HOSPITAL CASE MANAGEMENT™

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

AHC Media LLC

IN THIS ISSUE

■ **MS-DRG:** Documentation more important than ever . . . . . cover

■ **Present on admission:** Documentation required beginning Oct. 1 147

■ **Important Message:** Tips for meeting the Medicare requirement 148

■ **Guest Column:** When are patients deemed 'unsafe' for home care?. 150

■ ***Critical Path Network:*** Poster alerts patients to discharge responsibilities; DM plan helps unfunded patients 151

■ ***Discharge Planning Advisor:*** Plan targets Latino diabetes patients; consultant says CM should move to disease management model 155

■ **Inserted in this issue:**
— *Patient Safety Alert*

Financial Disclosure:
Managing Editor Jill Robbins, Associate Publisher Coles McKagen, Editor Mary Booth Thomas, and Guest Columnist Elizabeth Hogue report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Toni Cesta discloses that she is principal of Case Manager Solutions LLC.

OCTOBER 2007
VOL. 15, NO. 10 • (pages 145-160)

Documentation is more important than ever under MS-DRGs

System captures severity level with CCs and major CCs

Now that the Centers for Medicare & Medicaid Services (CMS) made the decision to replace the current DRG system with the Medicare Severity-DRG (MS-DRG) system for reimbursement, hospitals will be challenged to provide accurate documentation of patient conditions in order to receive the correct reimbursement, says **Deborah Hale**, CSS, president of Administrative Consultant Services Inc., a health care consulting firm based in Shawnee, OK.

"If case managers are responsible for documentation improvement, they need to understand the changes in the system and familiarize themselves with the new MS-DRGs. Continuing the same practices as in the past is likely to result in disaster," Hale adds.

The shift to the MS-DRG system for reimbursement is the first major revision to the inpatient prospective payment system since it was implemented in 1983. The new system replaces 538 DRGs with 745 new MS-DRGs to more accurately reflect the severity of each patient's condition and creates a distinction between severity levels by separating major comorbidities and complications from comorbidities and complications.

In addition, the final rule takes steps to ensure that Medicare no longer pays for the additional cost of some preventable conditions acquired in the hospital **(for more information, see related article on p. 147)** and expands the list of publicly reported quality measures to 27. Hospitals must track and report on all the measures in order to receive the full payment update.

In a surprising move when it issued its proposed rule for 2008 in April, CMS announced its intention to use the MS-DRG system instead of any of the five other severity-adjusted DRG systems being evaluated by the Rand Corp.

The agency asked Rand to evaluate the MS-DRG system using the same criteria applied to other DRG systems and did not rule out switching to an entirely different payment system for fiscal year 2009.

NOW AVAILABLE ON-LINE! Go to www.ahcmedia.com/online.html. Call (800) 688-2421 for details.

Based on Rand's analysis and strong support for the MS-DRGs among the 900 comments it received on its proposed rule, CMS announced that it anticipates adopting the MS-DRG system for long-term use.

"We plan on using Rand's report to further refine and improve the Medicare inpatient payment system and expect that any future refinements will be based on the MS-DRG," CMS stated in its final rule.

Despite suggestions to the contrary, CMS ruled out delaying the implementation of the MS-DRGs but is phasing in the financial impact of the new system by blending the relative weights for this year with those proposed under the MS-DRGs.

By better recognizing severity of illness, MS-DRGs shift payments from the less expensive to the more expensive cases. Under the MS-DRGs, urban hospitals, which typically treat more severely ill patients, will have a higher case mix index, and rural hospitals, which tend to treat less severely ill patients, will be likely to have a lower case mix index.

"The financial impact for some hospitals will be significant. Those who lose money the first year are likely to lose a whole lot more," Hale says.

The MS-DRG system renumbers DRGs hospitals have become accustomed to and splits base DRGs into three categories: MCC — major complication/comorbidity; CC — complication/comorbidity; and non-CC — neither of the above.

"The DRG numbers we've know all these years will not be recognizable. The base DRGs will remain the same but most are split into classifications," Hale says.

For instance, DRG 127 (congestive heart failure, or CHF) has been replaced by three MS-DRGs: MS-DRG 293 (CHF without a CC), MS-DRG 292 (CHF with CC), and DRG 291 (CHF with MCC).

Here's an example of how documentation could affect reimbursement for one hospital:

In the old system, reimbursement to a typical community hospital for congestive heart failure was $5,776. Under the MS-DRG system, reimbursement for DRG 29 is $4,024; DRG 292 would be $5,618; and DRG 291 would be $8,167. (Payment calculations are based on a hospital-specific rate of $5,500.)

CC list revised

Aside from a totally new numbering system, the most significant change in the 2008 final rule is that the CC list has been completely revised, Hale points out.

Many CCs have been eliminated. These include: uncontrolled diabetes, dehydration, angina pectoris, atrial fibrillation, chronic obstructive pulmonary disease, urinary tract infection, chronic renal insufficiency, and acute/chronic blood loss anemia.

The revised CC list comprises significant acute diseases, acute exacerbations of significant chronic illnesses, advanced or end-stage chronic

Hospital Case Management™ (ISSN# 1087-0652), including **Critical Path Network**™, is published monthly by AHC Media LLC, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Case Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 Mon.-Thurs.; 8:30-4:30 Fri. EST. E-mail: customerservice@ahcmedia.com. Web site: www.ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $469. Add $9.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $78 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact AHC Media LLC. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421.

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

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This program has been approved by the American Association of Critical-Care Nurses (AACN) for 9 Contact Hours, Category O, file number 10852.

This activity has been approved by the Commission for Case Manager Certification for 18 clock hours.

This program was approved by the National Association of Social Workers (provider # 886399925) for 18 continuing education contact hours.

The target audience for **Hospital Case Management**™ is hospital-based case managers. This activity is valid 36 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Mary Booth Thomas**, (marybootht@aol.com).
Senior Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Associate Publisher: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@ahcmedia.com).
Senior Production Editor: **Nancy McCreary**.

Copyright © 2007 by AHC Media LLC. **Hospital Case Management**™ and **Critical Path Network**™ are trademarks of AHC Media LLC. The trademarks **Hospital Case Management**™ and **Critical Path Network**™ are used herein under license. All rights reserved.

AHC Media LLC

Editorial Questions

For questions or comments, call **Jill Robbins** at (404) 262-5557.

diseases, and chronic diseases associated with extensive debility.

These include cases that require intensive monitoring, such as an ICU stay; expensive and technically complex services, such as a heart transplant; or extensive care requiring a greater number of caregivers, such as care for a quadriplegic.

The revised CC list was developed to distinguish cases more likely to increase hospital resources due to a secondary diagnosis and includes only conditions that would substantially increase resource consumption. For instance, mitral valve diseases are now a CC but unless they are associated with other diagnoses, such as congestive heart failure or respiratory failure, they wouldn't be expected to increase hospital resource cost, according to CMS.

"When the DRG system was implemented in 1983, people were admitted to the hospital for conditions that would be treated on an outpatient basis today. Now, patients have a higher severity of illness and the old CC list doesn't accurately reflect the amount of care patients need today," Hale says.

In fact, CMS cites MEDPAR data that show that, based on the current list, 77.66% of all patients admitted have at least one CC. Based on the revised list, the figure drops to 40.34%.

Assuring that the patient's medical record has all the documentation to back up the DRG will be crucial with the MS-DRGs and will necessitate documentation that wasn't required in the past, Hale says.

"The MCCs have the highest weight for severity of illness, and in some cases, require documentation that we haven't tried to get in the past because it didn't make a difference," Hale says.

For instance, among gastrointestinal disorders in the MS-DRG system, gastritis is a non-CC, blood in stool and GI bleed are CCs, and GI bleed due to gastritis is a major CC.

When congestive heart failure is a comorbidity, detailed documentation will be necessary for the condition to count as a CC or an MCC.

If a physician writes just "congestive heart failure" or "heart failure," the condition is a non-CC. For the condition to count as an MCC, it would have to be specifically documented "acute systolic heart failure," "acute systolic and diastolic heart failure," "acute on chronic systolic heart failure," "acute diastolic heart failure," or "acute on chronic diastolic heart failure."

Conditions that count as a CC include "left heart failure," "systolic heart failure" (not otherwise specified), "chronic systolic heart failure," "chronic diastolic heart failure," and "systolic and diastolic heart failure."

"Physicians rarely document anything other than 'congestive heart failure.' Further documentation hasn't been necessary in the past but it can have a huge impact on reimbursement with the MS-DRGs," Hale says.

Case managers can play a role in helping physicians identify the documentation terminology that needs to change and to help walk them through it, Hale adds.

The only way to know if diagnosis is an MCC or a CC is to look at the list, Hale points out. Case managers should identify their hospital's top DRGs and focus on them. Look at the corresponding MS-DRGs, see what has changed, and identify the opportunities where documentation can be improved, Hale suggests.

"Every one of them is different. There's not anything that's not important to look at. If a hospital has a lot of patients in a particular DRG, case managers should make sure they understand the documentation for that DRG," Hale says.

*(For more information, contact **Deborah Hale**, CSS, president of Administrative Consultant Services Inc., e-mail: DeborahHale@acsteam.net.*

To review the final rule document, see www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf. The list of the new MS-DRGs begins on page 1,375. The list of the CCs and MCCs is available in the proposed rule at: www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-P.pdf. Table 6J "Major Complications and Comorbidities List" begins on page 882. Table 6K "Complication and Comorbidity List" begins on page 940.) ■

'Present on admission' could have big effect

Eight conditions not reimbursed next year

Beginning Oct. 1, as part of the Centers for Medicare & Medicaid Services (CMS) shift to value-based purchasing, hospitals will have to report the "present on admission" indicator for every diagnosis reported for a patient.

Beginning with admission on and after Oct. 1,

2008, CMS will not assign a higher-paying DRG to patients who have eight secondary diagnoses unless they are documented as being present on admission.

Conditions that will not receive reimbursement beginning in 2008 are: catheter-associated urinary tract infections; decubitus ulcers; vascular catheter-associated infection; mediastinitis (a preventable surgical-site infection that develops after heart surgery); falls; object left in during surgery; air embolism; and blood incompatibility.

"Beginning next year, CMS will not pay to treat these hospital-acquired conditions. The only way to determine if a condition is not hospital-acquired is if it was noted in the documentation that it was present on admission," says **Deborah Hale**, CSS, president of Administrative Consultant Services Inc., a health care consulting firm in Shawnee, OK.

While recording the "present on admissions" indicators is the primary responsibility of the coding staff, case managers who are involved in clinical documentation improvement must make sure that all conditions that are present when the patient is admitted are included in the documentation.

This will enable coders to identify the appropriate indicators as they review the charts and note which conditions were present on admission.

Here is an example from Hale that illustrates why the "present on admission" documentation is important:

Beginning next year, CMS will not pay for treatment of decubitus ulcers if they develop during the course of a hospital stay. The condition is not always well documented and often doesn't show up in the medical record until the wound care nurse is called in, Hale says.

"This could cause a dilemma for coders because, even though the patient may have had the condition when he or she was admitted, if it's not documented in the beginning, they must assume that is wasn't present on admission and the hospital won't be paid for the cost of treating the condition," she says.

Case managers should make sure that there is a complete assessment of patients at the time of admission so the record accurately reflects what conditions they came in with as opposed to what developed during the course of the hospital stay, Hale suggests.

Track diagnoses that are listed as "not present on admission" and those that develop during the hospital stay and identify areas for quality improvement projects, she adds. ■

Delivering the Medicare Important Message

Education, documentation will help you comply

If your hospital is having difficulty complying with the new Medicare rule for notifying patients of their right to appeal their discharge, you're not alone.

"It's difficult to deliver the message and everybody is struggling with the new components," says **Cassandra Barnes**, RN, MS, CCM, senior consultant for case management at Pershing Yoakley & Associates' Atlanta office.

The new rule, which went into effect July 2, updates a previous regulation establishing how hospitals must notify Medicare beneficiaries of their right to appeal their discharge, their financial responsibility, and how to appeal a hospital discharge.

The rule applies to traditional Medicare beneficiaries, beneficiaries enrolled in Medicare Advantage programs, and other Medicare health plans that are subject to Medicare regulations.

The Important Message (IM) from Medicare must be delivered within two calendar days of inpatient admission and must be signed by the beneficiary or his or her representative and dated and a copy must be given to that person. If a patient stays more than two days in the hospital, he or she must receive a copy of the original signed form within two calendar days of discharge.

CMS allows hospitals to issue the IM at preadmission but not more than seven calendar days before the admission.

Medicare beneficiaries who are admitted to outpatient observation can be given the IM when they are admitted if they are advised of the difference between observation and inpatient admission.

If the patient's status is converted to an inpatient level of care, the IM should be delivered within two days of when the level of care changes.

If a patient disagrees with the discharge and requests a review by the Quality Improvement Organization (QIO) following the hospital's or Medicare's determination that inpatient care is no longer necessary, the hospital must give the patient a more detailed notice that further explains the appeals process. This notice should be delivered as soon as the QIO notifies the hospital that a Medicare beneficiary has requested a QIO review.

Historically, patient registration staff have delivered the initial IM from Medicare, but just handing patients a notice and getting their signature doesn't meet the intent of the law, Barnes points out.

"The whole intent of the Important Message is to let Medicare beneficiaries know that they have the right to appeal their discharge date if they disagree with the physician. This means that all hospital staff involved in the delivery of the Important Message must make sure that patients understand what they are signing," she says.

Barnes recommends that hospitals create a script for the admissions staff, making sure they explain what the notice of appeal means in order to meet the intention of the requirement and maintain continuity in the delivery process.

"We tell the admissions staff to make sure the patients understand that if they are in the hospital more than two days, they'll get another copy. Otherwise, they may be confused when they get the second notice," Barnes says.

When is the best time?

At Weatherford Regional Medical Center in Weatherford, TX, patients are given the Important Message from Medicare when they go through registration. Then the case managers discuss the document with the patients and family members and make sure they understand it when they make their initial assessment, says **Lyn Clark**, RN, BSN, MHA, director of case management for the 99-bed hospital.

"Sometimes patients coming into the hospital are disoriented and put it with their other papers. Admission may not be the right time to make sure they understand it. That's why we cover it when we complete our initial assessment," she adds.

The case management secretary at Southern Ocean County Hospital in Manahawkin, NJ, is responsible for making sure that Medicare patients receive the Important Message in a timely manner. She goes on every unit each morning and gives the document to the new patients.

If the patient doesn't seem to understand the document, she notifies the case manager, who talks to the patient about the document and contacts the next of kin or person with power of attorney for the patient, says **Marilyn Butler**, RN, MSN, CCM, director of case management.

Hospitals should take an interdisciplinary approach to ensuring that the patients get the Important Message as specified by the regulation, Barnes says.

"In most organizations, case managers don't work 24 hours a day, seven days a week. Hospitals must make sure that someone delivers the Important Message when case management is not available," she says.

Make sure that all hospital staff who may be involved in delivering the Important Message can accurately inform beneficiaries of their appeal rights and answer questions.

"Ultimately, the entire organization is responsible for becoming compliant with this process," adds **Lorraine Larrance**, BSN, MHSA, CPHQ, CCM, manager with Pershing Yoakley & Associates.

Schedule follow-up

She suggests setting up a mechanism to ensure that the follow-up copy of the Important Message is delivered on weekends and holidays, or other times when the case manager is not available and assign responsibility to the charge nurse, house supervisor, discharging nurse or other staff member.

Any staff who may be responsible for delivering the Important Message should receive formal education on the process and what is required. The same formal education should be part of orientation for new employees, Larrance adds.

"Clinical conditions may change drastically during the day. If the doctor says a patient can be discharged at 5 p.m. on Sunday, Medicare recognizes that the patient recovered sooner than anticipated but that doesn't eliminate the necessity to deliver the Important Message. It's OK to give patients the Important Message on the day of discharge. However, there should be a four-hour window between the time the Important Message is delivered and discharge to give the patient a chance to appeal," Barnes says.

At Weatherford Regional Medical Center, nurses and house supervisors are trained to deliver the notice if the discharge takes place sooner than anticipated and the case manager is not on duty.

In the event that a patient wants to request a review by the QIO, someone on the staff should know what steps the hospital should take, Larrance says. This could be charge nurses, house supervisors, case managers, social workers, or utilization review nurses, she says.

Someone on the evening, night, and weekend shifts should be educated on the process, adds Larrance.

Larrance suggests preparing a packet of infor-

mation with specific instructions on copying/faxing the medical records, QIO contact numbers, designated contact persons for the QIO, required turnaround times, and other information that will help staff facilitate the QIO review process.

Making sure that patients with longer lengths of stay receive the Important Message two days before discharge has proved to be a challenge, Barnes says.

"Some organizations have chosen just to deliver the notice every couple of days so they won't be noncompliant. This is really confusing to patients and should not be the normal practice," she adds.

Hospitals can ensure that they are compliant and not issuing notices unnecessarily by proactively identifying potential discharges, she adds. Interdisciplinary team meetings, bed control meetings, and hospital rounds are all ways to capture potential discharges.

"If you watch patients' clinical progress, there is a point at which you can recognize that the patient is almost ready for discharge. Taking this proactive step can help hospitals comply," Barnes says.

At Weatherford, the case manager puts a sticker on the front of the chart noting the date that the Important Message has been delivered and alerting staff that the patient needs to receive another copy if the length of stay exceeds two days.

"We look at the charts every day to see what the anticipated discharge will be and make sure the Important Message is delivered within the specified time frame," Clark says.

At Southern Ocean County Hospital, the case management secretary keeps a spreadsheet showing who has received the document and communicates with the case managers on each unit every morning to find out which patients may be discharged within the next few days — then makes sure that they receive a copy of the form.

Documenting that the Important Message was delivered is important, Larrance points out. She suggests creating an admissions checklist so that patient registration staff can document that Medicare beneficiaries admitted to inpatient or outpatient observation status receive the initial Important Message.

Discharge planning worksheets should provide documentation of the discharge planning activities, including anticipated discharge dates. They should be updated every two to four days, she adds.

Larrance suggests monitoring compliance with all aspects of the rule at least every three months until trends are stable and the compliance officer has determined that compliance with the rule has been achieved. Include the results of the compliance audits in your process improvement initiatives, she adds.

*(For more information, contact **Marilyn Butler**, RN, MSN, CCM, director of case management, Southern Ocean County Hospital, e-mail: mbutler@soch.com; **Lyn Clark**, RN, BSN, MHA, director of case management, Weatherford Regional Medical Center, e-mail: zlaclark@hotmail.com; **Lorraine Larrance** BSN, MHSA, CPHQ, CCM, manager with Pershing Yoakley & Associates, e-mail: llarrance@pyapc.com.)* ■

GUEST COLUMN

When are patients deemed 'unsafe' for home care?

By **Elizabeth E. Hogue**, Esq.
Burtonsville, MD

Discharge planners/case managers are likely to encounter instances in which home care, hospice, and home medical equipment (HME) providers state that they cannot accept patients because they are "unsafe" at home. The use of this term may be confusing to discharge planners/case managers. What is it about patients' homes that make them "unsafe" for them to receive services there? Aren't all patients appropriate for home care?

First, discharge planners/case managers may not have provided services in noninstitutional settings. If so, it may be difficult to make a crucial distinction between institutional care and home health services.

Specifically, in institutional settings the provider controls the "turf" on which care is rendered. In post-acute care at home, providers have very little control over the environment in which services are provided. In fact, patients control the "turf" in home care because services are rendered in their private residences over which patients have almost absolute control.

Consequently, home care providers often con-

(Continued on page 155)

CRITICAL PATH NETWORK™

Poster alerts patients to their discharge responsibilities

Markers allow family members, nurses to write questions and answers

Patients at Seton Medical Center are made aware of their proposed discharge date early in the stay through a laminated poster with a Wizard of Oz theme titled "The Road Home."

The 11x17-inch poster, written in English and Spanish, prompts patients to ask questions ahead of time instead of waiting until the day of discharge.

"We provide dry-erase markers that allow family members and patients to jot down questions and communicate back and forth with the nurses and case managers, and to get their questions answered in a timely manner so they'll be prepared for discharge," says **Patricia Ramming**, RN, network director of patient logistics at Seton Healthcare Network in Austin, TX.

The poster includes questions patients may want to ask about discharge, such as details about diet, post-discharge activities, and medications they will have to take. It includes other questions such as, "Are you going to have problems getting your prescription filled?" and "Do you have transportation home?"

Using the poster to get patients ready for discharge is one of a series of throughput initiatives that are part of a partnership among case management, the clinical staff, admitting, and the housekeeping department.

For instance, the case management team compares the hospital's length of stay, weighted for acuity, to other hospitals and targets Seton for the top 10%.

In 2004, faced with an increasing number of patients on hold overnight in the emergency department, Seton Medical Center created a throughput department that operates 24 hours, seven days a week. Department staff include house supervisors, express admissions nurses, and nonclinical bed board staff. The hold time in the emergency department dropped dramatically after the department was created.

"We are continually looking at ways to be more efficient on the discharge end. We typically run at 85% capacity and are looking at ways to get more beds utilized without increasing our capacity," Ramming says.

Among the initiatives are a daily bed briefing to discuss bed and staffing issues for the day; a discharge team that brainstorms about patients with complex discharge needs; and a network-wide bed board that tracks capacity throughout the entire hospital system.

Representatives from all areas of the hospital, including charge nurses from every floor, managers and directors of every department, case management, and human resources, attend the morning bed briefing.

The multidisciplinary team also includes representatives from plant operations in case there are mechanical issues; central supply, which provides all patient care equipment; and environmental services so they know what to expect and can staff as needed for the projected volume for the day. The house supervisor leads the meeting.

"We share the plan for the day, looking at all discharges and arrivals and identifying areas where there might be bottlenecks. We work as a team to expedite the admissions and discharges we know about in the morning," Ramming says.

The team comes up with a plan to ensure that admissions and discharges flow smoothly throughout the day. For instance, if the ICU is at capacity, and there are patients scheduled for surgery who

will need to be in the ICU, the ICU team facilitates moving patients out if they can be transferred safely to another unit.

"The ancillary departments are part of the multidisciplinary team and we problem-solve together on ways to expedite the tests and procedures patients need before discharge. For instance, we have teamed with the laboratory to develop a bright-pink sticker that shows we need these labs run first," she says.

Dealing with complex discharge needs

A discharge team meets weekly to discuss discharge options of patients with complex discharge needs. The team includes case management, nursing, admitting, and sometimes social work, depending on the needs of the patient.

The team discusses any obstacles to discharge, including financial constraints if the patient is stable enough to move to another level of care.

"We determine if we need to get financial clearance with a post-discharge provider. If the patient has Medicaid pending, we have contracts with post-acute providers so that Seton provides the financial support to the patient; then once Medicaid is approved, the facility reimburses us," Ramming says.

The team conducts a cost-benefit analysis to determine if it's cheaper to pay for a lower level of care instead of keeping the patient in acute care.

"This arrangement helps decrease length of stay and frees up the bed for patients whose care is covered by a payer," she says.

Each hospital site has a patient flow committee, a multidisciplinary team that meets once a month to examine any type of discharge problems that come up regularly. The system is expanding the initiative to the network level with a network committee that will share successful initiatives with peers in other Seton hospitals.

Bedside discharge

The hospital has eliminated one step in the discharge process, sending financial counselors to patient rooms to go over billing issues and collect copayments rather than having them stop by the admissions office on their way out of the hospital.

When the patient tracking system indicates that a discharge is pending, the financial counselor clears it with the nursing staff and goes to the patient's room. The initiative is called courtesy discharge rounds and was started at one site and has been rolled out across Seton's campuses.

"It's more private to have a discussion in the room and the patients are more relaxed. This has eliminated having several patients waiting at the admissions office at one time," she says.

The hospital's electronic bed board gives the staff real-time information on what beds are ready for patients, which ones are being cleaned, which are blocked, and pending discharges and admissions. It allows the admissions staff to determine when beds will be needed on which unit and set priorities for the housekeeping staff.

The board includes information about scheduled admissions for the next five days, giving staff the opportunity to make sure paperwork is in order before the patient arrives.

"The admissions case manager can see when a bed request comes in and can proactively make sure the documentation is in place so that the patient meets InterQual criteria," she says.

Physician offices can make one call to find out capacity in any Seton hospital.

"We have systems in place to give an upcoming admission visibility. Admissions can complete the insurance verification; the case manager can review the doctor's orders ahead of time and make sure the patient meets InterQual criteria," she says.

The system helps with forecasting and scheduling of patients. For instance, Seton does not have an outpatient infusion center and anyone who is receiving a blood or chemotherapy infusion must be in an inpatient bed. If someone is coming in for a blood transfusion or chemotherapy and one campus is at capacity, the bed board staff can divert the patient to a facility that can serve them immediately rather than having them wait.

When a physician calls the central phone number to admit a patient to a particular hospital, staff can see instantly if the hospital is full.

"If Seton Medical Center is full, they can tell the doctor that there is a potential discharge in four hours or they can admit the patient directly to Seton Northwest," she says.

The bed board gives the staff the ability to visualize the emergency department's volume at all hospitals within the system.

"If we're getting a transfer request for a tertiary care center, we can focus that request to the emergency department that can handle the patient," she says.

The Seton network has a zero-diversion agreement with the local emergency medical systems. The EMS system can communicate through the

Seton system and find out which hospitals have capacity in the emergency department and bed availability.

"Our network includes a Level II trauma center, a children's center, a cardiac and heart transplant center, and other tertiary care centers. Whenever possible, we can triage patients to the most available facility for stabilization and transfer them to other facilities where they can get the care they need," she says.

Other initiatives include:

• Creating the position of an express admissions nurse who floats through the hospital and helps whenever needed, getting the paperwork started, conducting a history and physical, drawing blood, or taking care of other admission needs for the patient.

• Expanding the patient tracking system so that the admissions staff can see projected discharges in a timely manner and work up front to collaborate with case management and nursing staff to identify where and when beds will be available.

• They are piloting a new case management structure on some floors. "Instead of case managers being located geographically in the unit, we are focusing more on the patient illness and scope of services," she says.

For instance, the same case manager follows a pulmonary patient from the ICU to the floor, instead of handing it off to another case manager when the patient is transferred to a different unit.

"We have reestablished the relationship that the case management team has with the utilization review team. The utilization review team works in partnership with the case managers proactively for the patient instead of getting involved on the back end," she says.

*(For more information, contact **Patricia Ramming**, RN, network director of patient logistics, Seton Healthcare Network, e-mail: pramming@Seton.org.)* ■

Disease management plan helps unfunded patients

Hospital system manages care of chronically ill

A disease management program implemented by nurse case managers helps chronically ill unfunded patients cared for by the North Broward Hospital District avoid hospitalizations and emergency room visits.

The hospital system started the program eight years ago to help alleviate the number of unfunded patients with chronic illnesses who were coming to the emergency department because they didn't have a primary care provider and were not getting the care they needed to keep their condition under control.

The program focuses on patients in the community who may have access issues, financial limitations, and who may never have been to a primary care provider.

"It's a win-win situation for everyone. We get these patients established with a doctor or a nurse practitioner and make sure they get the right care. The patients are healthier and we keep patients who have no ability to pay out of the hospital and the emergency room. Our strategy was to ensure a healthier community and it has worked," says **Lori Kessler**, BSW, MHSA, district manager for disease state management programs.

The program illustrates the benefit of educating people with chronic illnesses about their conditions and helping them stay healthy, Kessler points out.

"We did a cost-avoidance analysis and the program has paid for itself. People with chronic illnesses who don't take their medications, monitor their conditions, or keep their appointments with their primary care provider are likely to be hospitalized. By monitoring these chronic illnesses, we are improving the quality of life for these patients and cutting down their medical costs at the same time," she adds.

North Broward Hospital District, with headquarters in Fort Lauderdale, FL, has five acute-care facilities and 11 primary care sites. The nurse case managers are located at the primary care site and coordinate care for patients with asthma, hypertension, congestive heart failure, HIV-AIDS, breast cancer, and high-risk pregnancies.

Patients without insurance and those with Medicaid are eligible for the chronic illness program. There is no charge to the patient for participating in the program.

The nurse case managers work face-to-face with patients, meeting them at the doctor's office and acting as their liaison and advocate.

"The nurse may accompany patients to doctor visits and may suggest that patients show the doctor their blood sugar log or peak flow log or prompt them to give the doctor information about symptoms or to ask questions about the

treatment plan," Kessler says.

They educate the patients to help them gain control of their disease, to understand their disease and its complications and comorbidities. They also teach them about the importance of adhering to their treatment plan, seeing their physician regularly, and to act before their symptoms become severe enough to warrant hospitalization or an emergency department visit.

They teach their patients the importance of receiving recommended tests and procedures, such as eye examinations for diabetics. They call to remind patients of physician appointments and to get their medications filled.

"We take a team approach to managing care. We work closely with the providers to make sure that the patients follow the treatment plan. The providers are happy that our nurse case managers are there on site to provide patient education, like teaching the patients how to use a glucometer," she says.

About 60% of the patients are referred by the hospitals in the North Broward District. The rest are referred by the clinics and community agencies.

When patients are referred to the program, a case manager examines their records in the hospital system's electronic medical record to get clinical details, then calls the patient and develops a plan for managing the patient's condition.

Finding patients' medical homes

When a patient is referred to the program, the nurse case managers find out if the patient has a medical home. If patients have been hospitalized or visited the emergency department and don't have a medical home, the case managers help them find a physician at a convenient location and ensure that they get the follow-up care they need.

The nurses stratify the patients based on psychosocial issues, utilization of health care resources, and clinical indicators.

In addition to seeing them in the clinic, the nurse case managers contact the patients at regular intervals, depending on the patient's risk for a decline in health status and other factors.

"Even if a patient has a good control of her medical [condition] but may have just lost her husband, the case manager will call more frequently. Or, if someone has started a new medication, the nurse will call to make sure everything is going well," she says.

The nurse case managers slowly build relationships with their patients, working on the issues that are most important to the patient as they educate the patient about their disease and the importance of preventive care while being culturally sensitive to the patient.

"Sometimes the patient presents to the case manager and all she can think about is how bad her eyes have gotten. Before we can move into any other real [area] of her care, we get her eyes checked. This gives the nurse a starting point and over time she can expand to other health care problems or health-related issues the patient needs to address," she says.

Sometimes patients are in denial because they don't have symptoms and the case manager must educate them on the disease. "They may have hypertension but they don't feel bad or have symptoms until they have the first stroke. If they have no funds, they can't go for preventive care," she says.

They assess the patients' needs and work with community agencies to make sure eligible patients are receiving food stamps and other needed resources.

The case managers are assigned to patients by location, rather than disease.

"So many of these patients have comorbidities so it's better to have one nurse coordinating the care for all of the conditions. The nurses can always call on others for help and often co-manage patients with complicated diseases like HIV or cardiovascular disease," Kessler says.

Because the patient population is culturally diverse, most of the staff speak more than one language, including Spanish, Creole, and French.

In addition to conducting one-on-one education, the nurse case managers in the program arrange regular group sessions for patients with a particular disease, often partnering with other resources in the community. For example, the program organizes "Foot Days" and invites all the patients with diabetes to participate.

Kessler brings in a podiatrist from Nova University to help with the education sessions and to conduct foot examinations. She gives the participants small mirrors and encourages them to check their feet regularly.

"We get the patients educated and their feet checked for free and the Nova University students get good experience," she says.

*(For more information, contact **Lori Kessler**, BSW, MHSA, district manager for disease state management programs, North Broward Hospital District, e-mail: lkessler@nbhd.org.)* ■

(Continued from page 150)

front barriers to the provision of services that many discharge planners have not experienced. Staff have, for example, encountered "attack" geese when they arrive at patients' homes and risk the consequences of a serious "pecking" in order to reach patients' bedsides! Or, they have come eye to eye with a pet alligator named "Bubba" in a mobile home in Louisiana!

Although patients may not be adversely affected by pecking geese and may have a cozy relationship with "Bubba," there may be other factors over which home care providers have no control that clearly jeopardize the well-being or safety of patients. These factors may make it impossible for providers to render services at home.

Patients' homes may, for example, be in such disrepair that both patients and caregivers are at risk. A home health nurse, for example, recently fell through the floor of a patient's home as she approached the patient's bedside.

Patients' homes also may be infested with roaches, rodents, and/or vermin of various types and descriptions.

Patients may suffer repeated falls at home despite appropriate interventions from providers that make it risky or "unsafe" for patients to remain at home.

Despite these examples, discharge planners/case managers still may be unclear about why patients cannot be cared for at home when post-acute providers decline referrals on the basis that patients are "unsafe." It may be helpful for providers to be much more specific in their communications. Specifically, it may be more helpful for providers to say, "The patient's home environment will not support services at home for the following reasons . . ."

When providers' communications with discharge planners/case managers are vague or unclear, it may be helpful for discharge planners to prompt more specific communication by asking: "What are the specific reasons why this patient's home environment will not support home care services?"

Institutional care and home health services are fundamentally different models of care. Because the differences are so great, it is reasonable to expect that providers who practice primarily in institutions and those who work in home care may not always understand or account for important factors involved in different types of care. Clear, specific communications are, therefore, absolutely essential for the well-being of patients. ■

Discharge Planning Advisor®

– the update for improving continuity of care

- Accelerated discharge
- Staff cooperation
- Placement strategies
- Reimbursement
- Legal issues
- Case management

Project targets diabetes in Latino community

'Secondary gains' affect willingness to accept help

The "yes-means-no" phenomenon was one of several challenges encountered by the team conducting a community case management pilot project for diabetes patients in Nogales, AZ, says **Donna Zazworsky**, RN, MS, CCM, FAAN, diabetes care center manager for the Tucson-based Carondelet Health Network.

The project — which targeted emergency department (ED) "frequent fliers" with diabetes — focused on establishing the care team and developing a case management toolkit for home diabetes education visits, she adds.

"Nogales is primarily a Latino community, with a very high incidence of diabetes," Zazworsky notes. "Carondelet Holy Cross Hospital had started an inpatient case management program where anyone hospitalized with diabetes would be seen by a nurse case manager/diabetes educator and referred to diabetes self-management classes held in the community."

This helped people who were hospitalized, but the process missed those ED frequent fliers with diabetes, Zazworsky says. "These individuals were not making their way to the classes.

"Many of these patients said that it was just too hard to get to the classes," she explains, "or there was a secondary gain they had. In one case, a gentleman wanted to get on disability and needed to get documentation, so he didn't want to get any better.

"Others wanted to [use their disease to] get attention from family," Zazworsky says. "They had the wherewithal to get to classes, but just didn't go."

Another barrier identified by the team was "the concept of 'yes means no,'" she points out. The phrase, used as the title of a book written in regard to Native Americans, also applies to Latinos, Zazworsky says. "It's not polite to tell you, 'No, I don't want to do that,' so they say, 'Yes.'"

Carondelet Holy Cross Hospital in Nogales received a grant from the Arizona Department of Health Services to conduct the pilot project in March 2007, she says, and had to complete it by June 30. We had to use [the funds] by the end of the fiscal year.

"We already knew the community nurse case management program would be funded beginning July 1, but we got the grant to fund the nurse to identify the tools, test them, and put them in place," Zazworsky adds.

"We had a tracking system in place for inpatients and were building a database for why we needed a program to extend beyond the walls of the hospital," she explains. "When the grant came along, it gave us the opportunity to put the structure in place for that program."

Starting line-up

The program was promoted to the hospital's ED nursing supervisor, case manager, and social worker, each of whom was involved in shaping the pilot, Zazworsky says. "The program targeted only patients who came through the ED for a diabetes-related episode."

One of the objectives of the project was to reconvene the Nogales Diabetes Partnership Team, which already had been instrumental in establishing a number of programs and services related to diabetes for the Nogales community. The team met every other Thursday from noon to 1 p.m. over a period of seven weeks.

In addition to Zazworsky, that team includes a diabetes nurse practitioner with the Carondelet Diabetes Care Centers; the diabetes nurse case manager and several other clinicians and administrative staff with Holy Cross Hospital; and three representatives from the Mariposa Community Health Center in Nogales.

The behavioral health specialist from the Mariposa center was an active member of the partnership team, Zazworsky notes, attending the biweekly meetings and available to coordinate visits to his counseling program.

As part of the pilot project, the team used assessment tools from the Case Management Adherence Guidelines (www.CMSA.org), as well as a risk assessment tool that was already in place for Carondelet diabetes inpatients, she adds. "We were targeting everybody and trying to get a baseline on readiness, knowledge, and motivation."

The tools were translated into Spanish by a licensed translator from the area who works with the Carondelet system, Zazworsky says. "This is important to guarantee that we are using the appropriate terminology specific to our Latino region.

"The bottom line was that we were able to get patients into the program and agree to have a nurse case manager make a home visit," she says. "The key was the ED nurse, who provided patient referrals to the community nurse case manager and explained the program to patients. There had to be some kind of handoff so that the patient was aware of the program."

To facilitate that process, Zazworsky notes, the ED nurse made 3x5 note cards explaining that the nurse case manager would call to set up a time for a home visit in order to see how she could help the patient.

The nurse case manager would call within 24 hours to set up the visit, and would then make the visit within 48 hours, Zazworsky says. During the visit, she adds, the nurse case manager would use the tools to gauge the patient's knowledge, readiness, motivation, and literacy level in regard to the diabetes.

Of 36 patients contacted about participating in the pilot, 20 — ranging in age from the 40s to older than 70 — became part of the project, she explains. Fifteen patients actually completed the project.

Short-term outcomes, she adds, showed that "the tools worked, and helped guide the case manager on how to do her work, and there was immediate improvement in patients' levels of confidence."

The project evaluation process showed that even with short-term nurse case management interventions in the home, the target goal of 4.5 out of 5 in confidence levels was met in these areas:

- make healthy food choices (4.5);
- identify foods with carbohydrates (4.5);
- find diabetes information and support (4.5);
- detect and take action for low blood sugar (4.8);
- examine feet for problems and know how to care for them (4.6);
- work with a health care provider (5).

However, project results showed that patient confidence levels went down in one area — how diabetes medications work and their possible side effects. That drop may be related, team

members suggested, to an increase in medication awareness that happened as a result of patients' ED visits and their work with the case manager.

"Patients were either put on new meds or they realized they didn't understand the action of their medications," Zazworsky notes.

As a result of the pilot, she adds, the partnership team will continue to monitor numbers to determine appropriate cutoffs for risk level, adherence level, and intervention strategies.

"We still have those outliers that refused services from the nurse case manager and continued to use the ED," she says. "We know as case managers that we are not able to convince everybody that they could benefit from our help."

One of the team's observations in regard to the outliers, Zazworsky says, was that high knowledge/high motivation does not equal better self-care, and that in fact, modifiers — such as the desire for more attention from the family — have a greater effect on patient behavior.

"When we realized that, we really wanted those patients to have some behavorial health [intervention], but they weren't willing to get the appointment, and it wasn't the kind of scenario in which we could have [therapists] come into the home."

One possibility for addressing that issue, she adds, is to look at "telebehavioral health" — a video phone setup that allows the therapist to work with the patient remotely.

"That can open the door to other modalities," Zazworsky says. "What it's about is building the trusting relationship."

(Editor's note: ***Donna Zazworsky*** *can be reached at donnazaz@aol.com.)* ■

Consultant: CM must move to DM model

Gap between research, practices cited

With studies showing that 10% of patients are using 90% of the nation's health care resources, traditional case management must move to a disease management model, says **Bob Whipple**, RNC, CCM, CCS, MHA, a Boston-based senior management consultant with ACS Healthcare Solutions.

"Moving to a disease management model gives greater flexibility for meeting new challenges," Whipple adds. "It is the future of case management."

CNE *questions*

13. How many quality measures must hospitals report when the CMS final rule for fiscal year 2008 goes into effect Oct. 1?
A. 25
B. 26
C. 27
D. 28

14. Beginning in October 2008, Medicare will not reimburse hospitals for treating eight hospital-acquired conditions. Which of these is NOT one of the conditions?
A. Catheter-associated urinary tract infections
B. *Staphylococcus aureus* septicemia
C. Air embolism
D. Mediastinitis

15. CMS allows hospitals to issue the Important Message from Medicare, which informs patients of their right to appeal their discharge, at preadmission but not more than seven calendar days before admission.
A. True
B. False

16. Lorraine Larrance, BSN, MHSA, CPHQ, CCM, suggests assigning which of the following disciplines with ensuring a follow-up copy of the Important Message is delivered on weekends or holidays when case managers are not available?
A. Charge nurse
B. House supervisor
C. Discharging nurse
D. All of the above

Answer key: 13. C; 14. B; 15. A; 16. D.

CNE instructions

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

Disease management — preventive, diagnostic, and therapeutic services for types of patients considered at risk — is widely considered to be a more cost-effective approach to care, he points out. The Disease Management Association of America, Whipple notes, defines disease management as "a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant."

Those conditions, he continues, include these chronic diseases:

- congestive heart failure;
- asthma;
- cancer;
- coronary artery disease;
- chronic obstructive pulmonary disease;
- cystic fibrosis;
- depression;
- diabetes;
- HIV/AIDS
- hypertension;
- lupus;
- multiple sclerosis.

Medical research has created a growing body of evidence on the most effective protocols for treating chronic diseases, Whipple notes. "However, reports by the Institute of Medicine and others have observed that a large gap often exists between such evidence-based treatment guidelines and current patterns of practice."

The case management model in place at most hospitals, he contends, is not adequately addressing the needs of the chronically ill.

Whipple points out a number of broad differences between case management and disease management, and elaborates on them as follows:

- **Characteristics of patient population.**

Case management: People at high risk for costly, adverse medical events and poor health outcomes. **Disease management:** People diagnosed with a specific disease.

- **Methods for identifying patient.**

Case management: Mailed questionnaires; data on use of hospitals and emergency departments; referrals by physicians using criteria to identify "high-risk" patients. **Disease management:** Data on presence of a particular diagnosis; prescription for certain drugs used to treat a disease; referrals by physicians who treat many patients with that disease.

- **Patient education.**

Case management: No standardization of curriculum or educational materials; highly individualized. **Disease management:** Standardized curriculum and educational materials for a specific disease.

- **Reliance on evidence-based treatment guidelines.**

Case management: Low. **Disease management:** High.

- **Reliance on protocols and standardization.**

Case management: Low. **Disease management:** High.

- **Importance of using social support services.**

Case management: High. **Disease management:** Low.

- **Importance of engaging family and caregivers.**

Case management: High. **Disease management:** Low.

- **Reliance on care coordinator.**

Case Management: High. **Disease management:** Medium.

A disease management program designed to improve health care quality and reduce medical expenses for those with complex or clinically advanced illnesses resulted in a 38% decrease in hospital admissions, reduced costs by more than $18,000 per patient, and garnered high satisfaction rates among 92% of the patients, according to a recent report in a prominent medical journal.

The report — on a study of Blue Shield of California HMO members — was published in the February 2007 edition of *The American Journal of Managed Care,* Whipple notes, and examined the program's impact on those with illnesses such as late-stage cancers or degenerative neurological conditions.

There are several reasons traditional treatment models fall short in the care of the chronically ill, he suggests, including the difficulty physicians have in keeping up with the latest developments in view of the tremendous growth in the number of medical studies.

In addition, Whipple says, patients with multiple medical conditions may receive care from many different physicians or providers at the same time, take a number of different drugs to treat their various conditions, and are often called upon to manage their own care at home.

As for what he calls the inadequacy of the case management model, Whipple says his experience as a consultant with a wide range of hospitals indicates that "there are lots of case managers and most are not certified."

"It's 'teach as you go,'" he adds. "There may

be 15 or 20 case managers at a big hospital and not all have the same expertise." In many cases, Whipple says, "there is no way to ensure consistency, for example, on what they approve as inpatient or observation status.

"The big thing is case managers in the emergency department," he notes, "but some [facilities] have them, and they don't really know how to interact. They are floating between patients, and the physicians don't know who they are and sometimes resent them."

The best way to provide disease management in the hospital is to have advanced practice nurses make rounds with physicians, Whipple contends. "They are able to provide more interventions than a case manager.

"These nurse practitioners who round are actually involved with medical care, and determine whether a patient is compliant or not," he says. "They work with case managers to develop a discharge plan that really looks at the patient's needs. The big reason [chronically ill] patients get readmitted is lack of compliance."

Early identification important

Crucial to the development of an effective disease management program is early identification of patients with chronic conditions, Whipple says. "At a minimum, we need to learn to identify these patients on readmission. It's as important as getting the correct address and phone number."

That could mean instituting a different admission protocol, he notes, such as having a code to designate patients as "frequent fliers." That information should be communicated as soon as possible to case management staff, Whipple adds, so an appropriate treatment and education plan can be put in place.

What occurs more often than not in today's health care environment, Whipple says, is that patients — including the chronically ill — go through the care process under whatever designation they came in, whether it is correct or not.

"Often what happens is the patient comes in, especially if he or she is a frequent flier, sits in front of the registration person, and [the registrar] says, 'Any changes since the last time?' The patient says no, and [the employee] just automatically fills that in."

Whipple's experience doing assessments at all kinds of facilities — from 700-bed inner-city hospitals to 12-bed rural hospitals — has shown him that "admitters sometimes put patients on the floor that don't meet local medical review policies," Whipple says.

Physicians in the emergency department don't necessarily know anything about medical necessity, he points out, and residents in training at large teaching hospitals often want to admit a patient simply because many tests have been ordered on the person.

Adding clinical expertise to every part of the revenue cycle is one way to ensure that only patients who belong in the hospital are admitted, and that those who do need to be admitted receive the proper care, Whipple says. Someone in patient access, he adds, such as a preadmission coordinator, "needs to able to step in and say, 'This person doesn't meet medical necessity.'"

(Editor's note: ***Bob Whipple*** *can be reached at Bob.Whipple@acs-hcs.com.)* ■

CNE 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

- Improving patient access beginning with the ED
- Involving case management in quality initiatives
- How hospitals are managing the care of indigent patients
- Determining the optimal caseload for case managers

RTI reviews Medicare chronic care programs

Eight Medicare chronic care improvement demonstrations cost more than they saved in their first six months, according to an early review of the programs by RTI International.

The initiative is designed to test a P4P contracting model and intervention strategies for chronically ill Medicare beneficiaries while achieving savings. Authorized by the Medicare Modernization Act, the programs target Medicare fee-for-service beneficiaries with heart failure and diabetes.

The programs primarily use disease management organizations and health insurers, but also integrated delivery systems and physician group practices. The efforts were directed primarily at providing participants with telephonic care management services, including nurse-based and other education and coaching. ■

To reproduce any part of this newsletter for promotional purposes, please contact:
Stephen Vance
Phone: (800) 688-2421, ext. 5511
Fax: (800) 284-3291
Email: stephen.vance@ahcmedia.com
Address: AHC Media LLC
3525 Piedmont Road, Bldg. 6, Ste. 400
Atlanta, GA 30305 USA

To reproduce any part of AHC newsletters for educational purposes, please contact:
The Copyright Clearance Center for permission
Email: info@copyright.com
Website: www.copyright.com
Phone: (978) 750-8400
Fax: (978) 646-8600
Address: Copyright Clearance Center
222 Rosewood Drive
Danvers, MA 01923 USA

BINDERS AVAILABLE

HOSPITAL CASE MANAGEMENT has sturdy plastic binders available if you would like to store back issues of the newsletters. To request a binder, please e-mail **ahc.binders@ahcmedia. com**. Please be sure to include the name of the newsletter, the subscriber number, and your full address.

If you need copies of past issues or prefer on-line, searchable access to past issues, you may get that at **www.ahcmedia.com/online.html.**
If you have questions or a problem, please call a customer service representative at **(800) 688-2421**.

EDITORIAL ADVISORY BOARD

Consulting Editor: Toni G. Cesta, PhD, RN, FAAN
Vice President, Patient Flow Optimization
Corporate Quality Management
North Shore-Long Island Jewish Health System
Great Neck, NY

Kay Ball,
RN, MSA, CNOR, FAAN
Perioperative Consultant/Educator
K & D Medical
Lewis Center, OH

Steve Blau, MBA, MSW
Director of Case Management
Good Samaritan Hospital
Baltimore

Elaine L. Cohen, EdD, RN, FAAN
Director
Case Management, Utilization Review, Quality and Outcomes
University of Colorado Hospital
Denver

Beverly Cunningham
RN, MS
Vice President
Clinical Performance Improvement
Medical City Dallas Hospital

Teresa C. Fugate
RN, BBA, CCM, CPHQ
Case Manager
Crescent PPO
Asheville, NC

Deborah K. Hale, CCS
President
Administrative Consultant Services Inc.
Shawnee, OK

Judy Homa-Lowry,
RN, MS, CPHQ
President
Homa-Lowry Healthcare Consulting
Metamora, MI

Cheryl May, RN, MBA
Director
Nursing Research and Professional Practice
Children's National Medical Center
Washington, DC

Patrice Spath, RHIT
Consultant
Health Care Quality
Brown-Spath & Associates
Forest Grove, OR

HOSPITAL CASE MANAGEMENT™
WEEKLY ALERT

Join our free weekly e-mail alert today

Subscribers of *Hospital Case Management* can join our *Hospital Case Management Weekly* e-mail list. This alert is designed to update you weekly on current case management issues that you deal with on a daily basis. Many of the articles in this alert will be followed up in detail in upcoming issues of *HCM*.

To sign up for the free weekly case management update, go to www.ahcpub.com and click on "Free Newsletters," for information and a sample. Then click on "Join," send the e-mail that appears, and your e-mail address will be added to the list. If you have any questions, please contact our customer service department at (800) 688-2421. ■