HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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IN THIS ISSUE

■ **Readmission reduction:** Case managers can help hospitals avoid penalties .....cover

■ **Discharge planning:** A proactive approach to preventing readmissions 120

■ **Post-acute care:** Choose settings carefully.....121

■ **Managing care transitions:** Study suggests care transition managers can help prevent readmissions 122

■ **Nurse transitionists:** Program helps reduce readmissions from skilled nursing facilities.....128

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Readmission reduction takes center stage

Help your hospital avoid penalties

The stakes are rising in the Centers for Medicare & Medicaid Services' readmission reduction program, making it important for hospitals to ensure a safe discharge and prevent patients from coming back.

Beginning October 1, penalties for excess readmissions will increase to up to 2% for hospitals that have the most readmissions within 30 days of discharge. The penalty will top out at 3% in fiscal 2015. In the first years of the program, 67% of all hospitals began losing reimbursement for having more readmissions than their peers for heart failure, acute myocardial infarction, and pneumonia. CMS has proposed adding two more measures beginning in fiscal 2014 — readmissions for hip and knee arthroplasty and chronic obstructive pulmonary disease (COPD), which applies to patients with a primary diagnosis, or acute respiratory failure as a principal diagnosis with a secondary diagnosis of COPD.

CMS's attention to readmissions and the discharge process underscores what case managers have been saying for years: that hospital

EXECUTIVE SUMMARY

As penalties for excess readmissions rise and more diagnoses are included in the program, case managers can play a major role in helping their hospitals avoid penalties.

- Take the time to complete a thorough assessment of patients and talk to their family members and caregivers to uncover psychosocial issues as well as medical issues and use the information to develop the discharge plan.
- Collaborate with post-acute providers to ensure that patients receive the services they need after discharge.
- When patients are readmitted, conduct a root-cause analysis to determine why they came back, track the data, and use it to develop process improvement projects.

case management can make a difference in the bottom line, says **Peggy Rossi**, BSN, MPA, CCM, a retired hospital case management director who now is a consultant for the Center for Case Management.

"Hospitals are finally realizing how important case management is. For years, they've seen us only as a product they have to give because of the Medicare Conditions of Participation as opposed to a revenue-producing unit. Now hospitals are saying that case managers may be their method of survival but healthcare is moving so rapidly that case management can't catch up," Rossi says.

The healthcare arena has changed since the early 1990s, when **Teresa C. Fugate**, RN, BBA, CCM, CPHQ, a case management consultant based in Knoxville, TN, was ordered to discontinue a readmission reduction program at the hospital where she worked at the time.

"The program was preventing about 20 readmissions a week and at the time, that was considered to be a bad thing. Now the payment structure is catching up with what case management has been trying to achieve all along," she says.

Preventing readmissions not only helps hospitals do well in CMS' readmission prevention and value-based purchasing programs — it allows hospitals to utilize resources for other patients, Fugate says.

Patients who are readmitted are likely to give hospitals lower patient satisfaction scores than those who have a successful discharge, she points out. From a quality standpoint, patients are at greater risk of falls, medication errors, and infections when they are in the hospital, she says.

"It's better for the patient and for the hospital to avoid unnecessary readmissions. CMS is putting a huge emphasis on discharge planning and reducing readmissions for just this reason," she adds.

Patients move so fast through the continuum that case managers don't have the time to do everything they should do to prevent readmissions, Rossi says.

"Patients come in when they are in crisis and are treated, stabilized, and discharged, often in just three days. Case managers must start early in the stay to ensure that the continuum of care is there to provide for patient needs after discharge," says **Cindy Reilly**, RN, BSN, vice president of quality and patient safety at Marlborough (MA) Hospital, part of UMass Memorial Healthcare. Reilly served on a multidisciplinary expert panel assembled by the state of Massachusetts to look at readmissions and what clinicians can do to prevent them.

In many hospitals, case managers have unrealistic caseloads and too many roles so they can't perform all of them well, Rossi points out. For

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instance, many case managers have a caseload of 25 patients and have to do utilization review every day to make sure patients meet continued stay criteria. At 15 minutes a patient, utilization review would take five hours, leaving only three hours to complete all their other tasks, Rossi adds.

Many case managers are tasked with utilization management as well as care coordination and discharge planning, she says. In some hospitals, social workers often have the dual role of discharge planning and dealing with psychosocial issues.

Rossi advises case management directors to educate the hospital administration on the changing Medicare requirements, the patient population being served, the hospital's readmission rate and what's bringing patients back. Ask that the department be staffed accordingly, keeping in mind that case managers need a minimum of 30 minutes to complete an assessment even on an uncomplicated discharge. For complex patients, the assessment querying needed can often take an hour or more.

Penalties are increasing, but they may not be high enough yet for hospital executives to see the benefit of adding the necessary staff for a readmission prevention program, Fugate says. As CMS adds DRGs and increases the penalties, hospitals may start losing enough revenue to make a readmission reduction program more cost-effective, she says.

"Readmissions can be a vicious cycle. Patients are treated, stabilized and discharged, but once they get home, they begin to decompensate and are readmitted and treated again with nobody looking at the first discharge plan to determine what went wrong," Reilly says.

When patients are admitted, do a mini root-cause analysis to determine what happened after discharge, Reilly suggests. Find out if patients had everything they needed at home or what happened at the skilled nursing facility that caused the patient to bounce back. "Look at what you are doing during the current stay to enhance patient stabilization so patients can return as much as possible to their previous status," she says.

The medical factors behind readmission have been the primary focus in the healthcare system, but that needs to change, adds **Anne Meara**, RN, MBA, associate vice president for Network Care Management at Montefiore Medical Center in Bronx, NY. "We need to look beyond the medical issues and find out about other factors that could result in the patient coming back. We need to delve deeply into other reasons for readmissions, such as housing, finances, transportation, and the ability to obtain medication and food," Meara says.

"There are many variables that contribute to readmissions. We might not be able to prevent all readmissions, but we can do a full assessment to get a realistic idea of patients and living situations, educate the family, make sure that patients understand their treatment plan, and that they can afford their co-pays and any other out-of-pocket expenses," Reilly adds.

Since the majority of unplanned readmissions start in the emergency department, that's where case managers should start the assessment, Reilly suggests. Start assessing their needs and find out what they see as their discharge destination. The emergency department often is the best place to get information from family members since they may work and visit the patient in the evenings, when case managers are not on duty, Reilly says.

Case managers should sit down with patients and find out the full picture, Meara says. For instance, instead of just asking if the patient has a caregiver and checking off a box, ask where the caregiver resides. It might be in another state.

Spend time talking to patients and family members about the costs of healthcare they may incur once they leave the hospital, or even when they're still in the hospital, Rossi says. "Talking about finances is the most valuable part of an assessment. We tend to think that because patients have insurance, the cost of care is covered. Case managers need to look at the specific things that are covered by the policy and how the patient is going to pay for them," she says. For instance, after the Medicare benefits for a skilled nursing stay are exhausted, can the patient afford the daily rate? What are the limits of home health services, and is the patient likely to need more than his or her policy covers?

It's not always the clinical situation that brings patients back to the hospital, Meara points out. "We can do everything right in the hospital but if the patient's life circumstances interfere with the ability to follow the treatment plan, it's likely to result in a readmission," Meara says.

Case managers need to assess patients for their health literacy to make sure they understand their treatment plan, Rossi says.

Understanding patients' perception of their healthcare and ability to manage after discharge

is an important part of developing a successful discharge plan, Reilly says. Ask patients how they felt at home and how they feel now. Find out about their social setting and the support they have at home, she says.

"Massachusetts is very lucky to have a lot of resources for patients after discharge, such as Meals on Wheels, the Visiting Nurse Association, and other agencies that provide assistance to patients. Somebody has to have a conversation with patients and find out that these services are needed," Reilly says.

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A proactive approach to preventing readmissions

Education, follow-up are the keys to success

If you wait until the day of discharge and spend 15 minutes explaining the discharge plan and educating patients on what they should do at home, your discharge plan may not be very successful.

"Most adults retain only 20% of what they are told, and if their only education is right before discharge, they don't learn much. People are being readmitted because they don't understand the importance of a follow-up appointment or how they should take their medication," says **Teresa C. Fugate**, RN, BBA, CCM, CPHQ, a case management consultant based in Knoxville, TN.

The patient population is more complex and challenging than ever before, and lengths of stays are shorter than ever. Patients often are overwhelmed by all the discharge information they receive, adds **Cindy Reilly**, RN, BSN, vice president of quality and patient safety at Marlborough (MA) Hospital, part of UMass Memorial Healthcare.

Reilly recommends that case managers start patient and family education early in the stay. "Forget teaching on Day 1. It's not effective to try to educate patients when they are in crisis. However, you cannot wait until they are stabilized because that's discharge day," she says.

At one hospital where she worked, Fugate created a disease-specific educational program for the top DRGs and produced folders, color-coded by DRG, that were placed in patient rooms. The folders outlined three or four goals for each diagnosis and included a script that clinicians could follow. For instance, for heart failure, the topics included signs and symptoms, weight monitoring, and medication. The information also was placed on a whiteboard on the wall.

Every clinician—physicians, dieticians, case managers, therapists, and nurses on all shifts—had a conversation with patients on an educational topic and documented what they covered every time they entered the patient room. The night shift clinicians didn't talk to the patients at 2 a.m., but they did conduct the education as long as the patient was awake.

"It's more important for the staff to talk about how to care for themselves instead of talking about last weekend's football game or the NASCAR race on TV. Patients might prefer to talk about what's on television, but that's not why the patient is in the hospital. The goal is to make sure patients can take care of themselves at home," she says.

Bedside shift reports offers another opportunity for the nurse to repeat the discharge teaching, she says.

"Patients may get tired of hearing it over and over, but when they get home, they'll be grateful that they learned how to take care of themselves," she says.

Make the follow-up appointments when the patient is still in the hospital, she suggests. "When the patient calls, it may take 30 days to get an appointment, but a case manager may be able to get them in to see a physician in two days after discharge," she says.

Talk to family members several days before discharge to find out a good date for a follow-up physician visit within three or four days of discharge, Reilly adds. "We involved the family because they are likely to be providing transportation. It doesn't do much good to make an appointment with a physician if the patient can't get there," Reilly says.

Since many Medicare patients are taking five or more drugs, set up a pharmacy consultation to make sure patients are on the right drugs and the right dosage and to educate patients and

family members on how to take their medication, says **Peggy Rossi**, BSN, MPA, CCM, a retired hospital case management director who now is a consultant for the Center for Case Management. In addition, double-check that they can afford the medications and that they have transportation to get the prescriptions filled.

Multidisciplinary rounds are an important part of preventing readmissions, Rossi says. Use the opportunity to talk to the nurses and to educate physicians on patients' living situations and alert them when you don't think the patient can be safely discharged, Rossi says. Learn to say "no" when you feel the patient cannot be safely discharged, she adds.

Consider home evaluations for at-risk patients, Fugate suggests. Some patients may meet criteria for a home care evaluation. If not, consider sending a staff member into the home to assess the home for safety issues and to check the refrigerator and cabinets for high-sodium or high-sugar foods, depending on the patient's diagnosis.

It may not be practical to send a staff member to a rural area to check on patients, she adds, but as penalties increase, it may be a good return on investment, she says.

Follow-up calls are a good way to reinforce the discharge plan and let patients know that somebody cares, Fugate says. "If nobody checks on them, they may interpret it that following their plan of care isn't important. If they know somebody is going to call in a week to check on their weight or whether they've seen their doctor, they're more likely to adhere to the plan," she says.

At Covenant Health System in Knoxville, TN, where Fugate was vice president for case management services until August 2013, case managers make post-discharge phone calls two days after discharge, a week after that and a week later and ask open-ended questions about the patient's understanding of the treatment plan, medication regimen, and follow-up appointments. They continue to make the follow-up calls as long as needed.

"Open-ended questions are very important, because if patients can answer 'yes' or 'no,' they don't go into the details of what is really happening," she says.

Fugate recommends developing scripting so the phone calls are consistent. Collect information during the phone calls and use the data to make improvements. For instance, track how many patients went to their follow-up calls on the day that hospital staff set up.

Marlborough (MA) Hospital has developed a process to make a recorded call to every patient within 72 hours of discharge. The recording asks a series of questions that patients answer by pushing buttons on the telephone. If there are questions or concerns, the call is transferred to a clerical employee who refers the callers to a clinician if appropriate.

"Patients need to ask questions, but clinicians are so busy that they may be hesitant. Case managers help the patient and family members feel empowered," she says. ■

Choose post-acute settings carefully

Involve patient, family in options

Historically, clinicians have always done *for* the patient and not *with* the patient, a practice that has to change in order to ensure a safe discharge and prevent readmissions, says **Cindy Reilly**, RN, BSN, vice president of quality and patient safety at Marlborough (MA) Hospital, part of UMass Memorial Healthcare.

"Case managers must involve patients and their families or caregivers in the plan of care from the beginning. We need to start to educate the patient and family about the next step early in the stay and make sure they are comfortable with their expected discharge destination," she says.

Case managers need to ensure that the continuum of care is available to support patients after discharge. Develop strong relationships with local skilled nursing facilities, home health agencies, short-term rehab facilities, and other post-acute providers, Reilly advises.

"Now that post-acute providers are being monitored by the Centers for Medicare & Medicaid Services (CMS) and The Joint Commission, they have a vested interested in preventing readmissions," Reilly says.

Peggy Rossi, BSN, MPA, CCM, a retired hospital case management director who now is a consultant for the Center for Case Management, recommends holding case conferences with families to find out what they really want and involving high-risk patients' insurers to bridge the continuum of care.

Don't just send patients with high post-acute needs to a nursing facility. Make sure the facility can take care of the patients and that staff are trained to handle your patient's specific needs, she adds.

Rossi advises case managers to do their homework on which facilities could meet patient needs. Keep up with the latest state surveys for your local facilities and also visit the facilities in person and take the administrative tour during the day, but go back at night to see what happens when the administration has left. Check out the ambiance, the smells, how the staff interact with patients, and if the patients seem happy.

When Rossi was a case manager she visited all 40 facilities in the Sacramento area twice a year.

When you send queries to post-acute facilities, make sure to send enough information so the facility can determine if the patient would be a good fit. Call ahead to make sure they can take care of patient needs. "If a patient is high risk, even if you have dozens of skilled nursing facilities in your area, it may be that only one or two can care for the patient," she says.

For instance, if a patient has a tracheotomy and needs multiple suctioning, a skilled nursing facility may not be able to fill the need and the patient might be better off with a subacute or long-term acute care hospital (LTACH) stay.

Be familiar with your state administrative code and requirements for skilled nursing facilities. "For instance, the state of California requires one RN on duty for every 99 patients during the day, with care at night provided by LPNs or aides. California requires only 3.25 hours of patient care per day. If patients need more intensive care, they're going to come back to the hospital," Rossi says.

Make sure all the I's are dotted and the T's crossed during the discharge process, Rossi says. For instance, the pharmacy at some nursing home facilities is closed on weekends. If patients are discharged on Friday with no medication available until Monday, they'll be back in 24 hours.

Instead of handing family members a list of multiple facilities, give them only a few you have determined would be a good fit for the patient. Encourage families to take the formal tour of facilities, but go back at dinner time and observe what is happening. Encourage the family to review the state survey on nursing homes and Medicare's Nursing Home Compare website in addition to visiting facilities.

"Create the right expectation for families. They may think one facility looks wonderful and have their mind set on it, but that facility may not be able to meet the patient's needs," she says. ■

Study: Interventions help prevent readmissions

CMs follow patients before and after discharge

Only 17.6% of patients who received two or more interventions by a care transition manager were readmitted to the hospital within 60 days, compared to 26.3% of patients who received the current standard of care, according to a pilot study by the Bronx Collaborative, a group of three hospital systems and two health insurers. Patients who, for a variety of reasons, received one intervention had a higher readmission rate, raising the overall 60-day readmission rate to 22.8%.

The collaborative includes Montefiore Medical Center, Bronx Lebanon Hospital Center, St. Barnabas Hospital, EmblemHealth, and Healthfirst. "The results of the pilot study show the value of making personal contact with patients before and after discharge and ensuring that they see their doctors for follow-up to

EXECUTIVE SUMMARY

In a study by the Bronx Collaborative, patients who received two or more interventions by a dedicated care transition manager had a 17.6% readmission rate compared to a rate of 26.3% for patients who received the current standard of care.

- Three hospital systems and two health plans collaborated to develop the pilot project.
- Care transition managers, whose only job was facilitating transitions, visited patients in the hospital and followed up within 48 hours after discharge and again 14 days after discharge.
- The care transition managers educated the patients on their treatment plan, gave them a personalized booklet with details of their treatment plan, and followed up to answer questions and concerns and make sure they were following the plan.

CASE MANAGEMENT INSIDER
Case manager to case manager

Back to Basics: A Day in the Life of a Hospital Case Manager – Part 2

By **Toni Cesta**, PhD, RN, FAAN

Introduction

In last month's *Case Management Insider* we began to review the case management process. The process has a total of eight steps, and we completed our review of six of them. This month we will continue with the final two steps in the case management process and discuss best practices for doing an admission assessment. We will also review a case study that should help you in applying the steps we have been reviewing!

Step 7: Patient Discharge and Disposition

By the time we have reached step 7, the patient should be close to ready for discharge. As discussed last month, the patient should be reviewed daily for any changes that may impact on the discharge plan's destination. Step seven requires one last look at the selected destination for assurance that it still meets the patient's post-discharge needs and has been approved for payment by the patient's insurance plan or provider. Once all elements have been determined as correct and appropriate, the patient's transition to the next level of care should take place.

The transition of the patient is an important step in the case management process. There are important pieces of this step to keep in mind and ensure that they are completed before the patient leaves the building. These would include the following:

- Have the patient and family agreed to the discharge plan and destination?
- Have they been educated as to anything they need to know regarding medical care, medications and care at home?
- Are all post-discharge arrangements in place?
- Has the patient been given a written list of instructions for care at home?
- Have their medications been reconciled?
- Do they have a follow-up appointment with their primary care physician or specialist within five days of discharge?
- Do they have a written communication outlining when their physician follow-up appointment is, and do they have a way to get to the appointment?

All of these elements help to provide a smooth transition for the patient and family. Never assume that the patient and family know all they need to know. Repeating the educational information multiple times will help to improve their retention of the information. All of these elements, if completed properly, will also help to reduce the probability of the patient's return to the emergency department and potential readmission to the hospital.

Step 8: Repeating the Process / Ongoing Evaluation

Despite our best efforts and intentions, sometimes our patient's condition changes at the last minute. In some other cases, the family may change their mind or suddenly be unable to care for the patient at home. This is when you may have to move to step eight. Step eight requires that you take a step back in the process. This may mean you will have to go back one, or multiple steps. As discussed last month, the case management process is not always a linear one, and in some cases, the need to circle back happens at the very end of the process. If the patient's condition or situation changes in such a way that the discharge plan is no longer a safe one, then the case manager has an obligation to stop the discharge until the plan has been revised as necessary. While this may delay discharge and increase the length of stay, it will most likely be the better option toward ensuring that the patient has a safe and appropriate discharge destination. The delay may be hours or days, depending on the cause. Either way, it is better to delay than have the patient back in the emergency department and readmitted to the hospital.

Case Management Admission Assessment

The case management assessment sets the stage for the implementation of the case management process that we have just reviewed. It is a *critical* first step! In the earlier case management models, patients were screened, and if they met specific criteria, then they were followed by a case manager. In today's contemporary models, we now

need to case manage every patient. In order to do this adequately, then every patient must have a case manager and must be assessed by a case manager. Not unlike the staff nurse or the physician in the hospital, this admission assessment must be done by the case manager on the day of admission. In the past, the assessment was done up to three days after admission. Later, some hospitals moved this to within twenty-four hours of admission.

Initial Assessment Must be Completed on Day of Admission

Today's nationwide average length of stay is around 5.1 days. Within a five-day length of stay, the case manager has a lot to do, as evidenced by the myriad of issues to be addressed in the case management process. Waiting even 24 hours can delay the discharge planning process and extend the length of stay for those patients who will be requiring continuing care services in the community.

The case management admission assessment informs the case manager regarding a number of important data sets, such as:

- Where the patient was admitted from.
- What their social situation is including social supports.
- What their mental status is.
- What their financial status is.
- What day the patient may be discharged.
- Where they may be going after discharge.
- What their clinical status is.

The case manager should be gathering this information from a variety of sources. These would include:

- The prior medical record.
- The current medical record.
- The patient.
- The family / social supports.
- The community physician.
- The admitting physician.
- The staff nurse.

Having a standardized admission assessment form ensures that standard information is being collected on every patient in a uniform manner and no information is being forgotten or overlooked. Having a form also streamlines the process, taking the guesswork out of it. The data can be collected in the electronic medical record, in the case management database, or on paper. The method of collection will depend on your hospital's systems and available information technology support. If you collect the data in a case management software application, then you must be sure that the data transfers over to the electronic medical record, or paper medical record.

The Conditions of Participation for Medicare require the following:

"Screen patients to determine their risk for readmission, assess at-risk patients for discharge needs, create a discharge plan, and implement a discharge plan." (www.cms.gov/cfcsandcops/)

A case management assessment can accomplish both the initial risk assessment as well as the initial discharge plan, thereby combining two steps into one.

The following categories should be included and can be used to format your own case management admission assessment form:

Patient Information
- Patient demographic information

Admission Information
- Admission information including
  - o Admit date
  - o Admit diagnosis
  - o Admitting service
  - o Attending physician
  - o Admit source

Financial Information
- Financial information
  - o Insurance
  - o Plan number
  - o Medicaid eligibility

Spoken Language(s)

Source of Admission
- Admitted from:
  - o Acute rehab
  - o Ambulatory surgery
  - o Another acute care facility
  - o Behavioral health
  - o Emergency department
  - o Home
  - o Home with home care
  - o Long-term care
  - o MD office or clinic
  - o Sub-acute

Significant prior medical history
- o Angioplasty
- o Behavioral health
- o Substance abuse
- o Blindness
- o CABG
- o CAD
- o Cancer
- o Cardiomyopathy
- o CHF
- o COPD
- o Deafness
- o HIV / AIDS
- o Hypertension
- o Pacemaker
- o Paraplegic
- o Quadriplegic
- o Renal failure
- o Stroke
- o Vent dependent
- o Other
- o None

Mental status prior to admission
- o Alert
- o Not alert
- o Confused
- o Oriented x 1

o Oriented x 2
o Oriented x 3

Ability to make needs known:
o Able
o Unable

Living arrangements
o Adult home
o Apartment
o Assisted living
o Group home
o Homeless
o House
o Naturally occurring retirement community (NORC)
o Nursing home
o Shelter
o Stairs
o Elevator
o Other
• Lives:
o With adult children
o With dependent children
o Alone
o With other family
o With spouse / significant other
o Domestic partner
o Other
• Support system
o Name
o Telephone number
o Relationship
• Can patient return to prior living arrangements:
o Yes
o No

Activities of daily living:
o Dependent
o Independent
• Assistive device
o Yes
o No
• Which assistive device:
o Cane
o Oxygen
o Walker
o Other

Prior resource use:
o Children's services
o Adult services
o Adult day care
o Behavioral health services
o Dialysis center
o Home health care services
o Infusion therapy
o Meals on Wheels
o Medication assistance program
o Non-medical home care
o Support group
o Health Home
o Medical Home
o House calls
o Other
o None

Does patient have a primary care provider:
o No
o Yes
PCP Name _____
Address _____
Phone number _____

Social Work triggers
o Abuse – Domestic violence
o Abuse and/or neglect of a child
o Abuse and/or neglect of elder/ adult
o Abuse – sexual assault
o Adjustment to illness/ Difficulty coping
o Behavioral management problems
o Crime victim
o Cultural and/or language issues
o Drug abuse
o Ethical concerns
o ETOH abuse
o Family concerns and/or conflicts
o Guardianship
o Homeless requesting intervention
o Hospice placement
o Inadequate social support
o Inadequate financial support
o Long-term care placement
o Major illness causing lifestyle change
o Multi-system trauma
o Name of patient unknown
o Non-compliance issues
o Poor prognosis
o Shelter placement
o Uninsured
o Undocumented
o Other
o None
• Referred to Social Work:
o No
o Yes
Name _____
Contact info _____

Home Care Triggers
• Patients requiring assessments/ education relating to:
o New diagnosis
o New medications or change in medications
• Change in patient's physical environment and/or new assistive device.
• Patients with unstable disease process; cardio/pulmonary, diabetes, neurological, neuromuscular, metabolic, cerebrovascular, cardiovascular, renal, cancer, pediatric/including asthma, premature infants, psychiatric
• Patients with open wounds, VAC wound care, pressure ulcers
• Patients with ostomy, trachs, feeding tubes
• Patients with drainage tubes and catheters
• Patients requiring I.V. and injectable drug therapies
• Patients with recent change in functional status including but not limited to; falls, paralysis, fractures, amputation or other physical impairment, change in custodial needs, ortho, neuro and/or deconditioned diagnosis
• Patients with pain control management
• Patients with end-stage disease and palliative care needs
• Patients with new oxygen and/or nebulizer treatments
• Patients receiving any type of home care services, i.e., CHHA, LTHHCP, PCA, private care, at time of hospital admission
• Patients re-hospitalized within 60 days and/or known history of repeated hospital readmissions.
• Patients requiring expedited discharges (EHD/Bridge Program)

The above Guidelines can be utilized at:

- Admission
- Patient care rounds
- Individual case conference with members of the health care team
- Inquiry from patient/family/physicians
- Review of medical records

Initial Anticipated Discharge plan

- Acute Care – Transfer
- Acute rehab
- Adult home
- Assisted living facility
- Home
- Home hospice
- Home with home care (skilled)
- Home with home care (home attendant)
- Home with home care (infusion)
- Skilled nursing facility - chronic care
- Skilled nursing facility – chronic care with hemodialysis
- Skilled nursing facility – custodial
- Skilled nursing facility – skilled
- Sub-acute rehab
- Traumatic brain injury unit
- Other
- Not known

Case Study – The Case Management Process

This case study outlines the differences in planning for a patient discharge depending on the patient's age and clinical condition. These factors, along with the patient's response to care while in the hospital, will help to inform the case manager as to the best possible discharge destination for the patient. The process also requires that the patient is re-assessed on a daily basis.

Day 1: Patient assessed

Initial discharge plan: Home after exploratory laparoscopy

1. Young, healthy patient or
2. Elderly, healthy patient or
3. Young, medically complex patient or
4. Elderly, complex patient

Day 2: Patient re-assessed. No changes in discharge plan.

Day 3: Patient re-assessed. Plan is still to send patient home.

Day 4: Patient begins to show signs of sepsis. Discharge plan is now:

1. Young, healthy patient: Home
2. Elderly, healthy patient: Home with home health, possibly durable medical equipment (DME)
3. Young, complex patient: Home with home health, possibly durable medical equipment (DME)
4. Elderly, complex patient: Skilled nursing facility

Day 5: Patient in Intensive Care Unit (ICU) with circulatory and respiratory collapse.

Discharge plan should be reassessed as the patient's condition has changed significantly and the length of stay has been extended accordingly.

1. Young, healthy patient: Home with home health, possible durable medical equipment
2. Elderly, healthy patient: Skilled nursing facility
3. Young, complex patient: Skilled nursing facility
4. Elderly, complex patient: Long-term acute care facility (LTAC)

Day 6: Patient continues to recover

Day 7: Patient continues to recover

Day 8: Patient recovering. Plan to transfer to surgical unit with telemetry monitoring on day 9. Drains in place. Stage 2 pressure ulcer.

1. Young, healthy patient: Home with home health, possible durable medical equipment
2. Elderly, healthy patient: Home with home health, possible durable medical equipment, or skilled nursing facility
3. Young, complex patient: Home with home health, possible durable medical equipment, or skilled nursing facility
4. Elderly, complex patient: Skilled nursing facility or long-term acute care facility (LTAC)

Day 9: Patient recovering on surgical unit. Telemetry discontinued. Drains in place. Pressure ulcer improving.

1. Young, healthy patient: Home with home health, possible durable medical equipment
2. Elderly, healthy patient: Home with home health, possible durable medical equipment or skilled nursing facility
3. Young, complex patient: Home with home health, possible durable medical equipment, or skilled nursing facility
4. Elderly, complex patient: Skilled nursing facility or long-term acute care facility (LTAC)

Day 10: Patient recovering. Drains in place.

Day 11: Plan for discharge tomorrow with drains in place. The discharge plan is adjusted to reflect the patient's continued recovery and reduction in complexity.

1. Young, healthy patient: Home with home health
2. Elderly, healthy patient: Home with home health, possible durable medical equipment
3. Young, complex patient: Home with home health
4. Elderly, complex patient: Skilled nursing facility

As can be seen above, the discharge plan has been reduced significantly from the higher possible discharge destination to the lower. This reduction is reflective of the patient's continued recovery and positive progress.

Our case study demonstrates the need to continuously reassess the patient's clinical condition and response to treatment. In this example, had that not been done, the case manager would have spent a significantly greater amount of time on day 11 readjusting the plan to reflect the patient's condition at that time. ■

help prevent problems that frequently contribute to readmissions," says **Anne Meara**, RN, MBA, associate vice president for Network Care Management at Montefiore Medical Center in Bronx, NY, who led the project design team.

The program has been continued at two of the four campuses where the pilot was conducted, Meara says. "Each hospital continues to work internally on incorporating the best practices identified in the pilot into the usual care so we can scale the intervention to all the patients in our hospital," she adds.

Participants in the pilot program were covered by the two health plans and identified by a predictive modeling program that assigns patient risk scores based on clinical and other information.

Many patients in the population served by members of the collaborative have socio-economic issues as well as multiple chronic diseases and/or psychiatric comorbidities. "We believe, based on the overall socio-economic profile of the area we serve, that our patients are more at risk for readmission than the average patients," Meara adds.

A key element of the readmission reduction program is care transition managers, experienced RN case managers who work only with patients in the program and have a caseload of about 35 patients at a time, a mixture of new patients and those who need follow up after discharge. The care transition managers conduct intensive education while patients are still in the hospital, ensure that patients have a follow-up appointment with their primary care provider, and call patients after discharge to go over the treatment plan and answer any questions or concerns. They are supported by care transition analysts, who are not clinicians but help with setting up transportation, arranging for durable medical equipment, and other non-clinical tasks.

"A concentrated focus is important to prevent readmissions, and it's difficult to integrate that kind of focus into the jobs of people who have other tasks," Meara says.

The care transition managers meet with patients while they are in the hospital, perform an extensive assessment that includes the patient's living situation, support system, financial issues, and other information necessary to develop the right discharge plan. During the pilot this information was recorded in a care transition record built into the platform of the local health information exchange, The Bronx Regional Health Information Organization. This made the information accessible at each hospital in the event that the patient presented at another hospital and was readmitted. "For the discharge plan to be successful, someone needs to have the time to sit down with patients and find out pertinent information that can assist in setting up a successful discharge. Unfortunately most case managers don't have the time to do this and, furthermore, the concept of sharing this type of information is in its infancy stages," she says.

The care transition managers spend time educating patients in the hospital and make sure they have food in the home, have transportation to the pharmacy, and make sure they have a follow up appointment with their physician. They give patients a personalized booklet, written in easy-to-understand language, that lists their medication, how and when to take it, any medical red flags to look for and what to do if they occur, and the time of the follow-up appointment.

The care transition managers call patients within 48 to 72 hours of discharge and go over the discharge instructions, identify any questions or concerns, review symptoms and medication, and verify that patients have a follow-up appointment with a physician within 14 days of discharge.

"This is a critical phone call because there is so much going on during a hospital stay that patients may forget the information they received," she says.

They call again 14 days after discharge to follow up on the physician visit and see if there are other problems.

The care transition managers set up whatever services the patients need, including home care, durable medical equipment, or medication assistance. If patients need help at home, they may reach out to a family member, a neighbor or a church group. "They make sure everything is in place to make sure patients can manage at home," she says.

They follow patients for as long as 60 days if they have ongoing issues and work closely with the case managers at the health plans if they need longer-term follow up.

Members of the Bronx Collaborative developed the research project using grants from the New York State Health Foundation and the New York Community Trust. "We've worked together in the past, and this gave us an opportunity to look across organizations at high utiliza-

tion and readmissions. Since each hospital takes financial risks in some form and the health plans are struggling to reduce readmissions, our incentives were very much aligned," Meara says.

Clinical representatives from all five organizations researched the literature and a number of readmission prevention models to design a model that would work in the Bronx community, where residents face social and economic challenges. "We looked for elements that are included in all the models, such as face-to-face meetings with patients, medication reconciliation, and scheduling follow-up appointments and designed a program we hoped would work in our community," Meara says.

The clinical design workgroup is continuing to meet to discuss the next steps in the process. "This includes standardizing the capture of psychosocial indicators that we believe contribute to readmissions so that we can factor that into our predictive model and share it through health information exchange," she says. ■

Transition CMs reduce readmissions from SNFs

Nurses work with staff, patients, families

By establishing a nurse transitionist program to improve communication between the hospital, the staff at skilled nursing facilities, patients, and their families, Western Maryland Regional Medical Center, a 275-bed hospital in Cumberland, MD, has reduced the readmission of patients from participating facilities from 30% to 18%.

"We haven't completely stopped readmissions, but we have reduced them significantly. Patients in skilled nursing facilities have a lot of issues that bring them back to the hospital, but we are preventing unnecessary admissions," says **Carol Everhart**, RN, MI, director of care coordination and quality initiatives.

The program was begun as part of an initiative to cut down on readmissions, Everhart says. An analysis of readmission data showed a high volume of readmissions among nursing home patients. A team from the hospital met with the director of the hospital-owned skilled nursing facility and analyzed what was driving the readmissions. "As we looked at the readmissions and talked it through, we realized that poor communication was a major cause," she adds.

The hospital created the position of nurse transitionist to be a liaison between the hospital and the nursing home and work with nursing home staff, patients, and family members to ease transitions. The program started in June 2012 with the hospital's own nursing home and has expanded to six of the eight skilled nursing facilities in the area. The program now has two nurses who jointly carry a caseload of about 70 patients at any time. "We are very creative in collaborating with the local skilled nursing facilities. For all of us to survive, we know that we all have to work together," Everhart says.

The transition case managers follow patients who are admitted from a skilled nursing facility from the time they are admitted to the hospital. They begin following patients who are going to a skilled nursing facility for the first time from the time that they are accepted into a bed. They visit the skilled nursing facilities to which the patients are discharged for 30 days after discharge from the hospital at intervals determined by peak times for readmissions.

When the position was created, Everhart opened it up to the entire case management staff and interviewed those who were interested. She chose a case manager who had worked at the hospital-owned skilled nursing facility before coming to the acute side. "She already had a relationship with the staff at the nursing home. They trusted her and didn't see

EXECUTIVE SUMMARY

At Western Maryland Regional Medical Center, having nurse transitionists act as a liaison between the hospital and nursing facilities has reduced the readmission rate from participating facilities from 30% to 18%.

- The nurse transitionists carry a caseload of about 70 patients and work closely with the nursing home staff, patients, and family members to improve transitions.
- They follow patients who are admitted from a skilled nursing facility from the time they are admitted and patients who are going to a skilled nursing facility for the first time from the time that they are accepted into a bed and for 30 days after discharge.
- They visit the nursing home within 24 hours of transfer, meet with the patient, family, and staff and answer questions. They return on Day 5, between Day 11 and Day 14, and again at 25 to 30 days.

her as a threat. She knew that she was there to help, not to criticize or judge," Everhart says. The implementation went smoothly and when the second case manager transitionist came on board in October 2012 and was trained by the original transitionist, she was accepted readily at the skilled nursing facilities.

"The most important part of working successfully with a skilled nursing facility is being familiar with long-term care, how nursing homes are organized and staffed and how they are different from the acute-care setting. Our transitionists go in as a partner, rather than someone who is there to instruct or judge," she says.

After seeing the success of the program in the first skilled nursing facility, other nursing homes in the area approached the hospital about participating. "This is a small community, and the word spread. Once the program got started, the success was well known and other facilities wanted to come on board faster than we could manage," she says.

The transitionists have an office in the hospital and rotate which of the two is in the field or in the hospital. They cover the nursing facility patients six days a week. Typically, one transitionist is in the office and the other is in the field. Both transitionists work with the staff and patients at all nursing homes. "We do not assign them patients or nursing facilities, so we'll have cross coverage for all patients. They work autonomously so they can meet the needs of all the patients and family members," she says.

The transition case managers use electronic work lists that track all nursing home residents who are in the hospital and other patients for whom a bed selection at a skilled nursing facility has been made. The unit case managers are responsible for the day-to-day management of the patients, coordinating length of stay and medical necessity. As discharge approaches for patients returning to a skilled nursing facility or transferring for the first time, the transitionist takes over the case.

Since they begin working with the patients and reviewing the medical record while they are still in the hospital, the transitionists understand what happened during the admission and what the discharge plan is, which enables them to assist with the transition into the nursing facility, Everhart says.

The transition nurses visit the nursing home within 24 hours of transfer, meet with the patient, family, and staff and answer questions. They assist with medication reconciliation, explain the treatment plan, and answers questions. "They make sure that the handoff is smooth, that the staff understands the care of the patient, and that everybody is on the same page," Everhart says.

The case managers return to the nursing home to visit the patient, family, and staff on Day 5 to check on the treatment plan and the patient's progress and to answer any questions. They visit again between Day 11 and Day 14 and again in the 25-30 day timeframe.

"Depending on what is going on with the patient, the nurse may come back earlier than scheduled. The primary focus is to make sure that the transition goes smoothly and that the nursing home staff knows what the patient needs," she says.

When the staff at the skilled nursing facilities feel they need to send a patient back to the hospital, they call the transitionist, who may be able to make suggestions that could help avoid the readmission. Four out of the six skilled nursing facilities use the Interventions to Reduce Acute Care Transfers (INTERACT) tool, designed to improve the identification, evaluation and communication about changes in nursing home residents' status. INTERACT gives the front line staff, usually certified nursing assistants, guidance on what to do when a patient's condition appears to change. *(For more information on the INTERACT tool, visit http://interact2.net/about.html.)*

If patients do need to be admitted to the hospital, the nurse visits them when they get to the unit to find out what has been going on with the patient that might have caused the readmission. The transitionist reviews the patients' care in the skilled nursing facility, including their diet and activity level. In one case, a heart failure patient came back to the hospital or was taken to the hospital's heart failure clinic at regular intervals. The transitionist drilled down and determined that the nursing facility had a "Hot Dog Day" and the patient was eating sodium-loaded hot dogs, which exacerbated his condition.

"When the nurses find something that could be causing the readmissions, they talk to the patient about lifestyle changes, such as eating a low-sodium diet or increasing ambulation. They conduct that structured re-education every time they see the patient, not from a scolding

standpoint but from a collaborative standpoint to help the patients improve their health," she says.

Nursing facility residents don't want to come back to the hospital, Everhart points out. "We try to be that stabilizing force that works with all the players to keep the patient in the secure setting that is best for them," she says. ■

Silence kills if no one is willing to speak up

'Make candor a core competence'

Checklists and clear protocols for clinical care have been highly successful in infection prevention and other fields, but can be easily undercut by a simple non-action: silence.

Following up on earlier work on this topic, the Association of periOperative Registered Nurses (AORN) and several partners reported in *The Silent Treatment* that health care has yet to fully overcome a culture wherein people observe errors but fear the consequences of speaking up.[1]

The study included data from more than 6,500 nurses and nurse managers from health systems around the United States during 2010. All research participants were members of the AORN and the American Association of Critical-Care Nurses. The study used two research instruments: a "story collector" and a traditional survey. The story collector generated qualitative data, while the survey recorded purely quantitative data.

The researchers found that 85% of respondents have been in a situation where a safety tool warned them of a problem. In addition, 32% said this happened at least a few times a month, a finding that confirmed that safety tools work and that checklists, protocols, and warning systems have an essential role in patient safety.

However, the research also documented that the effectiveness of safety tools is undermined by so-called "undiscussables." Of the nurses who had been in situations where safety tools worked, 58% had also been in situations "where they felt unsafe to speak up about the problems or where they were unable to get others to listen," the researchers noted.

The research findings pointed to several key hazards, including:

Dangerous shortcuts: Overall, 84% of respondents said that 10% or more of their colleagues take dangerous shortcuts. Of those respondents, 26% said these shortcuts have actually harmed patients. Despite these risks, only 17% have shared their concerns with the colleague in question.

Incompetence: Overall, 82% say that 10% or more of their colleagues are missing basic skills and, as a result, 19% say they have seen harm come to patients. However, only 11% have spoken to the incompetent colleague.

Disrespect: Overall, 85% of respondents say that 10% or more of the people they work with are disrespectful and therefore undermine their ability to share concerns or speak up about problems. And yet, only 16% have confronted their disrespectful colleague.

"Fortunately, not all survey respondents remained silent," the authors state. "The study identified a small minority of nurses who spoke up when they observed dangerous shortcuts, incompetence, or disrespect. By studying these successful outliers, the research uncovered the high-leverage behaviors all healthcare practitioners should master in order to change the trajectory of harmful patient care."

The report underscores that while safety tools are one part of the solution to improving patient care, they do not compensate for crucial conversation failures in the hospital. "Silence still kills," the authors conclude. "It's time for healthcare systems to make candor a core competence."

Editor's note: The full AORN report is available at www.silenttreatmentstudy.com

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Treating depression helps the workplace

Programs boost job performance

Depression takes a toll on nurses and other health care workers. They may have trouble focusing on instructions, staying on task, or problem-solving, in addition to personal and physical problems that accompany depression.

That lag in productivity has a quantifiable cost in "presenteeism," but it also represents an opportunity.

A focused program that includes care coordination, work coaching, and cognitive-behavioral therapy can help employees cope with depression and improve their functioning at work, says **Debra Lerner**, MS, PhD, director of the program on Health, Work and Productivity at Tufts University in Medford, MA.

Lerner developed the Work and Health Initiative to address a pervasive and often unrecognized condition. About one in five nurses suffers from depression, a rate that is twice the national average, a recent study showed.[1] In a pilot study, the initiative improved work performance and reduced absenteeism, producing a cost-savings of $6,000 per participant.[2]

"There is a lot of undiagnosed depression. Even among people who do have a diagnosis, there is under-treatment," says Lerner. And the treatment for people with depression rarely addresses specific issues with functioning at work, she says.

"Usually physicians don't hear about work problems until the employee is on the verge of losing their job or wants to file a disability claim," she says.

The Work and Health Initiative provides voluntary, confidential support to employees who have depression and are struggling at work, Lerner says.

The Work and Health Initiative is an eight-week program that connects employees with counselors in hour-long phone-based sessions. The counselors work with employees to create a plan for addressing functional problems at work.

The initiative uses work coaching to target specific performance issues and cognitive-behavioral therapy to change behavior. The counselor also provides care coordination with the employee's provider, such as communicating about the effectiveness of antidepressant medication.

"If the employee will give us permission to contact their physician or therapist, we will send a report every four weeks while they're in our program updating the provider about depression symptoms and how well the person is functioning on the job," says Lerner. "We can close the loop on the medical care system and the workplace."

In a study of 79 Maine government employees,

COMING IN FUTURE MONTHS

- Inpatient vs. observation: How to decide
- What case load should case managers have?
- Proving your value to the administration
- Coordinating care for uninsured patients

CNE QUESTIONS

1. What is the minimum time case managers need to complete an assessment even on an uncomplicated discharge, according to Peggy Rossi, BSN, MPA, CCM, a retired hospital case management director who now is a consultant for the Center for Case Management?
   A. 10 minutes.
   B. 15 minutes.
   C. 30 minutes.
   D. An hour or more.

2. At Covenant Healthcare System in Knoxville, TN, with what frequency do case managers make follow-up calls after patients are discharged?
   A. Two days after discharge, a week after that, and a week later.
   B. Two weeks after discharge.
   C. One day after discharge and two weeks later.
   D. Two days after discharge and 30 days after discharge.

3. What was the caseload of care transition managers in the Bronx Collaborative's readmission reduction program?
   A. About 15 patients.
   B. About 25 patients.
   C. About 35 patients.
   D. About 50 patients.

4. How soon after patients are transferred to a nursing home do nurse transitionists at Western Maryland Regional Medical Center visit?
   A. Within 48 hours.
   B. Within 24 hours.
   C. Within a week.
   D. Within two weeks.

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 healthcare industry at large
- discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.

the Work and Health Initiative led to improved symptoms. That group also showed significant improvement on job tasks, time management and productivity and reduced absenteeism compared to a control group.[2]

It's important for employees to know that they can get help with work functioning as an adjunct to medical treatment for depression, says Lerner. The services can be coordinated through an employee assistance program.

"There is a connection between having depression and having difficulty functioning at work. A lot of people don't make that connection," she says. "It is important to let them know they can get help."

The Work and Health Initiative is not yet commercially available, but Lerner hopes to have a product by early 2014. Meanwhile, employee assistance programs can help employees with depression in a disease management model, she says. Just as "a person with cancer or migraine headaches or COPD has the medical side and the functional side [that] both need to be addressed," depression also has functional dimensions that impact the workplace, she says.

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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%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■