

HOSPITAL CASE MANAGEMENT™

the monthly update on hospital-based care planning and critical paths



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Help your patients make decisions about end-of-life issues

As an advocate, you can help them plan the next level of care

Hospital case managers and social workers are in a perfect position to help patients and family members come to terms with end-of-life decisions before they are in a crisis situation, asserts **Catherine M. Mullahy, RN, BS, CRRN, CCM.**

"We are living in a society where death is seemingly an option rather than an inevitability. Everyone in health care recognizes that we can't cure everyone. If you look at the role and function of case managers as an advocate for the patient, who is in a better position to help them plan for the next step in patient care and to choose how they want to live out the rest of their lives," says Mullahy, president of Mullahy Associates, LLC, a Huntington, NY, case management consulting firm.

When patients and family members are facing end-of-life issues, a caring social worker or case manager can make a lot of difference in helping them cope with the situation, adds **Elizabeth Clark, PhD, ACSW, MPH,** executive director of the National Association of Social Workers, based in Washington, DC.

"We can't fix all the problems. We can just see that the patient has the best death that is possible by making sure that the symptoms and pain are under control and that the family has the best experience they can have so that when death occurs, they don't have a legacy of guilt," Clark says.

Don't approach the family without approaching the patient as well. The patient and family are the unit of care, Clark suggests.

Keep in mind that you won't be able to help a person resolve all the problems of a lifetime in the last few days before death, she adds.

"One of the problems that happens at end of life is communication issues. The family is holding onto hope, and the patient may be more aware of dying than the family is. One of the real roles is helping the patient and family to talk to one another about the hard issues," she says.

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Case managers and social workers can facilitate symptom management and pain control to make the patient more comfortable and able to deal with end-of-life issues, Clark says.

"Death of a loved one is one of the most traumatic experiences anyone goes through. When you are invited into someone's dying moments, it's not just a job; it's a privilege to assist the patient and family in a major life transition," she says.

Doctors and other health care professionals who are treating patients should know what the

patient's eventual wishes are and that's where case managers can be of assistance, Mullahy says.

With terminally ill patients, talk with the treating physician as well as the patient and family. Ask your patients what they understand their diagnosis to be, what the treatment has been, how it's working and, if it's not working, what they would like to happen.

"It's important to get the patient's viewpoint on what the doctor has told him and how he feels about it," Mullahy says.

Case managers and social workers can provide a great service to their patients if they make sure that terminally ill patients are referred for hospice care as early as possible, adds **Elizabeth Hogue, Esq.**, a Burtonsville, MD, attorney specializing in health care issues.

"I see this trend throughout the country of people being referred to hospice really late. The hospice model of care isn't supposed to work that way," she says.

The average length of stay in a hospice program typically is short, Mullahy points out.

"This is unfortunately because most patients have been dying for many months if not for years and no one has had a discussion with them about end-of-life issues," she adds.

Many health care professionals have a mistaken impression of what a hospice program is like, Mullahy says.

She recommends that case management directors invite someone from a hospice program come in periodically and meet with the case managers to help them understand what hospice is all about.

"There are many wonderful hospice programs. Case managers need to understand what hospice is all about and educate themselves so they feel less fearful about it. Case managers can help raise awareness of hospice so that terminally ill patients can be in a peaceful environment rather than being in the hospital, where continuing treatment can be aggressive, uncomfortable, and futile," she says.

With today's short lengths of stay, social workers may be brought into the picture too late to establish the kind of rapport it takes to help the patient and family prepare for the end of life, Clark points out.

But health care professionals can still help the family through a difficult situation, she adds.

When a patient dies, advocate for the family to spend time with their loved one at the bedside, Clark suggests.

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Editorial Questions

For questions or comments, call **Russ Underwood** at (404) 262-5521.

"People's deaths are often difficult and it's very hard on the family. After the death, the body is peaceful, and it's a good time for the family to say goodbye," Clark says.

Sometimes, the family doesn't want to be alone and the social worker can help the family say goodbye, Clark points out.

Keep in mind that the person who died is not "the body" but is still the husband or wife or child, she advises.

Case managers and social workers can help the family by making sure that they learn about the death in an appropriate setting, Clark adds.

Clark talked to a woman who was told about her husband's death in a cloakroom filled with boots and coats. Other patients have told her that when they came into their loved one's room, staff were already removing the flowers from the room.

"When someone hears about a loved one's death, even if they were expecting it, it stays with them forever," Clark points out.

When Clark's sister died of cancer, the nurses came into the room and talked about what they remembered about the patient.

"It was very meaningful to have them talk about what she had meant to them as a patient," she says.

If you have the luxury to do so, get back in touch with the family a week or so after the death to see if you can assist in any way, Clark suggests.

Help your hospital arrange quarterly memorial services for the patients who have died. It's a way to help the staff say goodbye.

Case managers have an opportunity to take a proactive approach to end-of-life issues, helping patients be aware of the kinds of decisions they need to make, even if they're not facing death in the near future, Mullahy says.

In most hospitals, patients receive information on health care proxies and advance directives from the admissions office clerks, and the conversation doesn't come up with medical professionals until the patient is deemed to be in a terminal state, she adds.

Nobody on the hospital staff routinely brings up end-of-life issues, she says.

"Nurses don't feel like it's their place to start a conversation. Talking about end-of-life when a patient has just been admitted doesn't exactly encourage feelings of safety," she adds.

The conversation about advance directives should become a normal and natural part of the

conversations that case managers have with all their patients, Mullahy says.

"When I had staff, I asked them to include a discussion about advance directives as part of their initial evaluation and assessment. I think this could be a vital role for case managers to have," she says.

The Patient Self-Determination Act requires providers to ask all patients admitted if they have advance directives, Hogue says.

Check your patient record to make sure there is information about what advance directives the patient already has, Hogue suggests.

Patients should have a durable power of attorney and a living will or another document that gives direction about their wishes if they are terminally ill or in a persistent vegetative state, Hogue says.

Neither case managers nor hospitals should provide materials that they have prepared about advance directives, she cautions.

The statute requires each state's attorney general to develop materials related to advance directives. Case managers should provide only materials from their state's attorney general's office to their patients, she says. ■

Take stock of successes, avoid compassion fatigue

Be comforted by what you can do for dying patients

Health care professional who work with dying patients should be protective of themselves, take comfort in how they have helped patients and families, and seek support from their coworkers in dealing with the emotions that death and dying stir up, says **Elizabeth Clark**, PhD, ACSW, MPH, executive director of the National Association of Social Workers, based in Washington, DC.

"Professional grief is not a concept that is well understood. I believe that witnessing suffering is very hard, and we underestimate the impact that it has on staff. It's important for hospitals to have support for staff who are caring for dying patients," Clark says.

Caring professionals find it impossible to wall themselves off from their patients. They get involved with their patients and feel good when they get well and sad when they die, adds **Catherine M. Mullahy**, RN, BS, CRRN, CCM,

president of Mullahy Associates, LLC, a Huntington, NY, case management consulting firm.

“Case managers can feel good that when a patient is dying, they are there to help the patient get the pain management they need and get their affairs in order. It’s difficult to say goodbye, but it’s satisfying to know that you helped them have the kind of death they want,” she says.

Helping people deal with the end of life by bringing in services and providing support to make the rest of their life better is a great service, adds **Diane Siddall**, RN, CHPN, case manager with Hospice of Summa in Akron, OH.

“Death is a natural part of the cycle of life, and it doesn’t have to be chaotic and out of control. Our job is to help provide support in these difficult situations,” she says.

Health care professionals should step back and examine how they feel about the emotionally charged issues surrounding death and dying, Mullahy says.

“Case managers should see themselves as part of the solution. They can help patients have the kind of death that each of us would want,” Mullahy says.

Conduct an assessment of your psycho-social successes, Clark suggests.

“Take some comfort in what you have been able to do for the dying person,” she says.

Think of something special you have done for a patient or something you did that a patient really appreciated.

“You wouldn’t document in the medical record that you got a card for the patient who wasn’t going to be there for his wife’s birthday, but things like that make a huge difference to a dying patient,” she says.

She suggests a monthly conference where the hospice or oncology team can talk about psycho-social successes.

“Usually the treatment team is limited to having case conferences about problems. Have everybody bring a success to a conference,” she says.

Even if there’s no formal meeting, sit and talk to your fellow clinicians about your feelings and concerns and offer your support when they are grieving, suggests **Carol Kucharski**, RN, OCN, care manager in the acute palliative care unit at Summa Health System’s Akron City Hospital in Akron, OH.

Don’t put stress on yourself to come up with the perfect thing to say to a dying patient or his family, advises **Melissa Jones**, BSN, RN, CCM,

case manager and palliative care nurse coordinator at Methodist Medical Center in Oak Ridge, TN.

“Go in with the idea that you can’t fix everything but you can listen and lend support,” she says.

Allow your case managers and social workers to grieve, Mullahy advises. “It should be OK to cry on the unit, where you can have the support of your colleagues all around you,” she says.

If one case manager has to care for a number of dying patients and another one has been admitted who is not likely to have a good outcome, assign that patient to someone else, Mullahy advises.

“If you give people a break, it can prevent burnout,” she says.

Keep your work and your personal life in balance.

“The best nurses and social workers are people who are happy and adjusted in their own life,” Mullahy says.

Take a break and walk around the hospital grounds. Think of the people you did help and those who did survive, Mullahy suggests.

“We can’t save everyone, but if we can help people exit the world peacefully and help the family come to terms with it, it’s a real gift,” Mullahy says. ■

Patients flow seamlessly from hospital to hospice

Interdisciplinary team eases continuity of care

Summa Health System in Akron, OH, takes an interdisciplinary approach to the care of terminally ill patients, providing seamless support across the continuum of care, says **Diane Siddall**, RN, CHPN, case manager with Hospice of Summa.

“The biggest problem in any system is the hand-off between hospitalization and hospice. We have created a seamless process so that patients continue to receive the support they need whether they’re in the palliative care unit or at home,” Siddall says (**Summa opened a new palliative care unit in Akron City Hospital in the summer of 2006. For details, see page 28.**)

Summa’s hospice interdisciplinary team includes RN case managers, home health aides,

social workers, the spiritual care team, and board-certified hospice physicians, as well as assessment nurses who conduct the assessments in the hospital's palliative care unit. The hospice care team has its own pharmacist, who can give advice on pain management and symptom control.

"Hospice is a natural progression for many of the patients in Summa's palliative care unit. We work closely with the nurses and case managers in that program so that the handoff is very easy when patients come to the end of treatment that will be useful for them," she says.

The interdisciplinary team meets once a week to discuss the care plan for all of the patients who are receiving hospice services. For instance, if a patient who is receiving hospice care in the home has problems and needs pain management, he or she can be transferred to the palliative care unit.

The hospice case managers are assigned by geographic area to give the nurses more time to spend with patients instead of traveling.

Referrals from the hospice program come from physicians or sometimes family members who have read about hospice care or have friends who have experienced it.

"The public is much more educated about hospice care now than a few years ago," she says.

Siddall sees her role as doing whatever is needed to make the patient comfortable and able to function at his or her highest level, whether that means providing emotional support or bringing in equipment.

"People can't deal with their emotional and family issues at the end of life when they are distracted by a lot of pain. My role is to go into the home and get the symptoms under control and provide support so that the patients can interact with the people they love and do some of the things they want to do without suffering," she says.

For instance, patients with end-stage congestive heart failure can do well in hospice because they have someone helping them manage their symptoms and someone they can call when they get in trouble instead of ending up in the emergency department.

"We can help with symptom management or just provide someone to talk to. We provide small doses of narcotics in the home that gives the family a tool so they don't need to bring the patient to the emergency room. They can have one of our on-call nurses come in to help if needed," she says.

Summa's hospice team is working to educate the hospital's physicians about the kind of services

that hospice can provide and to help them learn how to present the idea of hospice to families.

"Our physicians are being trained now to understand what kind of services that hospice can provide," she says.

The hospice team works with physicians to help them learn how to present the idea of hospice to the family so that the patient and family can receive the services before the patient is in an end-of-life crisis situation.

"One of the biggest problems is that patients don't get into hospice soon enough. We present hospice as a way to help with symptom control and give the family support," she says.

When Siddall gets a referral, she makes an appointment with the family and friends of the patient and presents the program.

"The most important thing is to help the family understand that we are there to support their goals. The patient and family determine what they want to happen, and we support them in their choices," she says.

She assesses the family's knowledge about hospice and makes sure that they are ready for a regime that does not attempt to prolong life but keeps the dying person as comfortable as possible.

"We also provide volunteers to help with caregiver respite and patient companionship. Most times when families are admitted to hospice, they have been the sole caregiver for an extended period of time, so it's a relief for them to have our volunteers available," she says.

When she assesses the patient and family, Siddall determines what kind of services they will need, such as home health aides for personal care. If the family doesn't have a church home and wants spiritual care, she calls in Summa's chaplain.

"If the patients are lonely and don't have anyone to visit with them, we can bring in volunteers. If they have aches and pains that aren't related to their terminal illness, we can bring in a massage therapist," she says.

When the program first began, the case managers performed all the assessments. Now that the caseload has increased, the case managers can call on the assessment nurses to make the initial assessment and contact physicians for the initial order.

"I like to open my own cases. It's a very intimate time. It takes a few visits to catch up on knowing the patient and family if I don't open the case," she says.

The assessment typically takes two to four hours and includes consent forms and other paperwork but, most importantly, gives the case manager a chance to learn about the family.

"I begin by asking the patient and family to tell me their story. I need to hear in their words what they've been through so I can determine how I should work with the family," she says.

Siddall visits most of her patients twice a week unless they're having problems, such as symptom control.

She gives the family "care kits," sealed bags with small doses of medications that they can use to keep the patient comfortable.

"We give the patients and families a lot of education. We have a home folder with information on medication management and how to use the comfort medications. We encourage them to call hospice and let us walk them through the medication use if they experience new symptoms during the night that require intervention," she says.

She goes over the medical equipment and assesses the home for safety issues.

She does an assessment every time she visits the patient.

"As they decline, it's not a static situation. I prepare them for when they start having ambulatory problems. Falls are dangerous for the hospice situation, and prevention is a major goal as broken bones often require hospitalization," she says.

She stays in touch with her patients' physician, reporting any changes in the patients' conditions and getting orders for additional medications, if appropriate.

Most of the time, the patient's primary care physician remains his or her managing doctor under the hospice program. In addition, Summa's Palliative Care and Hospice Services physicians can make home or nursing home visits or assist with pain management if the primary care physician desires, Siddall adds.

The hospice team can get medications filled at the hospital and have a pharmaceutical courier deliver them. The on-call nurses or home health aides also deliver medications when they visit.

The program has more than 100 patients in home hospice care. Another team manages the care of hospice patients in nursing homes.

"If we can build a relationship with the nursing home and they get comfortable with one person coming in to see the patient, there is better communication between the nursing home and the hospital," she says. ■

Palliative care addresses medical, emotional issues

Results include better pain control, shorter stays

A palliative care program has resulted in better symptom control and pain management, decreases in length of stay for patients, and potential cost savings for Methodist Medical Center in Oak Ridge, TN.

The palliative care program, implemented in October 2005, is an outgrowth of the Comfort CareTrax program, implemented by the medical center in 1998 to improve the quality of care for patients at the end of life, according to **Melissa Jones**, BSN, RN, CCM, case manager and palliative care nurse coordinator at Methodist Medical Center.

Jones was on the team that developed the Comfort CareTrax program, which won national recognition.

The program's goals include pain management and control of other symptoms, addressing advance directives and entering them on the chart, addressing the patient's level of hope, and helping the patient and family define immediate and long-term goals of care.

"Although decreased length of stay and costs were not the primary objective, it was felt this would occur if we followed the patient's wishes and eliminated unnecessary tests or unnecessary transfers to the acute care unit," Jones says.

A financial analysis, based on a formula developed by Mt. Carmel Medical Center in Columbus, OH, showed a projected savings of \$390,679 a year, Jones says.

The typical definition of a palliative care patient is someone with a chronic illness that will eventually lead to death, Jones says.

"It could be five or six years down the road. We start addressing all the issues and talking about goals of care, even looking at social, emotional, and spiritual issues," she says.

In just over a year, 199 patients were referred to the program, including patients with cancer, end-stage renal disease, end-stage liver disease, gastrointestinal disease, stroke, AIDS, respiratory disease, and cardiac disease.

Patients who are in the palliative care program are on units throughout the hospital. Jones coordinates their palliative care, working with the case manager and social worker on the unit, the nurs-

(Continued on page 27)

CRITICAL PATH NETWORK™

Central admissions process improves patient care

Nurses manage the admission of all patients

At Central DuPage Hospital, a dedicated team of nurses, called patient admission coordinators, manage the admission of all patients.

This initiative, which began in July, is part of a comprehensive program to redesign the admissions process, the beginning point for patient flow and throughput, according to **Lea Ann Arnold**, BSN, manager of care coordination at the Winfield, IL, hospital.

The patient admission coordinators, who previously worked as utilization management nurses, staff the admissions office from 7 a.m. to 11:30 p.m. seven days a week and are the initial contact for all admissions coming into the hospital.

"It's like a centralized clearing house. Every admission goes through them," Arnold says.

The patient admission coordinators are able to take faxed or verbal admission orders from physicians and to accept clinical information from outpatient areas such as the cardiology lab and the emergency department.

"The patient admission coordinators are able to discuss signs and symptoms with the physician or the physician office nurse, determine the plan of care, and obtain a clinical picture of patients, which will help them determine the appropriate venue of care, appropriate admission status, and the unit where the patient will be admitted," she says.

The patient admission coordinators encourage the use of pre-printed order sets the hospital developed to promote compliance with the core measures and best practice guidelines.

"The core measures and best practice guidelines are embedded in the order sets. They have built-in ticklers, such as three options for simple,

complex, or aspiration pneumonia and options of antibiotics recommended as best practices," Arnold adds.

When a doctor's office calls to admit a patient, the patient admission coordinator offers to fax a copy of the preprinted order set. The physician can fill it out, sign it, and fax it back.

"In just a few months, we have gotten good response from the admitting physicians. They know that they can call and talk to a nurse who can understand the clinical picture of the patients and get them to the appropriate level of care," she says.

The initiative also aims to improve patient registration and clarify information on the notice of admit that is given to the insurance companies.

"The patient admission coordinators have a conversation with the registrar prior to admission to clarify the clinical picture and the reason for admit. Because the nurses are clinicians, they have better knowledge than the registrars about the admission status and diagnosis. Having the nurse involved in developing the notice of admission gives us more accurate information for the insurance company," she says.

Before the initiative began, patients were placed in beds through a variety of admission ports of entry, Arnold says.

The house supervisors placed patients from the emergency department, patients who were direct admissions, and patients admitted for unscheduled stays after outpatient procedures.

The centralized scheduling office, staffed by registration personnel, placed patients for medical admissions scheduled for the future and for

specific procedures that were done on the nursing unit.

The old system was frustrating for the utilization management nurses because patients already were in a bed by the time they saw them and they were not always placed in the right admission status, Arnold says.

As part of the redesigned admissions process, the hospital is in the process of implementing a new electronic bed board system.

The system will allow the admission nurses to work hand-in-hand with transportation and housekeeping and to be aware in real time when beds become available, Arnold says.

When the patient is ready to be discharged and transportation is called, the system will alert housekeeping to start cleaning the room. The housekeepers will log in when they get to the room and have a target of being finished in 20 to 30 minutes.

"The admissions nurses will have a bed tracking tool that allows them to see what patients are in what room, when they got there, and their disposition," she says.

Currently, the hospital has a bed board meeting at 9 a.m. seven days a week, during which the charge nurses from all units discuss the bed status and patient status on the unit with the patient admission coordinators.

"We look at which patients are scheduled to be discharged, what discharges are anticipated, what barriers there are to getting a patient discharged, and how we can work to overcome the barriers," Arnold says.

Additional meetings to discuss patient status and bed status are held at 4:30 p.m. and 4 a.m.

The electronic bed board will streamline the process and eliminate telephone calls between the admission coordinators and the units to find out if beds are available, she says.

The next phase of the redesign project is to have the initial clinical reviews performed by the admission nurse on the day of admission. The initiative will provide information to the care coordinators on the unit as soon as the patient is admitted.

The hospital is moving toward a documentation system for the care coordination team that starts with registration and admission, captures financial and pay information, and includes modules for discharge planning, medical necessity review, delayed days, and denials management.

"This is a work in progress. We're working synergistically to improve patient flow and the patient experience," Arnold says.

[For more information, contact Lea Ann Arnold, BSN, manager of care coordination, Central DuPage Hospital, lea_ann_arnold@cdh.org] ■

Help your hospital with CMS' 'inpatient only' list

Surgery in the wrong setting can cost revenue

As a hospital-based case manager, you're in a position to help your hospital avoid possible revenue loss by ensuring that Medicare patients who receive surgery at your facility are scheduled as inpatients if the procedure is on the "inpatient-only" list developed by the Centers for Medicare & Medicaid Services (CMS).

In issuing its final rule for 2007 for the Outpatient Prospective Payment System, CMS reaffirmed its policy to pay for procedures on the "inpatient-only" list only when the patient was an inpatient at the time the procedure was performed.

There has been speculation over the years that CMS will eliminate the inpatient-only list, but every year, CMS has stated its commitment to keep the list for the safety of Medicare patients, says **Deborah Hale**, CCS, president of Administrative Consultant Services in Shawnee, OK.

Case managers should stay abreast of the CMS changes to the inpatient-only rule because of its implications for payment, Hale adds.

Although physicians make the decision about whether surgery will be performed on an inpatient or outpatient basis, they get their fee even if the procedure is not provided in the inpatient setting. This means that hospitals have a responsibility to educate physicians about the inpatient-only rule and to ensure that surgery on Medicare patients is done in the proper setting, she adds.

"CMS holds the hospital responsible for making sure that services are provided in the most appropriate level of care," she says.

Hospitals should have admissions policies that address the "inpatient-only" list and a system that ensures that surgery on Medicare patients is

performed in the proper setting, says **Marianne Lundgren**, RHIA CCS, hospital payment monitoring program specialist with TMF Health Quality Institute in Austin, TX.

"Hospitals need to have an internal process set up so that whoever takes the orders for surgery can identify the procedures on the inpatient-only list and make sure that Medicare patients receiving procedures on the list are admitted as inpatients," Lundgren says.

There should be an up-to-date list of procedures on the inpatient-only list that people who are taking the orders for surgery can use to make sure that patients are scheduled for surgery in the proper setting, she says.

"Case managers should be familiar with what is on the 'inpatient-only' list and intervene with physicians to provide the procedures in the appropriate site of services," Hale says.

For case managers to be effective at making sure the surgery is performed in the right setting, they need to review the level of care order at the time the procedure is scheduled, Hale says.

"If the order for an inpatient admission is not written or verbalized until the inpatient-only procedure has been performed, the hospital is not entitled for payment for the procedure," she says.

Hospitals will get paid for follow-up care if patients are admitted after a procedure on the inpatient-only list is performed as an outpatient procedure. However, in those cases, the hospital will not be paid for the surgical procedure, Lundgren points out.

Here is an example from Lundgren of how the inpatient-only rule can affect reimbursement:

A patient receives a vaginal hysterectomy for uterine fibroids as an inpatient procedure. The principal diagnosis would be uterine fibroids, and the vaginal hysterectomy would be included in the grouping. These group to DRG 359 (uterine and adnexa procedure for non-malignancy without complication/comorbidity). The procedure has a weight of 00.8052.

On the other hand, if a patient was an outpatient when the vaginal hysterectomy for fibroids was performed and is then admitted as an inpatient for surgical after care, the principal diagnosis would be uterine fibroids, but the hysterectomy would not be included in the DRG grouping since the patient was not an inpatient at the time the procedure was performed. This groups

to DRG 369, menstrual and other female reproductive system disorders with a weight of 00.6577, which would result in a lower payment.

"The hospital payment is determined by multiplying the hospital's payment rate per case by the weight of the DRG. The money lost because the hospital does not receive payment for the procedure can result in a significant loss of money for a hospital over time," Lundgren says.

The inpatient-only rule was instituted in 1998 to regulate the setting in which Medicare patients undergo surgery. Procedures that may be appropriate as outpatient surgery for younger people may need to be performed on an inpatient basis for Medicare patients to ensure their safety and the best outcome, Hale adds.

"One important thing for hospital staff to remember is that just because a procedure has an APC payment code, it doesn't necessarily have to be done on an outpatient basis. If the procedure is on the inpatient-only list and the patient is a Medicare beneficiary, the hospital must perform the procedure in the inpatient setting in order to be paid," she says.

CMS determines that a procedure is on the inpatient-only list for three reasons, Lundgren says:

- * the nature of the procedure;
- * the need for at least 24 hours of post-operative recovery time or monitoring before the patient can be safely discharged;
- * the underlying physical condition of the patient undergoing surgery.

In the 1998 proposed rules initiating the inpatient only list, CMS acknowledged that some procedures classified in outpatient APC groups may seem closely related to procedures excluded from the OPSS on the basis of their status as inpatient procedures.

"We expect that when the former are performed in the outpatient setting, they will be only the simplest and least intense cases. The fact that a service is included in an APC group under the hospital OPSS should not be construed to mean that the procedures may only be performed in the outpatient setting. In every case, we expect the hospital to assess the risk to the individual patient and to act in the patient's best interest," according to the CMS document.

[For more information, contact Deborah Hale, CCS, Administrative Consultant Services, e-mail: deborah-hale@acsteam.net, Marianne Lundgren, RHIA CCS,

hospital payment monitoring program specialist with TMF Health Quality Institute, e-mail: mlundgren@txqio.sdps.org ■

Watch for Medicare discharge notice change

CMS issuing a revised Important Message notice

Beginning on July 1, hospitals will be required to give Medicare patients a notice of their right to appeal their discharge within two days of admission, answer any questions, and then obtain the signature of the patient or his or her representative.

If the date that the notice is signed is more than two calendar days before discharge, the hospital must give the patient a signed copy of the notice two days before discharge.

The requirements are part of the final rule, Notification of Hospital Discharge Appeal Rights, issued by the Centers for Medicare and Medicaid Services in November.

When the final rule takes effect, hospitals will be able to use a revised form of the Important Message from Medicare (IM) notice to explain discharge rights instead of having to create a new notice. CMS already requires hospitals to provide the Important Message to Medicare patients who are hospitalized.

CMS announced its intention to develop the revised IM documents in the next several months and to seek public comments in preparation for the July 1 implementation.

In the final rule, CMS announced its intention to include information about the discharge planning process in the revised IM and to encourage beneficiaries to talk to their physician or hospital staff if they have any concerns about discharge.

The discharge notice is required for both original Medicare beneficiaries and those who are enrolled in Medicare health plans.

If patients request a review by the Quality Improvement Organization (QIO) of the hospital's or Medicare health plan's determination that inpatient care is no longer necessary, the hospital or health plan must give the patient a more detailed notice.

In the final rule, CMS backed away from its initial proposal to require hospitals to submit a second notice of a patient's discharge appeal rights

24 hours before discharge, after receiving about 500 comments from professional associations, hospitals, health care professionals, state and national hospital associations, and managed care organizations. ■

CMS expands preventive service coverage

The Centers for Medicare & Medicaid Services (CMS) has expanded coverage for preventive services such as diabetes screening. Beginning Jan. 1, 2007, CMS is increasing payments for services that affect people with diabetes. Payments to physicians for some of the most frequently billed face-to-face doctor/patient services has increased and access for rural and underserved areas also has been enhanced. Preventive services, such as abdominal aortic aneurysm screening, have been added to the initial Medicare exam and colorectal screening procedures have been excluded from the Part B deductible. For more information on preventive tests covered by CMS, go to <http://www.cms.hhs.gov/partnerships/downloads/diabetesupdate.pdf>. ■

Joint Commission posts potential NPSGs for review

The Joint Commission on Accreditation of Healthcare Organizations has posted potential 2008 National Patient Safety Goals (NPSG) requirements and implementation expectations for field review by home care agencies.

Potential NPSGs considered for home care include:

- Addition of new requirements related to anticoagulation therapy as part of the goal to improve medication safety.
- Addition of a new goal to prevent patient harm associated with health worker fatigue.
- Addition of a new goal to prevent catheter and tubing misconnections.

The potential goals will be posted through Jan. 26, 2007. Go to www.jointcommission.org/Standards/FieldReviews/ to see the potential goals and the field review form. ■

(Continued from page 22)

ing staff, physicians, dietician, physical therapist, respiratory therapist, and home care coordinator.

At Methodist Medical Center, case managers are assigned by physician group. In addition to her duties as palliative care nurse coordinator, Jones is the case manager assigned to the hospital's oncologists.

"I'm already going over these kinds of issues with patients on the oncology unit. It comes naturally for me to do it with anybody I see," she says.

Beginning Jan. 1, Jones is devoting three full days a week to the palliative care program while someone else takes over her other case management duties.

"The hospital steering committee really likes the program. They've given us this extra time to help us provide services to the patients who need it," she says.

The program requires a physician's order before a patient can be referred for palliative care.

When Jones receives the order, she conducts an assessment to determine the patient's and family members' needs and helps them start a discussion about end-of-life issues.

"A lot of the frustration with hospice and comfort care occurs because people have to deal with issues they should have been thinking about months before. We help them start thinking about what may happen in the future," she says.

Jones talks with her patients and family members about advance directives and helps them complete them or at least get started talking about them.

"The goal of palliative care is to start people having serious conversations when it's not an end-of-life crisis. They may know that they won't be cured, but it's much easier if we can give psycho-social and spiritual support now, and not when there's a crisis situation," she says.

When Jones meets her palliative care patients for the first time, she asks them about their understanding of what their doctor has told them about their illness.

"We start from there. My job is not to change their minds about advance directives. My job is to make sure we understand as a hospital what their goals are and to help them achieve their goals," she says.

She assesses the patient's functional status to determine if they can perform activities of daily living without help and may bring in physical therapy to assess their needs.

Sources of support

Jones often asks the social workers to help deal with family and social issues or calls in a chaplain for spiritual support.

She helps them identify community resources and teaches the patient and family members symptom management at home.

"I educate them on everything from pain management to constipation or shortness of breath and tailor the education to the patient's individual needs," she says.

She arranges community support, whether it's referring them to support groups, arranging for home health, or setting up medical equipment.

"I'm there to give the patients information and support. I sit down and spend as much time as it takes to listen to all of their concerns. I may sit and cry with the family. I know I can't make everything right, but I can be there to listen and lend support. Sometimes 'touch' and 'presence' are more important than any words I could say," she says.

She works closely with the case managers and social workers on the unit when a patient needs to go to a skilled nursing facility or needs an insurance precertification. If the palliative care team recommends changes in the discharge planning for the patient, she notifies the case manager.

If there are symptom management or medication issues, she calls in Ronald Lands, MD, the medical advisor for the palliative care team.

"A lot of what I do is facilitating communication. I get the treatment team and the family together so everybody will be on the same page," she says.

Getting the family members with all of the patient's physicians at one time helps everybody understand the patient's true prognosis and condition, she says.

For instance, the family may cling to the cardiologist's declaration that the patient's heart is doing well but the nephrologist may be telling them that the kidneys are failing. The family meeting can address those issues, she says.

The palliative care treatment team has weekly meetings to discuss the plan of care for all of the patients in palliative care. The team includes Jones, Lands, a dietician, a social worker, the director of nursing, managers on the oncology unit, and clinical nurse specialists from the acute care unit, the patient's case manager, and a pharmacist when needed.

“With the palliative care patients, we see and evaluate everything that is going on with the patient and family and set up multidisciplinary conferences for the families so they’ll know what they’re facing and have all the information they need to make decisions,” she says.

The team shares information and articles on palliative care and discusses them and supports each other as they care for terminally ill patients.

“Our group meetings are like a therapy session. We are a small group, and we let our hair down. We discuss patients and their issues, but sometimes we have issues of our own and we help each other,” she says.

[For more information, contact Melissa Jones, BSN, RN, CCM, case manager and palliative care nurse coordinator at Methodist Medical Center, e-mail mjones@covhlth.com] ■

Palliative care unit tailors care to whole patient

Interdisciplinary team provides holistic care

The acute palliative care unit at Summa Health System’s Akron City Hospital takes a holistic approach to meeting the needs of patients with advanced complex illnesses and their families.

“The palliative care unit gives us an opportunity to look at everything the patient and the family needs and to provide them with physical, emotional, spiritual, and social support,” says **Carol Kucharski**, RN, OCN, staff nurse, who provides care to patients in the 12-bed unit.

The unit admitted its first patient in August 2006. Now the unit is almost continuously full.

Patients in palliative care have a serious or life-threatening illness and are looking at end-of-life issues, even if their illness is not considered terminal at the time of treatment, Kucharski points out.

The purpose of the unit is to address the needs of the patient and family member and allow them to go back to the home or another level of care. The average length of stay on the unit is three to five days.

“They progress well because we’ve impacted their lives,” she says.

Some of the patients are admitted from Summa’s home hospice program for pain and symptom management and return home. **(For details on Summa’s hospice program, see related article on page 20.)**

Others have an illness that they eventually will die from and come to the unit for pain and symptom management, then go home with home health care or hospice care.

Facilities

Summa’s palliative care unit was designed as a beautiful and soothing place for patients and family members during a difficult period in their lives. The unit has wooden floors, wall sconces, luminous ceiling tiles with nature and cloud images, live plants, and home-like window treatment. There are no restrictions on visits, and pet visitation is encouraged.

The unit has 12 large private patient rooms with space for family and friends to gather, and an area where a family member can sleep.

There are two family rooms where family members can gather to talk or relax, a kitchen area for patient and family use, a community room for private meetings with families and support groups, a kitchen area that family members and patients can use, and a place where they can shower. Patients can use a spa room with whirlpool tub.

The palliative care team includes physicians, RNs, LPNs, a spiritual care coordinator, a pharmacist, a dietician, a social worker, and members of the home hospice care team who work together to develop an individualized plan of care for each patient.

“It’s a specialized unit with people from a diversity of backgrounds, including the emergency department, the intensive care unit, telemetry, and oncology. Patients in the palliative care unit have a variety of needs requiring attention,” she says.

The interdisciplinary team has daily rounds to address the needs and concerns of each patient and to develop discharge plans. Before the conference, Kucharski gets input from her patients, “so I can feel like I can speak for them,” she says.

When she is assigned a new patient, Kucharski conducts a comprehensive assessment that goes far beyond the typical case management assessment.

“I sit down with the patient and family and

assess them emotionally to find out information about the family and the family situation. Palliative care is all about meeting people where they are and dealing with any issues they may have," she says.

Part of her job is just to listen.

"I give patients and family members a voice. I allow the patients and family members to verbalize what their needs are, and I really listen to them. I feel a lot better when I have been able to help them by impacting their feelings of frustration and hopelessness," she says.

She facilitates comprehensive management of the patients' physical, psychological, social, and spiritual needs, bringing in other team members when needed.

"People who are dying have extreme needs, and they are very diverse, and each family's needs are different," she says.

Kucharski concentrates on getting issues within the family resolved and may call in a social worker to help with psycho-social issues.

"I may assume the responsibility for bringing family members together. The patients are going to be stressed until their issues are resolved," she says.

The palliative care team makes sure that the patients are comfortable.

"Nurses are reluctant to give large doses of pain medication on the other units. We know all about pain medication and what relief it brings. Dying takes courage and it takes someone with expertise to help people through the process of dying," she says.

Three licensed health care professionals per shift work on the palliative care unit, providing care for 12 patients.

"These patients need a lot of attention. The team looks at their nursing needs and provides routine nursing care to keep them comfortable. We try to turn them frequently and provide other care to keep them comfortable so we don't always have to resort medications. It's an honor to work with this population of patients," she says.

Before the unit opened, the RNs and LPNs on the palliative care team went through a two-week orientation program.

The team continues its education at regular meetings and during rounds when the medical director brings in information on various topics that range from managing nerve pain, dealing with terminal agitation, the spiritual side of dying, and how to talk to patients about end-of-life issues, she says. ■

CNE questions

5. The Patient Self-Determination Act requires providers to ask patients if they have advanced directives. If patients need materials on advanced directives, what source should the hospital use in order to comply with the act?
 - a. Forms found on the Internet
 - b. Forms from the state's attorney general's office
 - c. Forms developed by the hospital
 - d. Forms from the hospital's attorney

6. A typical assessment for a new hospice patient at Hospice of Summa in Akron, OH takes how long?
 - a. one to two hours
 - b. two to three hours
 - c. two to four hours
 - d. one to three hours

7. What is the average length of stay for patients in Summa Health System's new palliative care unit?
 - a. 10 to 12 days
 - b. two to three weeks
 - c. three to five days
 - d. one to two weeks

8. If a Medicare patient undergoes a surgical procedure on CMS' "inpatient only list" and the order for an inpatient admission is not written or verbalized until the procedure has been performed, the hospital is not entitled for payment for the procedure.
 - a. true
 - b. false

Answer key: 5. b, 6. c, 7. c, 8. a

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

ACCESS MANAGEMENT

QUARTERLY

ED, primary care clinic pilot program for uninsured

'Working poor' are focus of services

A pilot program under way in Tucson, AZ, aims to direct uninsured patients who show up for care in the hospital emergency department to a nearby primary and specialty care clinic where they can find an ongoing medical home, says **Nancy Johnson**, RN, PhD(c), executive director of St. Elizabeth of Hungary Clinic.

The clinic, which is celebrating its 45th anniversary, was recently recognized by the Arizona Department of Health Services as the "gold standard" for care of the uninsured in southern Arizona.

People who come to the St. Mary's Hospital ED for conditions that are not emergencies because they have no regular provider and those who end up there because they are at the crisis point of an illness are the project's target population, adds Johnson, who also operates a consulting business called Quality Health Consultants with her physician husband.

"[ED staff] fax us every day a list of anybody who has come in for care that is uninsured, doesn't have a physician, and isn't an emergency," she says. "That's usually 12 to 15 people in a 24-hour period."

A staff member at the clinic calls the patients, explains how their names were obtained, and says something like, "We'd like to invite you over to establish St. Elizabeth as your medical home, a place to get care when there is not an emergency."

Patients at the clinic, which serves individuals who are not eligible for federal or state-funded health care programs, are put on a sliding scale and pay whatever they can afford, Johnson notes. "As a result, hopefully, the ED is seeing fewer uninsured people who are not emergency [cases]. ED care is very expensive and we want to make sure we have that for people who really need it.

"It's that idea of 'right person, right place, right service,'" she says.

"We're tracking what percentage of those people we can register for care, and what percentage actually keep their appointments," Johnson adds.

Cooperation between clinic and hospital staff is an ongoing focus at St. Elizabeth of Hungary, she says. "When one of our patients needs to have surgery for cancer, we call ahead to let the hospital know the person doesn't have insurance so they can be prepared to help rather than have it be a traumatic experience."

Clinic personnel work with hospitals to set up packages and payment plans for uninsured patients, Johnson adds. "It's a collaborative effort. We don't want people in the position of not seeking care because of fear of the system, that the cost will wipe them out [financially]."

One example is an arrangement with Tucson's University Hospital on obstetrics care, she explains.

Pregnant women without health insurance who don't qualify for government assistance are set up with a "package," whereby they make payments throughout the pregnancy, Johnson says. By the time the child is born, she adds, the payments are completed.

"It's a discounted total, but the flip side is that otherwise these women would just show up at the ED in labor with no [prenatal] care," Johnson points out. "The message here is that our staff work collaboratively with hospital registration and business staff, rather than letting things fall where they may."

Johnson says experience has shown her that most people—including many in the health care field—have a number of misconceptions regarding the uninsured population.

"People think [the uninsured] don't work, but in fact eight of 10 are working," she says. "These are the working poor. There are 46 million people

in the country without health care coverage, and here in Arizona, there are usually at least a million people without it at any one time."

Another thing many people believe, Johnson notes, is that it doesn't really matter if one has health insurance because necessary care will be provided regardless.

In fact, the uninsured are much less likely to get care, even with serious symptoms, she says, citing a woman with breast cancer who knew she had a lump but delayed seeking care because she was concerned about her inability to pay.

Children without health care coverage, Johnson says, don't get care for things like asthma, ear infections and sore throats.

At a recent presentation on uninsured care she made to a group of case managers, she notes, many had some of the same misconceptions as the general public.

Exacerbating the situation, Johnson adds, is the fact that health care insurance premiums were expected to rise between 6.7% and 9.9% in 2006. The average increase in Arizona was 10%, she says.

The web site (www.covertheuninsuredweek.org) is an excellent resource for health care professionals, Johnson says. "If you go there, you can click on your state, and it tells you, in English and Spanish, what services are available for the unin-

sured, how to find health insurance, and how to get both public and private coverage." ■

Hospitals told: Don't delay in getting ready for NPIs

Risks include lost, delayed reimbursement

Failure to adequately prepare for the advent of the National Provider Identifier (NPI) will have a significant impact on provider reimbursement, says **Beth Keith**, CHAM, senior management consultant for ACS Healthcare Solutions.

Rejected claims, delayed reimbursement, and potentially lost reimbursement will result, Keith cautions, if providers don't take the appropriate steps.

All health care providers covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), whether individuals or organizations, must obtain an NPI for use in identifying themselves in HIPAA standard transactions, she says.

A 10-digit numeric identifier that does not expire or change, the NPI must be used exclusively by May 23, 2007, to identify covered health care providers in standard health care transactions by HIPAA-covered entities, such as providers completing electronic transactions, health care clearinghouses, and large health plans. Small health plans must use only the NPI by May 23, 2008.

The identifier is used to ensure that medical claims are processed in a timely manner and payments are made correctly.

Keith advises hospitals to get ready for the change by making sure the following things have been done:

- NPI numbers have been obtained for all required providers;
- Existing provider master files have been cleaned and corrected;

CE objectives

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

- identify particular clinical, administrative, or regulatory issues related to the profession of case management;
- describe how those issues affect patients, case managers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■

COMING IN FUTURE MONTHS

■ How to determine the optimal case manager caseloads

■ Eliminating barriers to core measures compliance

■ How to improve your clinical documentation

■ Ways case management can be involved in disaster planning

- A crosswalk with NPI numbers and UPIN, payer identifiers, etc., for all providers has been mapped; and

- Dual NPA numbers and existing provider numbers are ready for testing claims submission to Medicare fiscal intermediaries, clearinghouses, and electronic billing vendors from Oct. 2, 2006, through May 22, 2007.

The change affects providers' information technology systems as well as their reimbursement, Keith points out, in that current claims-processing systems must accommodate the NPI identifier—in addition to current payer identifiers—from now until May 23, 2007.

"Following this initial implementation date," she adds, "the system must be prepared to switch completely to the NPI number by May 23, 2008, when small payers are required to comply with the ruling."

To facilitate the conversion, Keith points out, some organizations have volunteered to assist their medical staff through their medical staff credentialing offices. By assisting the physicians in obtaining these identifiers, she notes, these facilities have the data available for their IT system, which ensures their own success during the transition period.

"If your organization has not been involved in assisting your physicians in obtaining this impor-

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tant identifier," Keith says, "you must obtain these numbers from each medical staff member, enter them into your IT system, and validate their presence on the claim forms as of May 23, 2007."

It's advisable to get the number several months in advance so testing can be done between provider and payer systems to prevent any potential loss in reimbursement, she emphasizes. Following this initial effort, Keith suggests, providers should get the identifier as part of their physician credentialing information process. ■

HOSPITAL CASE MANAGEMENT™

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