HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Get ready: Bundled payments are in your future

CMS requires participation in pilot project

If there was any doubt that the Centers for Medicare & Medicaid Services (CMS) is serious about reforming Medicare reimbursement, the notion should by dispelled by CMS' plans to require hospitals in 75 geographic areas to participate in a test of bundled payments for joint replacement.

The Comprehensive Care for Joint Replacement (CCJR) payment model proposes to hold hospitals accountable for the quality of care they deliver to Medicare fee-for-service beneficiaries

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services' (CMS') mandatory bundled payment pilot project makes clear that the agency intends to reform Medicare reimbursement.

- Hospitals in 75 geographic areas are required to participate in a five-year pilot project that puts them at risk for the cost of hip and knee replacements from the time of surgery until 90 days after discharge.
- Already, more than 6,500 providers are participating in the Bundled Payments for Care Improvement project, a voluntary program where participants can choose from 48 clinical episodes and four models.
- Even if they won't be part of a bundled payments arrangement, case managers need to shift their thinking to prepare for the future of reimbursement by developing close working relationships with post-acute providers, knowing the services and quality delivered by post-acute providers, and being aware of the costs for the entire episode of care.
- Case managers will not be able to handle all the responsibilities necessary in a bundled payment arrangement if they have large caseloads.

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for hip and knee replacements from surgery through recovery.

All hospitals in the selected geographic area, with the exception of critical access hospitals, would bear risk for the cost of hip and knee replacement surgery from the time of surgery through 90 days after discharge.

Under the five-year model proposed by CMS, the program would begin with admissions on or after January 1, 2016. Hospitals would continue to be paid under Medicare's fee-for-service system. They would not be at risk the first year but, beginning in the second year, hospitals would receive an additional payment based on their quality and cost performance or would have to repay Medicare for a portion of the costs.

In a news release announcing the program, CMS pointed out that the rate of complications after joint replacement surgery is more than three times higher at some facilities than at others with the average Medicare expenditures for surgery, hospitalization, and recovery ranging from $16,500 to $33,000.

"This proposal furthers the administration's commitment to transform our health system to deliver better quality care and spend our healthcare dollars in a smarter way. We are committed to changing our healthcare system to pay for quality over quantity, so that we spend our dollars more wisely and improve care for patients," said Health and Human Services Secretary Sylvia M. Burwell in an announcement issued July 9. The agency is accepting comments on the proposal through Sept. 8.

According to CMS, the program builds on the demonstration projects already underway through the Bundled Payments for Care Improvement (BPCI) demonstration program, a voluntary program that began in April 2013 with more participants coming on board in January 2014. CMS reports that more than 6,500 providers are participating. Providers may choose from one of four models and 48 clinical episodes which CMS says represent 70% of Medicare spending.

"CMS is very committed to bundled payments and wants to expedite the rollout. Hospitals need to prepare for bundled payments because they are not going to go away," says **Deirdre Baggot**, PhD, MBA, RN, senior vice president of The Camden Group and expert panel reviewer for the BPCI, Models 2-4.

Most recently, CMS added oncology to the program. Baggot predicts that outpatient cardiology will be added in the future.

Quickly following CMS' initiatives, commercial payers and self-funded employers are following suit and developing their own bundled payment initiatives, Baggot adds.

Bundled payments are part of a whole alternative payment model by CMS with the goal of moving Medicare fee-for-services to a payment model based on quality, adds **Karen Zander**, RN, MS, CMAC, FAAN, president and chief executive officer of the Center for Case Management.

She points out that Burwell has announced a goal of making 50% of all Medicare fee-for-service payments through alternative payment models such as bundled payment arrangements and accountable care organizations by the end of 2018.

"Reimbursement models are changing and hospitals are going to have to change the way they think about providing care in order to succeed. Changing the mindset is

what is going to be difficult, but it has to happen," Zander says.

Bundled payments fundamentally change the way healthcare is reimbursed but the initiative represents just the beginning of changes in reimbursement models that are likely to be instituted in the future, says **Francois de Brantes**, MS, MBA, executive director of the Health Care Incentives Improvement Institute and chair of the Fifth National Bundled Payment Summit in Washington, DC, in June.

"The evolution of payment is going through a natural cycle. Up until now, the healthcare industry tended to pick one payment method or the other, either fee-for-service or capitation. My personal view is that we will end up with a number of modes of payment as being the most effective for certain goals. The healthcare industry is too complicated for just one or two payment arrangements," he says.

For instance, if preventive care were part of a bundle or a capitated arrangement, it would create an incentive for providers to reduce services. This would have a negative impact because when patients don't get preventive care, they may get sick and incur large healthcare costs, de Brantes adds.

When it first was rolled out, BPHI experienced some bumps in the road with data integrity and delays but much of that has been resolved, Baggot says.

"Think of this as a big research study and, yes, there was some attrition early on which is to be expected to some extent. Today, the program has stabilized and is working much better. Providers are happy and patients are getting better care, which is what really matters, after all," Baggot says.

Bundled payment arrangements have a relatively low entry point in that the initial investment is much less than for an ACO, for example, Baggot says.

Bundled payments are a fixed price or lump sum for a predetermined set of services over a specified period of time. Anyone can own a BPHI bundle and pay providers. However, the most common scenario has been health systems receiving the funds and distributing them, Baggot says.

> "HOSPITALS NEED TO PREPARE FOR BUNDLED PAYMENTS BECAUSE THEY ARE NOT GOING TO GO AWAY."

"Whoever owns the bundle also owns the risk, so it comes down to who has the financial wherewithal to bear the risk," she says.

The owners of the bundles subcontract with other providers for a fixed payment. One health system could work with hundreds of providers, she adds.

Bundled payment arrangements don't need to be confined to one giant health system, de Brantes points out. "There is more being done by different entities. Even if the parent companies are in competition, they are tied by a common payment program, whether the payer is Medicaid, Medicare, or one of the commercial health plans. The payment model forces some level of teamwork and if one organization doesn't want to participate, there are others out there," he says.

Bundled payments and other alternative payment models should significantly reduce unneeded tests and unnecessary treatments because there is no incentive to do more, Baggot says. In fact, the incentive is to do only what the patient needs. Under alternative payment models, the theory is that the population gets healthier and the cost goes down due to reduced unnecessary testing and treatments, she says.

"Bundled payments work and make the population healthy. Instead of over-testing and over-treating, providers start looking at what patients really need," Baggot says.

For instance, she points out that even with all the PSA screenings performed in the country, the death rate from prostate cancer has not been reduced.

The bundled payment initiative puts the focus back where it should be — on the patient and the care provided throughout the continuum, eliminating the silos that are prevalent in the healthcare industry, de Brantes says.

"All of these new payment models have been designed at the onset with the specific objective of putting the focus back on the patient and to foster teamwork between providers. Even if they are not part of the same organization, if they are tied financially to a contract, they will be inclined to act as a team and patients will benefit," he says.

Hospitals are going to have to evaluate their current practice patterns to identify potential areas for improvement, Zander adds.

"In order to survive in today's healthcare world, hospitals need to understand the major cost drivers for care and develop predictive care paths that replicate the most efficient clinical decisions across the care continuum. In order to do this, hospitals have to have

real-time reporting, monitoring and accountability for utilization, outcomes, and demonstrating value," she says.

Hospitals that are still paid on a fee-for-service basis may find it difficult to prepare for bundled payments, points out **Toni Cesta**, RN, PhD, FAAN, and partner and consultant in Dallas-based Case Management Concepts. But, despite the challenges, hospitals need to start preparing now for the changes that are inevitable, Cesta says.

"The hospital team needs to look at how bundled payments and other pay-for-performance measures are going to have a financial impact. They have to develop strategic plans now, rather than waiting until the change happens. Hospitals that are preparing themselves for the future are going to be the ones that do the best," she says.

Even if their hospitals are not participating in the bundled payment initiative, are not a part of an ACO, or in one of the geographic areas that must participate in the mandatory program, case managers still need to prepare for the future, says **Beverly Cunningham**, MS, RN, partner and consultant in Dallas-based Case Management Concepts.

"Hospitals and case management departments have to be prepared because changes in reimbursement are going to happen and when they come, they're going to come quickly. If hospitals wait to prepare for the new reimbursement initiatives, it will be much more difficult for them," Cunningham says.

To prepare for the future, hospital case management directors should develop a team to come up with bundled payment strategies and how they will work at your hospital, Cunningham says.

"We've always supported a case management steering committee made up of case managers, key physicians, nurses, and representatives from ancillary services who understand what is going on with case management. Now, as we face the possibility of bundled payments, we need a large oversight team to look at what happens after discharge," Cunningham says.

Case management directors should join Listserv mailing lists and keep up with the latest in reimbursement and rules and regulations from CMS and share them with their staffs, Cunningham says.

All case managers need to understand the changes occurring in healthcare, Cunningham says. She suggests an annual day-long educational update on what is going on in the healthcare environment and how it affects their responsibilities, Cunningham says.

"Even if you are not part of the bundled payments initiative, you have to know what is going on. If your hospital participates in bundled payments, you have to understand where you fit in the picture and how you need to align with the quality department, the hospitalists, and other key stakeholders in the hospital," she says. ■

New payment models require a shift in thinking

Value, not length of stay, should be the focus

Under the DRG payment system, case managers have been pressured to get patients out of the hospital as quickly and safely as possible, but that's not the case in bundled payment arrangements, says **Francois de Brantes**, MS, MBA, executive director of the Health Care Incentives Improvement Institute.

Bundled payments cover an entire episode of care, including services the patient receives for as long as 90 days after discharge, and hospitals are at risk for what happens to patients during that time, he adds.

"Case managers have to look at patients' support systems at home, the care they need, the quality of care provided by post-acute providers, and other factors that may have an impact on the quality of care, and on the total cost, which is included in the bundle," de Brantes says.

If hospitals are going to succeed with bundled payment arrangements, they are going to have to re-engineer their clinical and operational processes and manage care in a different manner, says **Karen Zander**, RN, MS, CMAC, FAAN, president and chief executive officer of the Center for Case Management. "Case managers have to discharge patients to the level of care that can deliver the best value for that particular patient. In addition, hospitals have to build relationships with post-acute providers and ensure that there are case management services across the transition. It's tough but achievable. Changing the mindset is what will be difficult," she adds.

Case managers are the linchpin in bundled payments, adds **Deirdre Baggott**, PhD, MBA, RN, senior vice president of The Camden Group and expert panel reviewer for the Bundled Payment for Care Improvement

Initiative (BPCI), Models 2-4.

"More today than ever, the case management role is driving the entire care team. The importance of ensuring that patients get the best care in the best setting is heightened with the Centers for Medicare & Medicaid Services' commitment to payment reform," she adds.

Case managers are going to have to understand all the implications of post-acute care and be collaborators and facilitators that help lead the hospital's bundled payments arrangement, adds **Beverly Cunningham**, MS, RN, partner and consultant in Dallas-based Case Management Concepts.

"Case managers have to look at what internal strategies they can put in place to move patients along in a timely manner and to increase communication between the inpatient and outpatient environment in the hospital as well as between the hospital and the next level of care," Cunningham says.

In order to help their hospitals succeed under bundled payments, case managers have to start thinking about the costs for the entire episode of care, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in Case Management Concepts. "Case managers are going to have to understand what the right resource consumption is for each individual patient and work with physicians to keep the costs in line," she adds.

For instance, if a patient is likely to be able to manage at home with outpatient rehabilitation, that should be the option the case manager suggests, even if the patient's insurance will pay for a subacute stay. Or, a patient may be able to stay a day or two longer, receive inpatient physical therapy, and avoid going to a skilled nursing facility, she adds.

"Case managers should be taking a far greater leadership role in the decision-making concerning patient care and discharge destinations. Finding an appropriate post-acute provider who can meet a patient's individual needs is incredibly important and case managers have to go beyond simply looking at what is available," de Brantes says.

A key strategy for success in the new world of healthcare is to focus on your post-acute care providers and develop close working relationships with them, Cunningham says.

"UNDER BUNDLED PAYMENTS, CASE MANAGERS HAVE A HEIGHTENED RESPONSIBILITY TO ENSURE THE VALUE OF POST-ACUTE PROVIDERS AND GUIDE PATIENTS ACROSS THE CONTINUUM."

When hospitals are sharing financial risk, there's no way they can succeed if they aren't a team player and collaborate with other entities throughout the continuum, Baggot adds.

While many healthcare organizations have initiated collaborations with post-acute providers, many have yet to begin the work of building a post-acute network, Baggot says.

"Collaborating with post-acute providers is going to be crucial in the future and the role of case managers becomes critical in referring patients to the providers who deliver high-quality care and to ensuring smooth transitions of care," Baggot says.

Be informed about the skilled nursing facilities, long-term acute care hospitals, rehabilitation facilities, and home care agencies that provide services to your patients after discharge, Cunningham says. Understand their readmission rates, their quality metrics, and what specialized services each one provides and use the information to develop discharge plans, she adds.

"We've always given short shrift to post-acute quality indicators, but we need to be more informed and cautious when the hospital is at risk for patient outcomes. Make sure that post-acute providers have a good track record of providing the care the patient needs," Cesta adds.

Case managers would benefit from profiling potential post-acute partners from cost, quality, and patient experience standpoints, Baggot suggests. "Under bundled payments, case managers have a heightened responsibility to ensure the value of post-acute providers and guide patients across the continuum," Baggot says.

Patients will still have a choice of providers, but case managers may elect to use one of the new transparency tools in an effort to better inform patients and family members as they make their decisions, Baggot says.

Transitions of care are critical, Baggot says. "We have evidence to support that the first post-acute setting correlates with the total cost of care. There must be significant coordination across every care setting," she adds.

Some participants in the BPCI are outsourcing the care coordination services during the post-discharge

period, Zander says. "Ultimately, any time you outsource to another company, it costs more money than if you create your own program. I am for having inpatient and outpatient case managers under one big umbrella for a health system," she says.

One new role that is emerging is the patient navigator, whose job is to ensure care transitions go smoothly and to manage readmission risk, Baggot says. Navigators communicate with patients once they get home, ensure that they connect with their medical home, and make sure that providers at the next level of care have the information they need.

"This is a support role for the case managers. Navigators are not required to have the extensive clinical knowledge that case managers do. Primarily, navigators handle the logistics, such as making sure the discharge information gets to the patient's primary care physician," Baggot says.

Having an integrated case manager who follows patients from admission through the continuum of care may be effective, but it's difficult to develop the role unless the provider owns all of the entities in the continuum of care, Baggot says. "If the system doesn't own all of the assets, the question becomes who bears the cost of the role. The role of the integrated case manager is a great strategy in ensuring smooth transitions in care. The challenge is how to operationalize it across partnering entities," Baggot says. ■

Adequate CM staff is vital as reimbursement models change

Lower caseloads are a must for success

Case managers can't do what is necessary to help their hospital succeed under the new global payment models if they are busy juggling care coordination for 25 or 30 patients, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in Dallas-based Case Management Concepts.

"Case managers have to have time to perform the care coordination piece, to think more carefully about the next level of care, and to take the time to put a good discharge plan in place, rather than doing the discharge planning at the last minute. If they have a large caseload, they're just putting out fires and not doing enough critical thinking and collaborating with physicians on the best plan for the patient," she says.

Bundled payment arrangements make it mandatory for hospitals to work closely with post-acute providers and to be familiar with the services each provides, and their quality metrics, adds **Beverly Cunningham**, MS, RN, partner and consultant in Dallas-based Case Management Concepts.

"For case managers to develop relationships and be collaborative with the outpatient environment, their caseloads need to be appropriate. If they are managing the care of 25 to 30 patients, they won't have the time," she says.

Case managers have to have the time to conduct an in-depth assessment of their patients to find out their support systems and identify their discharge needs, Cunningham adds. "This information is crucial in developing a successful discharge plan, but case managers can't spend the necessary time if they are inundated with other tasks," she says.

It's not that case managers don't want to do a better job, Cesta says. It's just that they have had so many duties piled on them that they don't have time to do everything well, she adds.

"The majority of case management directors in the hospital setting have the same concerns. They are worried about having adequate staffing to handle all the additional responsibilities heaped on them in this new world of reimbursement, and to do them well," Cunningham says.

She advises case management directors to talk to the hospital management about appropriate caseloads and to identify an executive sponsor of case management who understands the needs of the department, and can advocate for staff increases.

"If case management departments don't have adequate staffing and executive support for staff, all they can do is hit the high points. They won't have the time to think about what happens to the patient beyond the door of the hospital," she says.

It's sometimes a challenge to get hospital executives to understand why the case management department needs more staff, Cesta points out.

"They don't realize how case

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CNE QUESTIONS

1. The Centers for Medicare & Medicaid Services has announced a five-year mandatory bundled payment program for joint replacement surgery for hospitals in 75 geographic areas. When will the program begin?

A. January 1, 2016
B. October 1, 2015
C. January 1, 2017
D. October 1, 2016

2. According to Francois de Brantes, MS, MBA, what must case managers do before developing a discharge plan patients covered by a bundled payment arrangement?

A. Look at patients' support systems at home
B. Identify the care they will need after discharge
C. Determine the quality of care provided by post-acute providers
D. All of the above

3. For how long after discharge does the nurse navigator at Abington-Jefferson Health follow patients who are covered by the bundled payment arrangement?

A. 30 days
B. 60 days
C. 90 days
D. Until they stabilize

4. CMS has proposed loosening up its controversial two-midnight rule and allowing shorter stays to be reimbursed as inpatient stays if the documentation in the medical record supports it.

A. True
B. False

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

The Top 10 Mistakes You May Be Making In Your Case Management Department! Part 3

Toni Cesta, PhD, RN, FAAN

Introduction

In the last two installments of *Case Management Insider*, we reviewed the first four of the top 10 mistakes that you may be making in your case management department. We discussed roles and functions, best practice models, staffing ratios, and clerical support issues and opportunities for improvement in your department. This month, we will be discussing three more of the top 10 mistakes that your department may be making and how to potentially improve or eliminate them.

Case Management Department Mistake Number Five: "Working in Silos"

Another common mistake often made in case management departments is to operate the department in an isolated fashion, with poor or no integration with other members of the interdisciplinary team and/or other departments. There is a variety of ways in which case management can be integrated within the hospital organizationally and culturally. Integration is an important component for success and must happen throughout the hospital. By having strong formal and informal relationships with other departments and disciplines, the case management department will be better prepared for successful outcomes across the organization. There are teams and committees that can provide a strong foundation for good communication.

- Case Management Steering Committee
- Readmissions Reduction Team
- Hospitalist Team
- Denials Management Team
- Patient Flow Committee
- Medicare Spending Per Beneficiary Efficiency Team
- Long Length Of Stay Team
- Patient Financial Team
- Compliance Team
- Case Management Practice Team
- Interdisciplinary Rounding Committee

ANOTHER COMMON MISTAKE OFTEN MADE IN CASE MANAGEMENT DEPARTMENTS IS TO OPERATE THE DEPARTMENT IN AN ISOLATED FASHION...

While we can't go into detail on each of these teams and committees, I will highlight those that will provide the greatest return to the case management department if implemented and used properly.

The Case Management Steering Committee

This group may be one of the most important teams that a case management department will have. Whether you are re-designing an existing department or have an established department, the steering committee can provide an important function in assisting the case management department in achieving its desired outcomes. The steering committee should be a working committee that meets regularly to discuss issues relevant to the case management department, but also to any departments or disciplines that interface with case management. As we know, this is virtually any department in the hospital. The committee should be made up of members who have the authority to make decisions in the organization, so it is a high-level group.

The roles and purposes of the team include the following:

• Interdisciplinary leadership oversight of case management initiatives.

• Obtain input from leaders involved in case management processes.

• Focus on interdisciplinary team integration in processes related to case management.

• Assist in making recommendations for improvement in the case management department.

The committee should consist of the following members or their representatives. This is the minimum membership. Others can be added as needed, or invited on an ad hoc basis. Remember that committees work best when small; between six and 10 standing members is optimal.

Team membership can include the following:

• Executive team sponsor
• Case management leaders
• Nursing leadership
• Ancillary services leadership
• Patient access
• Finance
• Physician leader
• Hospitalist leader

Listed below are some of the activities that might be assigned to this committee:

• Develop, evaluate, and improve interdisciplinary processes related to case management initiatives.

• Develop and update/review walking around processes.

• Review dashboard and identify areas for improvement.

• Discuss role of case manager on the unit.

• Receive input regarding updated or changed case management model, roles, and/or functions.

• Plan for family meeting or patient care conference process.

• Discuss regulatory changes affecting case management, e.g. the two-midnight rule.

The Readmissions Reduction Team

As the Centers for Medicare & Medicaid Services (CMS) continues to add diagnoses to the list of those they are monitoring for 30-day readmissions, and as the percent penalty to Medicare billing continues to rise, it is important that every hospital have a dedicated team that is actively working on reducing the hospital's readmission rates. Even if the hospital has not yet received a penalty on their rate of readmission from CMS, it is imperative that yours stay ahead of the curve. Like most of the CMS metrics, this one is a moving target and changes as hospitals continue to improve their performance in this area. This means that as other hospitals improve, so must yours.

The roles and purposes of the Readmission Reduction Team include the following:

• Oversight of the CMS readmission metrics.

• Preparation for future changes to the metric, such as the addition of diagnoses.

• Development of hard-wired processes to support readmission reduction.

Team membership:

• Case management
• Nursing
• Emergency department leadership
• Post-acute providers
• Physician leadership
• Primary care leadership
• Primary care physician leaders
• Quality

As you can see, this team includes many leaders from beyond the walls of the hospital such as those in the primary care and post-acute areas. While case management can make many changes that will contribute to a reduction in readmissions, complete success will be dependent on including leaders from these other areas. Since patients return to the emergency department (ED) from any of these locations, strategies to reduce returns to the ED and potential readmissions are critical to the success of this team.

The team should review readmissions in an effort to identify patterns such as higher-than-average readmission from a particular nursing home or home care agency. Other activities should include interventions that should be performed in the emergency department or outpatient area, rather than readmitting the patient. An example of this might be a clogged PICC line.

Medicare Spending Per Beneficiary Efficiency Team

Another strategic and important group would be the committee assigned with monitoring the Medicare Spending Per Beneficiary metric, also known as the "efficiency measure." This metric monitors hospitals in their performance in length of stay and cost for selected diagnoses. Poorer than average performance means a financial penalty to the hospital. This measure involves spending that occurs three days before admission and follows to 30 days after discharge. Therefore, as the readmission reduction committee had to have representatives from beyond the hospital walls, this team should be structured in the same way.

Roles and purposes of the Medicare Spending Per Beneficiary Team (MSPB) include the following:

• Optimize and improve the MSPB metric.

• Understand the impact of the measure on the hospital.

• Create working teams to address areas of vulnerability.

Team membership:

• Case management
• Nursing
• Emergency department leadership
• Post-acute providers
• Physician leadership
• Primary care leadership
• Primary care physician leaders
• Quality

Examples of activities for the MSPB Team include the following:

• Review metrics on www.medicare.gov/hospitalcompare.
• Identify trends, both negative and positive.
• Create sub-teams to reduce resource consumption and length of stay in targeted areas.
• Review quality performance of post-acute providers in terms of cost and readmission rates.

Case Management Department Mistake Number Six: "Untimely Assessments and Interventions"

Mistake Number Six relates to the timing of the work within the case management department. As lengths of stay continue to shorten, timing of the work of the RN case manager and social worker is another key component for success. Gone are the days of assessing the patient within 72 hours of admission. Even 48 hours is much too long. Just as the staff nurse and the physician assess the patient on the day of admission, so should the RN case manager. By obtaining the initial assessment on the day of admission, or within one business day, you can use the information you collect to do your clinical review and begin the discharge planning process at the same time! This is a time saver and makes your work process more efficient.

Strategies for managing patient information in a timely manner:

• Each day, every new admission must be identified.
• If the patient was transferred to you from another unit, be sure you get hand-off communication from the prior case manager.
• If you are transferring the patient off your unit, be sure to include a written summary and provide a verbal hand-off to the receiving case manager.

Sharing timely information between and among case management staff is an important tool for effective communication and reduction in time delays. Once a new admission has been identified, the admission assessment process must begin. As already mentioned, this assessment should be done on admission in the majority of cases. Strategies for completing the assessment include the following:

• Review the patient's current and prior medical records.
• Interview physician.
• Interview patient and family.
• Complete admission assessment tool.

Another key strategy is to use a standardized admission assessment tool. Not only does this expedite the process, but it also ensures that all data is collected in a standard format and that data elements are not omitted. This is a very short sample of the data elements that should be included:

• Information obtained from patient/family/ED/prior medical records
• Patient gave permission to complete assessment and discuss discharge plan with _____
• Information obtained via_____
• Primary contact
• Special needs
• Living situation
• Type of housing
• Stairs
• Elevator
• Requires assistance
• DME used prior to admission

Here is the process outlined for the day of admission:

Step 1: Review the current medical record, including all relevant diagnostic test results, such as lab values and radiology reports.

Step 2: If the patient was admitted through the emergency department, review all available EMS notes.

Step 3: Obtain and review prior medical records if available.

Step 4: Discuss the patient with the admitting physician.

Step 5: Interview the patient and/or family.

Daily Assessments

In addition to seeing and assessing new patients on the day of admission, it is also critical to see your patients each and every day they are assigned to you. A daily review of your patients will ensure that you are up to date on their clinical progression. By updating this information daily, you will also be able to assess whether your discharge plan is still accurate and timely. Daily assessments can take many forms. The most efficient method is through the use of interdisciplinary walking rounds. It is during rounds that you will be able to see your patient and also hear updates from the other members of the patient's care team. The exchange of information that takes place during rounds can be comprehensive and quick, when done properly. Seeing a patient visually, as well as speaking to them, gives you a tremendous amount of information very quickly. Of course, this needs to be supplemented by the information

from the other team members and an update of any diagnostic test results or other information to inform the continued stay of the patients.

Daily documentation should include the following elements:

- Any updates to the patient's social, financial, or family situation.
- The status of the discharge plan.
- The completion of any compliance tasks such as the "choice list."
- Any barriers to the completion of the discharge plan.
- The status of any referrals made.
- Any legal issues, such as guardianship or immigration status.
- Any patient education needs.

When it comes to timeliness in today's contemporary case management departments, it is imperative that patients are seen in a timely manner and on a daily basis. This is a critical and important element of success.

Case Management Department Mistake Number Seven: "Five-Day-a-Week Department"

Number seven on our top 10 list is the frequent mistake of running the case management department on a five-day-a-week schedule. When case management departments were originally utilization review-only, five-day-a-week coverage worked and made sense. Today, however, we need to consider all the additional roles and functions that case managers perform that require additional coverage. For example, patient flow requires seven-day-a-week diligence, as patient length of stay needs to be optimized each and every day that the patient is in the hospital. The same logic would apply to discharge planning and the movement of patients out of the hospital, which should also occur seven days a week.

Additionally, patient admission assessments should be completed seven days a week, as well as reassessments. Even a skeleton crew working on the weekends cannot accomplish all of this. Therefore, it is recommended that the weekends be staffed at least 50% of the weekday staffing levels. Weekend staff should have a clear understanding of the scope of the work they are required to perform. The work should not vary depending on who is working on a particular weekend, but rather should be consistently applied by all staff. If you are running the staff at 50%, then staff can double up, covering two units on the weekend. Because admissions and discharges are usually somewhat slower than weekdays, it is more reasonable to expect that assessments, discharge planning, and patient flow activities will be able to be accomplished over the course of the weekend.

By smoothing the workflow across seven days, your department can prevent delays and excessive work on Mondays and days after holidays. These workloads result in delays that can stretch into the middle of the week at times and result in the staff constantly playing catch-up.

Other Areas to be Staffed

Another key area to be staffed aggressively is the ED. For all the reasons listed above, consider staffing the ED seven days a week as well. Also consider 12-hour shifts in the emergency department. Twelve-hour shifts allow for maximum coverage during peak hours there. You can also stagger the work hours between the RN case manager and the social worker to maximize the coverage in the ED.

If you have an access point case manager in the admitting area, this position can safely operate five days a week with coverage by the ED case managers on the weekends as needed. The denials and appeals staff can also work five days a week without compromising the work of the department.

Leadership staff should consider working at least one weekend day a month. This is a good way in which to get a feel for how the work is getting accomplished on the weekends and where issues or opportunities might lie.

As discussed in a prior issue, today's case management department should include clerical support staff. These staff should also operate on a seven-day-a-week schedule. This may be even more crucial if you are running a 50% staffing pattern on the weekends or even a skeleton staff on weekends. Clerical staff can support the work of the professional staff and remove weekend time wasters that will reduce their chances of completing all the work that we have listed above that requires the attention of the professional staff on the weekends.

Finally, consider "vacancy" coverage. Vacancy coverage refers to staff that are not routinely assigned to a unit but "float" where needed. These positions can cover for holidays, vacations, sick time, and any other reasons that staff may be off.

Summary

This month, we reviewed three additional mistakes that are commonly being made in case management departments in hospitals today. Next month, we will review the final three of the top mistakes that you may be making in your department. ■

managers can help the hospital's bottom line as payers shift their emphasis from fee-for-service to quality. Some of them still just don't get it," she adds.

Cesta recommends analyzing the workload, roles, and functions of social workers and nurse case managers, and re-engineering the case management department to align with the continuum of care and payment structure. "There is so much opportunity to develop strategies now that will prepare for the future," she says. ■

Bundled payment initiative means eliminating silos, standardizing care

Arrangement is "catalyst for rethinking patient care"

The bundled payment arrangement at Abington-Jefferson Health in Abington, PA has improved communication between all members of the treatment team and eliminated silos between the inpatient and outpatient sides of the hospital, says **Elissa Della Monica**, RN, MSN, NE/BC, vice president for post-acute and case management services.

"The bundle arrangement has been the catalyst for rethinking patient care. In the past, the inpatient and outpatient teams communicated, but it was disjointed. Now the team works together," Della Monica says.

The Centers for Medicare & Medicaid Services (CMS) launched the Bundled Payments for Care Improvement, a three-year pilot project, in 2013 as part of the move to base reimbursement on quality.

Abington-Jefferson Health's first bundled payment arrangement, focusing on joint replacement patients, went live on April 1, 2015. In the first three months, 115 patients were covered by the bundle.

The health system chose to pilot Model 2, which covers all Medicare Part A and B services during the initial inpatient stay, plus the post-acute services for 90 days. Participating providers continue to be paid on a fee-for-service basis. At the end of the pilot, total Medicare payments will be compared to the benchmark for the specific DRG. If total Medicare payments are less than the benchmark, the hospital will realize the savings, less a 2% CMS administrative fee.

The project was designed by two teams: a clinical team and a care coordination team.

The clinical team was charged with redesigning inpatient care, developing care paths, and improving clinical outcomes. The team included nurses, physicians, physical therapists, the physician assistant for orthopedics, case managers, and social workers.

"One of the main objectives was to standardize the medical care patients were getting by working with the physicians to develop order sets. The key to success was getting a diverse group of orthopedic surgeons on the same page and in agreement about what care should look like," says **Leslie McGrath**, MS, director of care coordination management and social work services for Abington-Jefferson Health.

The care coordination team looked at what should happen during the 90 days after discharge. The team included case managers, social workers, representatives from the hospital's public relations and marketing department, the billing department, finance department, a home health agency, and skilled nursing facilities.

Their goal was to develop care paths and flow charts to show what happens with patients once they are discharged from the hospital.

"We designed the flow chart to start while the patient is still in the hospital so the nurse navigator could interface with the inpatient team. The protocols focus on the 90 days after discharge but cross over into the inpatient stay to facilitate communication between the inpatient and outpatient team and to improve transitions in care," Della Monica says.

The care coordination team continues to meet weekly to discuss any issues and patient problems, McGrath says. Members of the inpatient team join the conference by telephone as needed. "That weekly call allows us to have a SWAT team approach to correcting problems because the various team members can take care of issues within their expertise," McGraths says.

Partnerships with post-acute providers are essential for success in the bundled payment project, Della Monica says. Before the program began, the hospital sent requests for proposals to skilled nursing facilities in the community.

The team chose four nursing facilities to partner with based on their proposals, their quality outcomes, reports on the CMS

Nursing Home Compare website, the Medicare STAR rating, and their readmissions data.

"It was not an easy decision. We chose the four facilities with outstanding outcomes and where our patients were often opting to go," McGrath says.

Abington Home Care, the health system's own home health agency, also participates in the program.

The hospital created the position of nurse navigator, an RN who acts as project manager, for the bundled payment initiative. The nurse navigator meets with patients while they are in the hospital, follows them for 90 days after discharge, and communicates with the inpatient team, including the physician assistant for orthopedics, case managers, and social workers, as well as the primary care physician and other staff as needed, Della Monica says.

When patients are scheduled for joint replacement surgery, the nurse navigator calls them and makes sure they are progressing through the required preadmission testing. In addition, a physical therapist makes a pre-surgery visit, assesses the patient, and conducts a home assessment that is shared with the hospital case management department and nurse navigators. That way, the hospital case managers know the patient's support system, the condition of the home, how many stairs the patient has to climb, contents of the cupboard and refrigerator, and other information they need to know to develop a discharge plan, she says.

"Having physical therapists see patients in their home environment helps us identify issues and deal with them ahead of time. We know what to expect and can deal with the entire continuum of care and start putting a safe and realistic discharge plan in place before the patient comes in," McGrath says.

The therapist's report goes to the navigator, the case management department, the orthopedic physician assistant, and the home care therapist. "If the physical therapists find major problems they send out an alert to everyone that this is a high-risk patient," McGrath says.

The hospital case managers who will follow the patients while they are in the hospital meet with them during preadmission testing, educate them on what will happen during their hospital stay and after discharge, and discuss the anticipated discharge plans and what the patients will need to do after they get home.

"THE GOAL IS TO DISCHARGE PATIENTS TO HOME AS MUCH AS POSSIBLE. IF THAT IS NOT APPROPRIATE, THE SOCIAL WORKER HELPS THEM CHOOSE A POST-DISCHARGE PROVIDER."

"The goal is to discharge patients to home as much as possible. If that is not appropriate, the social worker helps them choose a post-discharge provider," she says.

While patients are in the hospital, the nurse navigator makes daily phone calls to inpatient staff including nurses on the orthopedic unit, the physician assistant for orthopedics, case managers, and social workers. During the call, she discusses each patient on the unit, their discharge needs, and anticipated discharge date. The case managers and the nurse navigator collaborate on discharge plans to ensure a smooth hand-off, she says.

The orthopedic care plan calls for patients discharged to home to have a physical therapy visit within 24 hours of discharge and up to five home visits with a physical therapist in the first week, and the second week if needed, she says. Then patients typically are transitioned to outpatient therapy.

After patients are discharged, the nurse navigator calls them at least once a week, depending on their needs, for 90 days, she says. Patients who are stable and have gone back to work get bi-weekly phone calls. Some patients who need extra support may receive frequent calls until they stabilize.

If there is a problem, the nurse navigator contacts the physician and the clinical team in the hospital and alerts them to the issue. "She is constantly feeding information back to the inpatient side so we can rectify any problems," Della Monica says.

Most problems occur within the first few weeks, she adds.

Among the problems the nurse navigator has uncovered is pain medicine was not ordered for patients in skilled nursing facilities, patients are on anticoagulants as prescribed by the surgeon and the nursing facility is also giving them nonsteroidal anti-inflammatory drugs, and patients have not ordered their compression stockings or can't put them on.

"Medication issues sometimes are a problem. The nurse navigator conducts medication reconciliation, makes sure that patients understand their medication regimen, and that patients are on a bowel regime, especially if they are taking pain

medications," she says.

In one case, the patient reported excess draining from the incision and the nurse navigator was able to get him in to see a physician who changed the treatment plan and resolved the issue, she says.

When patients are transferred to a skilled nursing facility for rehabilitation, the nurse navigator coordinates the hand-off with the nursing facility staff and continues to follow the patients for 90 days, she says. A subcommittee of the care coordination team meets with the four providers on a weekly basis to discuss cases and resolve issues.

The bundled payment team is housed in Abington Home Care, making it easy for the nurse navigator to collaborate with home health providers, Della Monica says. She contacts other home care providers by telephone.

The team meets regularly to review data on patients in the bundle to track their progress and identify trends and opportunities for improvement, Della Monica says.

"We have created a template that we know what works and we can use it as we move into other bundles," she adds. ■

CMS proposes to OK one-midnight inpatient stays

QIOs to take over Probe and Educate

In a move that surprised many in the healthcare arena, the Centers for Medicare & Medicaid Services (CMS) has proposed loosening up its controversial two-midnight rule and allowing shorter stays to be reimbursed as inpatient stays if the documentation in the medical record supports it.

CMS made the proposal in the Outpatient Prospective Payment System (OPPS) proposed rule for 2016 issued July 1, saying the change was made based on feedback from hospitals and physicians and to emphasize the role of physician judgment. The policy is unchanged for stays of two midnights or longer.

The final OPPS rule will be issued in October and will go into effect January 1, 2016. CMS is essentially going back to pre-2013 rules which were in effect before the two-midnight rule was issued, says **Ralph Wuebker**, MD, MBA, chief medical officer for Executive Health Resources, a Newtown Square, PA, healthcare consulting firm.

"If the patient meets medical necessity criteria and the physician clearly documents it, the case would be appropriate to be paid as an inpatient stay, even if the patient stays less than two midnights," Wuebker says.

However, he points out that CMS states that it would be "rare and unusual" for patients to require an inpatient admission for a period of time that is only a few hours and does not span at least one midnight.

In a statement announcing the proposed change, CMS said the proposal was based on "significant input from stakeholders" including hospitals, physicians, the Medicare Payment Advisory Commission (MedPAC) and Congress, and from the Probe and Educate process conducted by the Medicare Administrative Contractors (MACs).

In the proposed rule, CMS did not use the term "hospital level of care" but changed back to using "inpatient" and "outpatient" care,

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) has proposed that stays shorter than two midnights be reimbursed as inpatient stays if the documentation in the medical record supports it.

- CMS made the proposal in the Outpatient Prospective Payment System proposed rule for 2016 and left the policy unchanged for stays of two midnights or longer.
- CMS also announced that the two Beneficiary and Family Centered Care Quality Improvement Organizations (QIOs), Livanta and KEPRO, will take over the responsibility of Probe and Educate and will review cases for medical necessity when patient stays are one midnight or less, referring hospitals with high denial rates to the Recovery Auditors.
- Case managers should continue to assist physicians in determining patient status and to make sure that the documentation is complete, accurate, and specifies the severity of illness.

points out **Steven Greenspan**, JD, LLM, vice president of regulatory affairs for Executive Health Resources. "This indicates that CMS is no longer focusing on patients being in the hospital for a certain amount of time but is basing patient status on the need for a certain level of care," he adds.

"The proposed rule keeps a good portion of the two-midnight rule, but it says that CMS recognizes that there are stays that are less than two midnights that are appropriate for inpatient status," Greenspan says.

CMS has been urged to develop a payment methodology for short stays, Greenspan says.

"The MS-DRG system already does this. Payments are averaged based on the geometric mean length of stay, meaning that some short stays within that DRG are less than the designated mean and some are greater. There are approximately 50 DRGs having mean lengths of stay less than two days and under the current system, payment for these short stays are already captured into the DRG payment just as those for stays that are above the mean," Greenspan points out.

CMS repeated its assertion that it would be "rare and unusual" for inpatient stays to last only a few hours and not span at least one midnight and stated that it would be monitoring stays of less than one midnight and prioritizing them for medical review.

CMS did away with the formal certification requirements for physicians in the 2015 OPPS but the documentation still has to include the justification for the inpatient admission, the expected length of stay, the treatment plan, and the discharge plan. Physicians must sign the record prior to discharge, Wuebker says.

Case managers should continue to use evidence-based criteria sets to ensure that patients meet medical necessity criteria as they assist physicians in determining patient status, he adds.

"The one-midnight proposed rule means that case managers need to make sure that there is complete and accurate documentation that specifies severity of illness. Physician documentation needs to make it clear that patients need not only hospital care, but inpatient care," Greenspan says.

CMS also announced that the two Beneficiary and Family Centered Care Quality Improvement Organizations (QIOs), Livanta and KEPRO, will take over the responsibility of Probe and Educate and will review cases for medical necessity when patient stays are one midnight or less.

If hospitals have consistently high denial rates, the QIOs will refer them to the Recovery Auditors for patient status reviews.

"The two-midnight rule says that if patients stay over two midnights, the stay is presumed to be appropriate for inpatient status. CMS believes there has been some gaming of this rule and that's probably where the auditors will focus," Wuebker says. ■

TJC, medical societies warn of EHR safety issues

Incorrect, miscommunicated information can lead to adverse events

In a recent Sentinel Event Alert, The Joint Commission (TJC) warned of how incorrect or miscommunicated information entered into health IT systems might result in adverse events.

The Alert cited incidents documented by the ECRI Institute in Plymouth Meeting, PA:

• A chest X-ray was ordered for the wrong patient when the wrong patient room number was accidentally clicked. The orderer noticed the error right away and promptly discontinued the order, but not in time for the X-ray technician to see that the order was withdrawn. The technician performed the test on the wrong patient.

• A drug was ordered as an intramuscular injection when it was supposed to be administered intravenously. The physician did not choose the appropriate delivery route from the drop-down menu.

• A nurse noted that a patient had a new order for acetaminophen. After speaking with the pharmacist, the nurse determined that the order was placed for the wrong patient. The pharmacist had two patient records open, was interrupted, and subsequently entered the order for the wrong patient.

TJC recommends an improved safety culture, process improvement, and leadership regarding EHR safety. In particular, the commission urges a "collective mindfulness focused on identifying, reporting, analyzing and reducing health IT-related hazardous conditions, close calls or errors." Report these instances internally, preferably at early stages, before a patient is harmed, TJC advises. The full Alert, with resources, is available online at http://bit.ly/1Ok0BEU.

The TJC warning came on the heels of a letter in which

representatives from 27 medical societies, including the American Medical Association, the American College of Physicians, the American College of Surgeons, and several other major medical organizations, expressed their worries about EHR safety to the national coordinator for health information at the Department of Health and Human Services.

"Unfortunately, we believe the Meaningful Use (MU) certification requirements are contributing to EHR system problems, and we are worried about the downstream effects on patient safety," they wrote. "Physician informaticists and vendors have reported to us that MU certification has become the priority in health information technology (health IT) design at the expense of meeting physician customers' needs, patient safety, and product innovation. We are also concerned with the lack of oversight ONC places on authorized testing and certification bodies (ATCB) for ensuring testing procedures and standards are adequate to secure and protect electronic patient information contained in EHRs." The full letter can be found online at http://bit.ly/183Z2ey. ■

Can you teach doctors to improve patient satisfaction?

Study finds that immediate feedback reaps rewards

A study in the May issue of the *Journal of Hospital Medicine*[1] may give hope to physicians and the hospitals where they work that they can learn the skills needed to improve the scores related to their interactions in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys.

The study used a variety of interventions to educate internal medicine residents on patient communication and satisfaction. Initially, they attended a communication conference and had real-time access online to the scores they received from patients. But the study authors found that those scores were reviewed only a couple times a year with supervisors, so they started directly emailing the results to both the physicians and their supervisors. In addition, there were three residents chosen each month for their standout performance on the surveys, which came with a small reward of passes for a movie and certificates for popcorn during the film.

Over the course of the year during which the project ran, the percentage of patients who responded positively to the three HCAHPS questions related to physician interactions increased by 8.1%, and the number of patients who said they would definitely recommend the hospital to friends and family increased by 7.1%.

The three questions are:

- Did your doctors explain things understandably?
- Did your doctors listen carefully?
- Did your doctors treat you with courtesy and respect?

The latter two questions had improvements that neared statistical significance, but the authors say it was the improvement in the first question that drove the overall improvement into statistically significant territory.

The authors postulate that having regular email coming to the physicians about patient satisfaction kept it front of mind, as did having a sense of competition. Previous work found little evidence that training sessions longer than what the doctors in this study participated in have much impact on patient satisfaction scores, so they discount the impact of their educational conference. It could be a matter of all the elements together, they note.

Given the increasing dollars that are at risk for hospitals that don't do well in patient satisfaction, they suggest that training physicians in this area is a relatively inexpensive way to limit that risk.

REFERENCE

1. Banka G, Eddington S, Kyulo N, et al. Improving patient satisfaction through physician education, feedback, and incentives. *Journ Hosp Med*. May 2015. 10.1002/jhm.2373. ■

COMING IN FUTURE MONTHS

- CM caseloads in pay-for-performance
- Why health literacy matters
- How the new CMS regulations affect you
- Ways CMs partner with community organizations

Hospital Case Management

Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report in the January 2016 issue detailing the results of this survey and the overall state of employment in hospital case management.

Instructions: Select your answers by filling in the appropriate bubbles **completely.** Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be strictly confidential. Do not put your name or any other identifying information on this survey form.

1. What is your current title?

- O A. case manager
- O B. director of case management
- O C. utilization manager
- O D. social worker
- O E. discharge planner
- O F. other_____

2. What is your highest degree?

- O A. associate or 2-year
- O B. diploma (3-year)
- O C. bachelor's degree
- O D. some graduate work
- O E. graduate degree
- O F. other_____

3. What is your sex?

- O A. male
- O B. female

4. What is your age?

- O A. 20-25
- O B. 26-30
- O C. 31-35
- O D. 36-40
- O E. 41-45
- O F. 46-50
- O G. 51-55
- O H. 56-60
- O I. 61-65
- O J. 66+

5. What is your annual gross income from your primary healthcare position?

- O A. Less than $30,000
- O B. $30,000 to $39,999
- O C. $40,000 to $49,999
- O D. $50,000 to $59,999
- O E. $60,000 to $69,999
- O F. $70,000 to $79,999
- O G. $80,000 to 89,999
- O H. $90,000 to $99,999
- O I. $100,000 to $129,999
- O J. $130,000 or more

6. Where is your facility located?

- O A. urban area
- O B. suburban area
- O C. medium-sized city
- O D. rural area

7. In the last year, how has your salary changed?

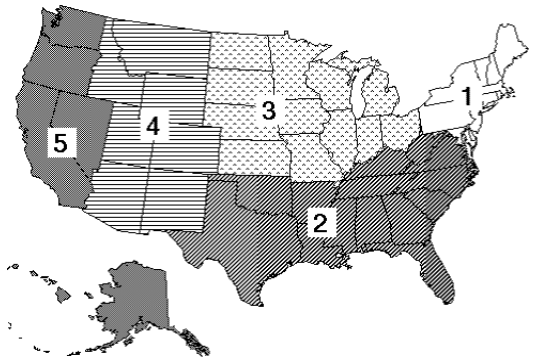
- O A. salary decreased
- O B. no change
- O C. 1% to 3% increase
- O D. 4% to 6% increase
- O E. 7% to 10% increase
- O F. 11% to 15% increase
- O G. 16% to 20% increase
- O H. 21% increase or more

8. What is the work environment of your employer?

- O A. academic
- O B. agency
- O C. health department
- O D. clinic
- O E. college health service
- O F. consulting
- O G. hospital
- O H. private practice

9. Please indicate where your employer is located.

- O A. region 1
- O B. region 2
- O C. region 3
- O D. region 4
- O E. region 5
- O F. Canada
- O G. other



10. Which best describes the ownership or control of your employer?

- O A. college or university
- O B. federal government
- O C. state, county, or city government
- O D. nonprofit
- O E. for profit

11. How long have you worked in case management?

- ○ A. less than 1 year
- ○ B. 1-3 years
- ○ C. 4-6 years
- ○ D. 7-9 years
- ○ E. 10-12 years
- ○ F. 13-15 years
- ○ G. 16-18 years
- ○ H. 19-21 years
- ○ I. 22-24 years
- ○ J. 25+ years

12. How long have you worked in healthcare?

- ○ A. less than 1 year
- ○ B. 1-3 years
- ○ C. 4-6 years
- ○ D. 7-9 years
- ○ E. 10-12 years
- ○ F. 13-15 years
- ○ G. 16-18 years
- ○ H. 19-21 years
- ○ I. 22-24 years
- ○ J. 25+ years

13. How many people do you supervise?

- ○ A. 1-3
- ○ B. 4-6
- ○ C. 7-10
- ○ D. 11-15
- ○ E. 16-20
- ○ F. 21-40
- ○ G. 41-60
- ○ H. 61-80
- ○ I. 81-100
- ○ J. 101 or more

14. How many hours a week do you work?

- ○ A. less than 20
- ○ B. 20-30
- ○ C. 31-40
- ○ D. 41-45
- ○ E. 46-50
- ○ F. 51-55
- ○ G. 56-60
- ○ H. 61-65
- ○ I. 65+

15. If you work in a hospital, what is its size?

- ○ A. <100 beds
- ○ B. 101 to 200 beds
- ○ C. 201-300 beds
- ○ D. 301 to 400 beds
- ○ E. 401 to 500 beds
- ○ F. 501 to 600 beds
- ○ G. 601 to 800 beds
- ○ H. 801 to 1,000 beds
- ○ I. >1,000 beds
- ○ J. I don't work in a hospital

Deadline for Responses: Nov. 2, 2015

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible. If the envelope is not available, mail the form to: Salary Survey, AHC Media LLC, P.O. Box 550669, Atlanta, GA 30355.