)* CMSA introduced the first case management standards of practice in 1995. The standards are intended to provide a foundation of the knowledge and skills that apply to the practice of case management, regardless of the case manager's practice setting or specialty. They apply whether the case manager performs some or all of the roles listed above.

Components of the standards relevant here include the definition of case management, the statement of philosophy, and the guiding principles.

Reviewing the case management literature will uncover a large number of definitions of case management. However, to standardize the specialty field of case management, an all-encompassing definition is critical. In 2009, CMSA approved and published the following definition:

"Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes."

In reviewing this definition, one can see that it applies to the field of case management in a universal manner, regardless of setting or discipline. It outlines the process as well as the outcomes that case managers are responsible for achieving on behalf of their patients or clients. It also provides the framework for the roles and functions as they are applied to specific practice settings along the continuum of care. *(For information on practice settings, see list, p. 184.)*

Your hospital might have its own definition of case management. If so, still be aware of the definition as it appears in your professional organization's standards of practice. It is the foundation upon which your work sits.

Within the "Standards of Practice" is a "Statement of Philosophy." *(To see the statement, go to www.cmsa.org)* This statement is designed to guide you in your practice and provides the framework for the guiding principles of case management practice. *(To view CMSA's guiding principles, see box, p. 184.)*

RESOURCE

www.CMSA.org - Standards of Practice. ■

CMSA 2009 Philosophy Statement

"The underlying premise of case management is based in the fact that, when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, the health care delivery systems and the various reimbursement sources. Case management serves as a means for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation … Case management services are best offered in a climate that allows direct communication between the case manager, the client, and appropriate service personnel, in order to optimize the outcome for all concerned."

SOURCE: CMSA.org. Standards of Practice, 2009. ■

The guiding principles for case management

The Case Management Society of America (CMSA) also provides case managers with a set of guiding principles that help to guide the practice of case management. These guiding principles apply to all roles and functions within the field of case management.

The CMSA (2010) guiding principles are:

- Use a client-centric, collaborative partnership approach.
- Whenever possible, facilitate self-determination and self-care through the tenets of advocacy, shared decision-making, and education.
- Use a comprehensive, holistic approach.
- Practice cultural competence, with awareness and respect for diversity.
- Promote the use of evidence-based care, as available.
- Promote optimal client safety.
- Promote the integration of behavioral change science and principles.
- Link with community resources.
- Assist with navigating the healthcare system to achieve successful care, for example during transitions.
- Pursue professional excellence, and maintain competence in practice.
- Promote quality outcomes and measurement of those outcomes.
- Support and maintain compliance with federal, state, local, organizational, and certification rules and regulations.

What makes guiding principles unique from roles and functions is that they apply to each and every role and function and are not roles and functions themselves.

We can use patient advocacy as an example of this. Advocacy applies to each and every role and function case managers perform, regardless of setting, profession, or caseload. Guiding principles transcend all of this. If you are working on a patient's discharge plan, you will use the guiding principles of advocacy. If you are coordinating care, you will use the same principle. You will advocate for the patient during each step or function of the case management process. ■

Practice settings for case management

Case management practice takes place across the continuum of care, but also takes place in the payer setting, government, and employer settings as well.

The following is a list of the practice settings in which case management takes place today:

- acute care including medical, surgical and behavioral health;
- sub-acute medical care;
- sub-acute rehabilitation;
- acute rehabilitation;
- long-term acute care;
- skilled nursing facilities;
- ambulatory settings including outpatient clinics and community-based organizations;
- employer settings;
- government insurance programs including Medicare and Medicaid;
- third party commercial payers;
- workers' compensation;
- disability management;
- independent case management companies;
- home health;
- hospice care;
- physician and medical group practices;
- disease management programs;
- assisted living, adult day, group, and adult homes. ■

The role of the CM and social worker

The roles of the case manager and social worker are standard regardless of the setting in which they are practiced. Case managers and social workers might perform one, or a combination of these roles. This concept will be discussed later when models are explored.

The definition of a role is an abstract one. In the context of case management, it refers to the set of key categories that we perform. The key roles performed in case management are applied differently in different settings across the healthcare continuum, but they provide a framework for the position we have as members of the healthcare team. When we are asked what it is that we "do," we should respond with the list of roles that we perform. These higher-level categories provide the context within which we work.

Role 1: Patient flow: coordination, facilitation of care

Patient flow has to do with the management of all the patient care processes that support patients as they transition through the continuum of care. In the hospital setting, case managers perform this role through the coordination and facilitation of the patient's tests, treatments, procedures, consults, and other care interventions. The purpose of this role is to optimize each day that the patient is in the acute care setting, including evenings and weekends.

Coordination of care includes the arrangement of care interventions that the patient will require so that they occur in the proper sequence. Facilitation of care includes the interventions necessary to ensure that those care processes occur in a timely manner and without delay.

The goals of patient flow/coordination and facilitation of care:

— the plan of care is expedited and barriers to efficient throughput are identified and corrected;

— the patient is provided for in a timely manner;

— that the patient moves smoothly through the acute continuum of care;

— that each hospital day is optimized.

The management of patient flow is the principle and most important role that the hospital case manager performs. All other roles stem from this role.

Role two: Utilization, resource management

Utilization review (UR) was possibly the first role assumed by hospital case managers.

Called utilization reviewers (or UR nurses), this role included a chart review process that was performed in isolation from the rest of the interdisciplinary care team. The role was seen as an antagonistic one because the UR nurse essentially policed the chart, looking for delays in care activities that might need to be corrected. Unfortunately, because the UR nurse was not seen as a part of the team, this role often caused conflict between the UR nurse, the physician, and other care team members.

One of the first strategies in the design of acute care case management models was the incorporation of the role of utilization review into the role of the case manager. Taking this role one step further, the case manager reviews the resources applied to the patient and ensures that they are appropriate to the level of care being provided. The two fundamental functions of this process include a review of services to ensure that they are medically necessary and reasonable and that they are provided in the most appropriate setting.

Through the role of utilization management, the case manager intervenes when the care interventions do not meet the level of care being provided or when a correction to a delay in patient flow is identified. At this point, we can begin to see how the roles interface with each other. Utilization management and patient flow correlate directly with each other.

Case managers also must ensure that resources are being used appropriately in the care of their patients. This role includes the overutilization as well as the underutilization of resources applied to the direct care of patients. Among these is the use of pharmacy, radiology, and laboratory resources. Case managers must ensure that these resources are used appropriately and in a timely manner in the care of the acute patient.

Role 3: Denial management

Denial management is defined as the process of monitoring and managing the third-party payer reimbursement from pre-admission to post-discharge, including pre-authorizations, billing, and appeals management.

This role interfaces with the finance department and is most effective when the department of case management and the department of finance work

collaboratively. Key functions for the case manager include ensuring that the clinical information available in the medical record is accurate and reflects the care rendered to the patient; ensuring that this information is provided, when necessary, to a third-party payer in a timely manner and based on nationally established guidelines; and ensuring that the patient is transitioned to the next level of care as quickly as possible once the patient no longer meets the clinical criteria for the current level of care.

Now we begin to see how our third role, denial management, interfaces with patient flow and utilization management. To carry out the role of denial management effectively, case managers must work closely with the precertification staff at the front end, or beginning of the process, as well as the billing staff at the back-end of the process.

When a denial cannot be avoided, the case management department might be responsible for appealing the denial received from a third-party payer. In the appeal, a case must be made for why the hospital believes that the care provided should be reimbursed. The appeals staff might complete appeals, or this function might be outsourced to a vendor.

In an era of recovery audit contractors (RACs), the appeals process is critical. Many RAC denials potentially can be overturned if the hospital has a strong appeal process in place. Of course, the best defense is always a good offense, and so the prevention of the denial in the first place is always the first goal.

Role 4: Variance tracking

Also known as avoidable days or avoidable delays, variances are defined as the causes of delays in patient throughput, care delivery, or discharge. They might not result in an increased length of stay, but they might represent delays in service and have negative affects on the quality of care.

Case managers perform the role of variance tracking while coordinating the patient's plan of care and while performing utilization management. The goals of variance tracking include the identification of important single events, undesirable variation from established levels, and patterns or trends that vary undesirably from expected outcomes.

Variance data can be collected in a spreadsheet or in a case management software program. The data should be analyzed on a monthly basis and be used to establish a foundation for quality improvement activities. As the variance is identified by the case manager, it also must be placed into a database. *(For more in depth explanation of the categories, see list, at right.)*

Variance categories for typical CM

Categorizing the types of variances is helpful in interpreting them, cataloging them, and correcting patterns over time.

The case manager's role in this process is to work with the interdisciplinary care team to identify, manage, and correct these issues where possible. Not all variances are immediately correctable, but even the ones that are not are important to identify and collect, as the data might lead to opportunities for improvement.

At the very least, the data can help explain why a patient's stay was extended or help identify patterns or trends that might lead to other opportunities for improvement.

• **Internal systems: Issues attributed to the internal delivery systems of the hospital.** Examples include:
— delays in stress testing;
— telemetry bed availability;
— operating room booking delays.

• **External systems: Issues attributed to the patient, either due to his or her clinical condition or other issues.** Examples include:
— bed availability in a continuing care facility;
— home care service availability;
— transportation delays.

• **Patient: Issues attributed to the patient, due to their clinical condition or other issues.** Examples include:
— delays in decision-making;
— change in condition requiring extension of the hospital stay;
— financial issues delaying discharge.

• **Family: Issues attributed to the family.** Examples include:
— decision-making delays;
— lack of cooperation in discharge planning activities, such as selection of a nursing home.

• **Provider: Issues associated with the providers of care to the patient.** Examples include:
— errors of omission or commission;
— lack of communication;
— delays in discharge.

• **Payer: Issues or delays attributed to the third-party payer.** Examples include:
— authorization delays;
— delays in obtaining preferred provider services;
— delays in processing forms. ■

continued from p. 182

an improvement advisor for Massachusetts's State Action on Avoidable Readmission (STAAR) project that focuses on improving transitions among levels of care. STAAR is a collaborative project between the Institute for Healthcare Improvement (IHI) and the Commonwealth Fund.

"The STAAR initiative builds on what we already were doing and has helped us continue to improve the services for our patients as they go from one level of care to the next," Cole-Poklewski says. ■

Heart failure rates cut after initiative

Education, follow-up are keys

After Charleston (WV) Area Medical Center began a readmission reduction program, readmission rates for a group of targeted heart failure patients was reduced by 50%.

The reductions are directly tied to better educating the patients while they are in the hospital, ensuring that they have a timely follow-up visit with a primary care physician, calling them after discharge to make sure they understand and are following their discharge plan, and improving transitions to post-acute providers, says **Dale Wood**, MBA, MHA, vice president and chief quality officer for the 838-bed tertiary care hospital. The program is focusing on heart failure patients, but the hospital plans to expand the initiative to include patients hospitalized with pneumonia and acute myocardial infarction, he adds.

"We knew that patients needed to see primary care physicians shortly after discharge and that heart failure patients needed to understand their medication regimen and the importance of weighing themselves daily. We assembled a multidisciplinary team to focus team on what we needed to change in order to prevent patients from coming back to the hospital," Wood says. *(For a look at what the team did, see related article on p. 188.)*

At Charleston Area Medical Center, case managers are assigned by unit and are paired with a social worker. They handle utilization review, discharge planning, and care coordination. When patients are readmitted, a case manager interviews them and reviews the chart to determine why they were readmitted. The case managers determined that many patients were coming back because of poor support at home, says **Leigh Ann Stone**, ADN, MHA, director for case management. "We found that the education needed to be beefed up while the patients were in the hospital," Stone says. "We needed to get a referral for home health services for appropriate patients so they would have more support after discharge and to better educate the family as well."

Early in the stay, case managers determine if patients have a primary care physician, and help those without a medical home identify a physician. Whenever possible, the case managers call primary care physician offices to set up post-discharge appointments before patients leave the hospital. When patients don't have a primary care provider or can't get a timely appointment, the case managers arrange an appointment at a special heart failure clinic the hospital set up at one of its urgent care facilities. "The clinic has a separate entrance and is open one day a week for follow-up care," Wood says.

The medical director for the hospitalist team and other physicians on the steering committee contacted all of the primary care physicians in the community to find out what information they need from the hospital to provide follow up care for patients. The Partners in Health team contacted providers and critical access hospitals throughout the state to ensure that patients get the follow-up and support they need when they return to their home communities.

The team implemented a computerized system to call heart failure patients after discharge and ask a series of questions. The nurses tell the patients to expect a call and tell them what will show up on caller ID to make sure they'll answer the phone. About 80% of patients who are called answer the questions.

Based on their answers, a hospitalist or nurse is alerted and calls the patient, gets more information and determines whether the medication can be adjusted, or if the patient needs to visit his or her doctor, or come to the emergency department.

Wood says, "We know that heart failure patients are likely to be readmitted but this program helps them stay healthy longer. We're also freeing up hos-

EXECUTIVE SUMMARY

Charleston (WV) Area Medical Center cut readmissions for targeted heart failure patients by 50% in just a few months.

- A multidisciplinary team designed the program.
- A subcommittee revised and simplified discharge materials.
- CMs make follow-up appointments while patients are in hospital.

pital beds for other patients and saving money for patients and the insurance companies."

SOURCE

For more information contact:

• **Dale Wood**, MBA, MHA, Vice President and Chief Quality Officer, Charleston Area Medical Center, Charleston, WV. E-mail: dale.wood@camc.org. ■

Hospital-wide team revamped processes

Before Charleston (WV) Area Medical Center started its initiative to reduce readmissions, the executive team appointed a multidisciplinary steering committee to review the elements of successful readmission reduction programs throughout the country. The committee set up subcommittees to focus on how to adapt each component to meet the specific needs of the hospital.

The committee included **Leigh Ann Stone**, ADN, MHA, director for case management, the physician advisor for case management, the medical director for the hospitalist team, the manager of the hospital's urgent care clinic, the clinical director of the medical service line, and the medical director for the hospital's Partners in Health program, a collaboration of representatives from other hospitals from across the state that transfer patients to Charleston Area Medical Center for treatment and federally qualified health centers in communities throughout West Virginia. Two master black belts from the hospital's Six Sigma department served on the steering committee to help facilitate projects.

An education subcommittee which included representatives from case management, social work, and nursing, reviewed the thick packets of educational material the hospital was giving to patients and concluded that the material was so lengthy that few patients were likely to read it all the way through. In additional to simplifying the patient education material, the subcommittee created a one-page, color-coded educational sheet that patients can place on their refrigerator or bathroom mirror. Based on the Heart Failure Zones concept, it tells patients what they should do every day to manage their condition and instructs them on what to do when they have certain symptoms.

Another subcommittee looked at improving transitions across the continuum. Stone and the physician advisor for case management set up a meeting with skilled nursing facility representatives to discuss ways to work together to provide better care. Based on their input, the hospital subcommittee worked on changing the order sets to better facilitate patient care, Stone says. For example, the facilities wanted more specific information on how long patients needed to be on certain medications.

"The skilled nursing facilities told us that they were not always getting information when a patient is transferred. We have worked on getting the discharge notes and specialty dictation sent in a timely manner," Stone says. ■

ACO final rule cuts provider burden

Quality measures reduced from 65 to 33

In response to comments from healthcare professionals, the Centers for Medicare and Medicaid Services (CMS) made significant changes to the final rule for the creation of accountable care organizations (ACOs), which encourage providers to better coordinate care across all settings.

ACOs are intended to encourage providers of services and supplies to better coordinate care for Medicare patients by rewarding the ACOs that lower healthcare costs and meet quality standards. Participants in an ACO might include group practices, networks of practices, partnerships between hospitals and practices, or hospitals employing physicians. The organization shares savings by better coordinating patient care, providing high quality care, and using healthcare dollars wisely.

The final rule makes changes in the way participants will be rewarded for better coordinating care and extends the deadline for applying to become an ACO through the end of 2012.

When CMS announced its proposed rule for ACOs, many healthcare organizations and industry trade associations expressed disappointment, arguing that the burdens were too high and the potential return too low.

"We commend CMS for listening to the concerns of America's hospitals. The hospital field is actively working on ways to improve care

EXECUTIVE SUMMARY

The Centers for Medicare and Medicaid Services (CMS) made significant changes in the final rule for creating accountable care organizations (ACOs) to coordinate care across healthcare settings.
- CMS made changes in how ACOs will share savings based on input from the industry.
- ACOs are one way the healthcare field is recognizing the value of care coordination.
- The number of quality measures on which ACOs report has been reduced from 65 to 33.

delivery and the final accountable care organization rule provides hospitals a better path to do so," says **Rich Umbdenstock**, president and chief executive officer of the American Hospital Association, with headquarters in Chicago.

ACOs mean opportunities for case managers as providers coordinate care across healthcare settings, says **Joanna Malcolm**, RN, CCM, BSN, consulting manager, clinical advisory services for Pershing, Yoakley & Associates in Atlanta. "Case managers are now being recognized as important players in the healthcare field. We are able to affect both the financial and the clinical side of patient care and see the big picture as patients move through the continuum of care," Malcolm says.

Case managers will become the glue that hold ACOs together and make them work, by making sure that the patients clinical needs are being met in a timely manner while keeping the financial piece in mind, she adds. "Improving transitions as patients move from one level of care to another is essential in an accountable care organization and this is where case managers have expertise," she says. *(For more about the role of case managers in ACOs, see, "Move to accountable care puts case management in the spotlight,"* Hospital Case Management*, September 2011, p. 129.)*

In addition to making changes to the Medicare Shared Savings Program to make it more appealing to providers, the final rule reduces the number of quality measures to be reported from 33 to 65. *(To view the 33 measures, see resources on right)* Under the final rule, providers will report quality measures in four domains: patient experience; care coordination and patient safety; preventive health; and caring for at-risk populations.

Participants in an ACO continue to receive payments under Medicare fee-for-services but will share in savings if they meet quality and performance standards. CMS will aggregate an ACO's spending across all individuals and compare it to the national healthcare spending trend. The higher quality of care the providers deliver and the greater effectiveness of their care coordination, the more savings they share.

RESOURCES/SOURCES

- To read the final rule, see: http://www.ofr.gov/OFRUpload/OFRData/2011-27461_PI.pdf.

A list of quality measures is on pages 324-326.

For more information contact:
- **Joanna Malcolm**, RN, CCM, BSN, Senior Consultant, Pershing, Yoakley & Associates, Atlanta. E-mail: JMalcolm@pyapc.com. ■

AMBULATORY CARE
QUARTERLY

Staff can determine shorter wait times

Volunteer team weeds out inefficiencies

When it's typical for patients to wait four hours or more to see an emergency physician, and your leave-without-being-seen (LWBS) rate is pushing 10%, you know it's time to rethink the whole process. And these were the grim realities facing the emergency department (ED) at Baylor Medical Center in Garland, TX, as recently as two years ago, explains **Steve Arze**, MD, the medical director of the ED.

"We had hit the point where our waiting times had just become too long to be safe," he says. "While there are certainly places in the nation where the wait times are longer, we were not in a place that we felt was appropriate for our patients."

Taking a closer look at the problem, administrators quickly realized the issue was hardly inadequate staffing levels. "As patients would pile up in our waiting room, there were doctors who were not seeing patients and nurses who were not seeing patients," says Arze. Instead, what was gumming up the process was a triage plan that was packed with too many unnecessary steps. "There is no reason to wait to see a triage nurse, for instance, if there are plenty of beds open in the area where patients need to go," adds Arze.

The ED managers could have re-engineered the process themselves but, instead, they handed the problem to a cross-section of ED staff who volunteered to put the patient-flow process under a microscope and identify inefficiencies, explains **Brennan Bryant**, RN, MSN, MSHCAD, the hospital's director of emergency services.

"They developed solutions to the bottlenecks," says Bryant, and the results have been stunning. The average length-of-stay (LOS) for patients discharged from the ED has decreased by 36 minutes, and the average LOS for admitted patients has decreased by 91 minutes. "In essence, we have added 11 beds without really changing anything other than the process flow through the ED," adds Bryant. "It's phenomenal." *(For more about productivity and other solutions, see related story, p. 191.)*

Take a team approach

To get the volunteer team started, management collected detailed time metrics on every portion of the patient-flow process from arrival to triage to the total LOS, explains Bryant. "We mined that data and presented it to them so they could basically brainstorm around what [changes] they felt would deliver the most bang for their buck," he says.

The team pored over the data and came up with 33 processes and efficiencies that could be improved; then the challenge was to whittle that list down to a workable group of changes based on frequency of occurrence and the impact on overall LOS, adds Bryant.

For example, the group streamlined the triage process so that patients are now asked a minimal number of questions — just enough to ensure that they proceed to the most appropriate area for care, which is either a location designated for lower acuity complaints or the main ED, explains Arze. "A full triage, including extensive histories about what happened to the patient, why they are there, what type of medicines they are on, and who their physicians are — all of that can be done later and does not need to be obtained before the patients are connected with a physician," he says. "The triage really becomes a quick screen to determine what area the patient needs to go to, and then a primary nurse gets the remainder of the information about that patient at a later point." *(For more information on how to handle lower acuity patients, see related story, at right.)*

Another change to the process is that physicians no longer have to wait until a chart is generated by a nurse before they see the patient, says Arze. "We have a team approach in that either of them can go on independently to see the patient."

If the physician sees the patient first, he or she will go ahead and take the history and issue orders without waiting for the nurse. This enables the team to see several people at a time rather than waiting for each patient to come through the process in a sequential manner, explains Arze. ■

Let low-acuity patients travel solo

Emergency Department (ED) managers at Baylor Medical Center in Garland, TX, are exploring different processes to lower their leave without being seen (LWBS) rates. Looking beyond triage, the center started a volunteer team to identify inefficiencies that could lead to patience having to LWBS. The volunteers realized that efficiencies could be gained by enabling lower-acuity patients to travel from one point of care to the next on their own rather than being escorted by staff.

To facilitate this "standard conveyance" model, the staff developed signage on the walls and floors so that patients could be easily directed to the right place, explains **Brennan Bryant**, RN, MSN, MSHCAD, director of emergency services at the center. "For patients headed to radiology, for example, we have these little bones on the floors. The patients are taken to where the bones start, and then they are told to follow the bones down the hall, turn to the right, and have a seat in the chairs where someone from radiology will pick them up," says Bryant.

A computerized tracking system lets ED staff know where patients are throughout their ED stay, adds Bryant. There are more than 40 computer monitors in the ED so that a monitor is available about every 10 feet to let staff see where a patient is on his or her journey, he explains. "They can see whether labs have been ordered, drawn, or returned, and the same thing for radiology and other procedures," adds Bryant.

Some job responsibilities have been realigned as well. For example, in the past, the charge nurse would typically take care of some of the sickest patients and assist staff when they became overloaded, says Bryant. "The team found that we had lost that high-level vision of what is going on in the whole ED ... so they rewrote the job description of the charge nurse to pull [this person] out of direct patient care and put him or her back where the position needs to be, which is as kind of the traffic cop of the ED," he says. "That has worked very well."

The volunteer team also observed that roughly 46% of the ED's volume was being handled in seven rooms that make up the rapid medical evaluation area, but these rooms were under-staffed, so they adjusted the staffing matrix to better support this area, says Bryant. However, as they addressed staffing for the lower-acuity patients, they found that this change also lessened LOS times for the more acute patients. "For patients admitted to the hospital, LOS in the ED was decreased by 91 minutes," adds Bryant.

Much of this improvement can be explained by the snowball effect that having success can create, suggests Bryant. "Once the team started to see results from the process changes that they had envisioned, it became kind of a self-fulfilling process," he says. "Success breeds success, and when the turnaround times began to rapidly go down, everybody realized that working together as a cohesive unit and actually bringing the patient into the care team really helps to effect change." ■

Look for productivity boost to empower staff

At Baylor Medical Center in Garland, TX, medical director **Steve Arze**, MD, ED, spearheaded an initiative to lower leave without being seen (LWBS) rates at the center. Any type of change is likely to prompt questions or even skepticism when people are used to doing things a particular way, but Arze emphasizes that in this case, there wasn't much grumbling.

"On the physician side, we were able to increase the number of shifts that we had because our productivity increased so much," says Arze, noting that the revenue to pay for these shifts came from capturing paying patients who previously left without being seen (LWBS). The LWBS rate has dropped from 10% to 2% since the improvement process began, adds Arze.

The improvements are also evident in the brand new ED that the hospital constructed about six months after the improvement process began. "We now use less space than we used to in our old ED to see the same number of patients," says Arze. "It's just purely because of the improvements in efficiency that we have achieved. Patients don't linger in our beds for a long time because we are able to move them through quickly. That has enabled us to essentially reduce the number of beds that we have to have operational at any one time."

If you want to see substantial improvement in one or more of your ED metrics, consider turning the task over to the people who actually do the work, advises **Brennan Bryant**, RN, MSN, MSHCAD, the director of emergency services at Baylor. "The most important thing is for the leadership team to put aside preconceived notions of what will work, and really trust in the bedside staff," he says. "The people who do the work day-by-day have the solutions, but often times they haven't been empowered to enact them."

While it is critical to loosen your control over the process, you do need to continually check with staff for progress reports as they are working on projects, and you need to celebrate their wins, Bryant emphasizes. "However, resist the urge to micro-manage or steer the boat in the direction you think it should go," he says.

Bryant contends this type of staff-driven approach fueled dramatic decreases in wait times and the LWBS rate in the ED at Baylor.

"I think that is why our [improvement] efforts have been so successful and why they will continue to be successful," he says. "They are staff-driven, not leadership-mandated."

SOURCES

• **Steve Arze**, MD, ED Medical Director, Baylor Medical Center at Garland, Garland, TX. Phone: (972) 487-5000.
• **Brennan Bryant**, RN, MSN, MSHCAD, Director, Emergency Services, Baylor Medical Center. E-mail: brennan.bryant@baylorhealth.edu. ■

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

■ How surgical CMs can improve compliance

■ Differentiating between inpatient and observation

■ Tips for delivering IMs from Medicare

■ How your peers are reducing readmissions

CNE QUESTIONS

1. When is the new Medicaid Recovery Audit Contractor (RAC) program going into effect?
   A. Jan. 1, 2012
   B. April 1, 2012
   C. July 1, 2012
   D. Oct. 1, 2012

2. True or False: If your hospital treats patients from more than one state, you may be dealing with more than one Medicaid RAC.
   A. True
   B. False

3. When Cooley Dickson Hospital convened a meeting with post-acute providers, what was the biggest complaint they heard?
   A. Not enough referrals from the hospital.
   B. Inconsistent information when patients were being transferred.
   C. Too many patients with poor insurance.
   D. Patients were transferred late in the day.

4. Case managers at Charleston (WV) Area Medical Center review readmitted patients to determine the reason why. What is the main reason that patients came back to the hospital?
   A. Poor support at home.
   B. Lack of a primary care physician.
   C. Inability to afford medication.
   D. All of the above

CNE instructions

Nurses participate in this continuing education program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
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