HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

AHC Media LLC

IN THIS ISSUE

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If you thought the RACs were a pain, just wait for what's coming next

Medicaid, commercial insurers are starting their own audits

By the end of the year, it's likely that every type of medical record in your hospital will be scrutinized by one auditor or another, predicts **Brian Flood**, managing director for KPMG LLP, the U.S. audit, tax, and advisory firm.

"It's a new world for health care. Medicaid is rolling out its Medicaid Integrity Contractor [MIC] program to audit Medicaid records, and commercial insurers are beginning to use the same model — and, in some cases, the same auditors — to review the records of their members," he adds.

The Pennsylvania Department of Public Welfare's Bureau of Program Integrity has been auditing fee-for-service Medicaid claims for the past three years, using one of the Centers for Medicare & Medicaid Services (CMS) contractors for the Recovery Audit Contractor (RAC) demonstration project, reports **Charleeda Redman**, RN, MSN, ACM, director of corporate case management for the University of Pittsburgh Medical Center, an integrated health system with 20 acute care hospitals.

The contractor has been auditing records retrospectively and recovering payment if there was a coding error or the patient didn't meet medical necessity criteria, she adds.

CMS has contracted with a different auditor to handle its MIC audits in Pennsylvania, but it will use a similar process, Redman says.

"The MIC auditor will request charts and make determinations. We will appeal through the Department of Public Welfare," she says.

The auditors may have different targets based on the contracts or scope of work they have with the state Medicaid office, Redman adds.

"Some quality issues have been identified as potential risks. In addition, the auditors are looking at the continuum of care, such as cases that are readmitted within a certain time frame," she says.

In addition, a large commercial insurer has contracted with the same

contractor used by the Department of Public Welfare to audit medical records in Pennsylvania with a focus on DRG validation. Another commercial health plan has a contract with another firm to review the records of its members for both medical necessity and coding, Redman says.

"The commercial insurers contract with vendors to audit specific areas where they have identified potential risk. So far, the contracts have varied from payer to payer," she adds.

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

Associate Publisher: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcmedia.com).

Director of Marketing: **Schandale Kornegay**.

Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@ahcmedia.com).

Senior Production Editor: **Nancy McCreary**.

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Editorial Questions

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

Thanks to the three-year pilot program, there's a lot of information available on the RACs and what the auditors focused on during the pilot project, and hospitals can use that information to get ready for the permanent RACs.

In comparison, information on the MICs is not readily available, and hospitals can't base their expectations on the experiences of other hospitals because what the MICs are focusing on may vary from state to state.

The auditors hired by commercial insurers may focus on a totally different area, depending on the contract specifications from each insurer. This means that the commercial audits may vary from insurer to insurer and possibly from hospital to hospital, depending on the terms of the contract.

The MICs are selected by CMS but will interact with each individual state's integrity program. This means it's more than likely that MICs will operate somewhat differently in every state.

"The MICs will be consistent in how they perform the audits, but they may be looking at different issues. In the beginning, the MIC focus is likely to be very similar to the focus of the RACs, but they may get into the finer details in the coming years," Flood says.

The MICs are going to focus on issues that are continually problematic in Medicaid, Flood points out.

Likely MIC targets

Upcoding, lack of documentation to support the coding that was billed, unbundling, violation of time-base codes for outpatient therapy and inpatient therapy services, imaging services, durable medical equipment usage, and medical necessity issues are likely to be MIC targets, he says.

The MIC process is different from the RACs in several ways.

MICs must conform to state laws in terms of time for hospitals to respond to their requests for data; so the time providers will have to respond will differ from state to state. Generally, requirements are between 15 and 45 days.

The RACs are limited to requesting data that go back three years, but MICs base their length of time on regulations in the individual states or the allowed rules of evidence based on the continuing nature of the activity being reviewed, Flood says.

MICs have no limits on the number of records they can request, while RACs are limited to 200.

In Arkansas, the MICs have been reviewing 100% of the records from 100% of providers,

Flood reports.

Unlike with the RACs, CMS will not reimburse providers for copying medical records requested by the MICs.

MICs are not paid by contingency fees but on a contracted basis, plus an award for performance during the contract year, which gives them an incentive to dig deep and identify as many improper payments as possible, Flood adds.

The MIC process is expected to be rolled out nationwide this month, when the last task orders will be assigned and the auditors are able to get staff on board. The MICs will audit the medical records of Medicaid managed care patients as well as fee-for-service patients. The process is expanding beyond inpatient services and will include outpatient treatment as well.

"Since many states have gone to a capitated rate and 60% of Medicaid patients are in managed care, if the MICs audit only fee-for-service beneficiaries, they'll miss an entire population," Flood says.

In addition to auditing hospitals, MICs will audit long-term care facilities, pharmacies, physician practices, labs, transportation providers, and other types of providers.

Largest hospitals probably first

When the MICs begin their audits of hospitals, the first targets likely are to be large hospitals or health systems in large population centers, Flood says.

"The MICs are picking organizations to audit based on population and growth. The largest providers in the largest population centers are likely to be first, but they eventually will get around to every facility in the state," Flood says.

Most of the MIC audits are likely to be "desk audits" — in which the auditors request records and audit them off site. However, the MIC auditors also may come in person to the hospital to review records and interview providers and their office staff.

In addition to auditing providers for coding and medical necessity issues, the MIC protocols require the auditors to review organizations for their handing of billing and costs and to begin measuring for governance of risk, Flood says.

"The MICs will be going beyond case management to determine how the hospitals are running the operations side of the medical encounters and how it impacts the financial side," he says.

For instance, if an auditor asks for certain files, the hospital has to be able to find them and deliver them on time.

The auditors also can ask to see organizational charts, such as a chart showing how the organization deals with overseeing risks and how internal audits are conducted.

They may look at the organization's compliance efforts, how many staff are responsible for compliance, what the budget is, how many audits are conducted each year, and what the results have been, Flood adds.

MICs get to heart of operations

"The MIC auditors are looking for a lot of different issues that the RACs did not focus on. Their scrutiny goes straight to the heart of the operations at the institution," he says.

For instance, if a hospital's compliance department has 25 full-time staff, extensive policies and procedures, regularly scheduled audits, and a database of audit results, the MIC auditor is likely to conclude that the organization has a good governance structure, he adds.

On the other hand, if the hospital has a part-time compliance office with no staff, and no clear description of what he or she does, the facility is likely to receive a lot of scrutiny from the auditors, Flood adds.

"When the auditors write their reports, they will note standard issues, including documentation and proper billing. The governance report will go to the state Medicaid integrity director, which will get the hospital on the radar of the state program immediately," he says.

As part of the Deficit Reduction Act of 2005, Congress required CMS to establish the Medicaid Integrity Program and hire contractors to review provider activities to determine if fraud, waste, or abuse has occurred; audit provider claims; identify overpayments; and conduct provider education.

There are three types of MICs: Review MICs, Audit MICS, and Education MICs. Review MICs analyze electronic Medicaid claims data and identify issues for the Audit MICs to pursue. Education MICs are charged with educating providers, state Medicaid officials, and others on Medicaid payment integrity, quality of care, and other issues.

When the MIC process begins, the institutions will receive a nine-page questionnaire and have 15 days to answer it before an entrance conference with the MIC auditor, Flood says.

An example of a question on the questionnaire

is "Please tell us all the instances you had to pay back state and federal funds, the reasons, and the amounts," he says.

The entrance conference may be on site or on the telephone and will include a document request and a time frame, typically 30 to 45 days, in which the hospital must respond.

After the audit is completed, the MIC will prepare a report that will be shared with the state and the provider. The state and the provider will be able to review and comment on the draft report.

CMS will use the information from the reviews to prepare a revised draft report and send it to the state for review and additional comments. Then CMS will identify any overpayments and send the report to the state to collect. Once the final report is issued, the appeals will be handled through the state appeals process.

"There is no appeal for providers at the federal level, even though these are federal contractors doing the work," Flood says.

(For more information, contact: ***Brian Flood****, managing director, KPMG LLP, e-mail: bgflood@kpmg.com;* ***Charleeda Redman****, RN, MSN, ACM, director of corporate case management, University of Pittsburgh Medical Center, e-mail: redmanca@upmc.edu.)* ■

Hospital reimbursement from all payers is at risk

Take proactive approach to responding to auditors

If your hospital has been focusing solely on improving Medicare records in preparation for the permanent Recovery Audit Contractor (RAC) program, you may find yourself in a bind as other payers roll out their own audit programs.

"There has been a lot of emphasis on the RACs, but in Pennsylvania, we've experienced other audits, and it's just a matter of time before other state Medicaid organizations and other commercial insurers are going to roll out their audit programs. It's no longer just Medicare reimbursement that's at risk; it is truly an organizational risk across all payers," says **Charleeda Redman**, RN, MSN, ACM, director of corporate case management for the University of Pittsburgh Medical Center (UPMC).

Hospitals should prepare for the MICs and the commercial auditors in much the same way as they have been preparing for the RACs, and develop an organized group, similar to the RAC committee, with well-defined roles with each discipline, says **Brian Flood,** CHC, CIG, Esq., managing director for KPMG LLC.

The committee should start immediately to get a coordinated plan in place to respond to the MICs and other auditors before they start getting requests for information because the response time is likely to be very short, he adds.

Develop a committee

To prepare for the audits, UPMC developed a steering committee made up of representatives of key departments including health information management, coding, care management, finance, compliance, and risk, Redman says.

The committee diagrammed the document flow for all audits, including the agencies involved. The group developed an internal process that includes tasks, tools, and turnaround time for all appeals.

UPMC has a dedicated staff for the appeals process specific to the external audits. The current scope of work is handled by a 0.5 FTE RN and a 30-hour-a-month physician who handles medical necessity appeals. The audit work is only a portion of the work done by those individuals, Redman says.

Facilities that focus on responding to just one type of audit are not going to be successful in the end, because the various auditors may use different criteria, Redman points out.

"The time frames are different. The roles are different, and the addresses where you send your responses are different. If you can't automate your response system, it will be difficult to manage," she says.

It is essential for hospitals to develop a comprehensive electronic system that can define the record request by type and track the deadlines and responses, Redman suggests.

"So many software vendors are focusing on RACs and Medicare, and they don't offer the ability to track three different audit types. That is going to be essential as the MIC audits and those by commercial insurance are rolled out," she says.

Hospitals that are part of a health care system should develop a process to oversee the responses to make sure they are covered systematically, rather than by each individual hospital, Flood suggests.

The team at UPMC has created a central

department to handle all record requests and appeals from each facility.

"We're working to change the initial requests for documents so they come to a central area. Once we get a letter, we enter who the auditor is and what the request is. This method will give us the ability to drive the work flow to the area that can respond and track where the charts need to be sent and the time frame," she says.

For instance, if an audit determines that a payment was improper, the letter is forwarded to health information management to review and respond if it's a coding issue. If it's a care management issue, it's sent to care management.

Redman's department handles any issue related to medical necessity, quality, and continuity of care.

Make sure that any letters that come into the system are immediately sent to the area that is responsible for responding, Redman says.

"The clock starts ticking from the day the letter is sent out. If you don't manage the process, you can't meet the deadlines and have no ability to appeal," she says. ■

Documentation is the key when issuing HINNs

Noncompliance could lead to future repercussions

If you aren't complying with the Centers for Medicare & Medicaid Services (CMS) requirements for issuing Hospital Issued Notices of Noncoverage (HINNs) and documenting them well, your hospital could face severe repercussions down the road, according to **Jackie Birmingham**, RN, MS, CMAC, vice president of regulatory monitoring for Curaspan Health Group, a Newton, MA, health care technology and services firm**.**

"Hospitals have to inoculate themselves against denials by doing the right thing and documenting it. Case managers should be conscious of the fact that HINNs are not just a pain in the neck. Not following the CMS guidelines could affect the hospital's reimbursement, increase the risk of audits by the Recovery Audit Contractors and others, and impede the patient's ability to understand what his or her rights are and what the hospital expects of the patient," she adds.

Hospitals are required to deliver HINNs to beneficiaries prior to admission, at admission or at any point in the stay when the hospital determines that the care the patient is receiving or is about to receive is not covered because it's not medically necessary, is not delivered in the most appropriate setting, or is custodial in nature.

"HINNs allow hospitals to build a paper trail showing that the hospital did everything possible to ensure that the patient was transferred to an appropriate level of care. Then, when the time comes to appeal a RAC denial, the hospital will be able to show that there was a valid discharge plan in place and the chances for a successful appeal are better," she says.

As Medicare rolls out the Recovery Audit Contractor (RAC) program nationwide, the RACs are going to be tracking patterns of denials and carefully scrutinizing hospitals for compliance, Birmingham points out.

"Failure to deliver a HINN and document it can have a real snowball effect down the road. If hospitals are audited for continued stays when a patient does not meet medical necessity criteria and they have no proof that they made an effort to discharge the patient to another level of care, the claim can be denied and the denial upheld," Birmingham says.

In addition, if the RAC finds the hospital has a pattern of keeping patients for three days, even though they didn't meet medical necessity, then discharging them to a nursing home, the hospital must have evidence it was trying to discharge the patient or it may face fraud charges, she adds.

"CMS, the RACs, and the Department of Justice all share information," she says.

This makes it even more important for hospitals to have documentation that the hospital determined that the service was appropriate in another setting, that it was available, and that the patient was given a choice of providers, she says.

"In the past, when patients needed post-acute care, case managers would call the provider and wait for a response. Often several days would elapse. Having an electronic tool to make and document referrals is important because there is instantaneous communication between the hospital and the post-acute provider. This ensures that the hospital can issue the HINN in a timely manner and document it," she says.

CMS is specific about when HINNs 10, 11, and 12 need to be applied and includes specific language on its web site, Birmingham adds.

"The most important thing is for hospitals to have the ability to retrieve documentation that

there was a valid discharge plan in place. Having good documentation is worth its weight in gold when it comes to appealing denials," she adds.

The HINN 10, also known as the Notice of Hospital Requested Review, should be given to patients when the hospital requests a QIO review because the attending physician does not agree with a discharge decision.

Before the HINN 10 is issued, the case manager should determine that the services the patient needs can be safely delivered in another setting and that an appropriate bed is available, then talk to the family members and physician, Birmingham says.

"If a hospital has a system in place so they can document that a referral was sent to multiple post-acute providers and that the services the patient needs are available in another setting, it can show the QIO that their request is valid," she says.

The HINN 10 should be given only when the treating physician does not write the discharge order, Birmingham says.

The hospital's utilization review committee, which must be chaired by a physician, must agree to requesting a QIO review of a continued stay, Birmingham points out.

"The case managers are not in this all by themselves. Their job is to get a plan in place and document it and have their physician advisor concur with them," she adds.

The HINN 12 should be issued any time the patient is staying beyond medical necessity criteria to inform patients of their potential liability for a noncovered continued stay because the care won't be delivered in the most appropriate setting.

"HINN 12 is intended for instances when a patient needs a service — such as IV therapy, physical therapy, or occupational therapy — and can get it in the hospital but it's more appropriate in another setting. The only way a hospital can prove that the service is available in another setting is to send a referral to a post-acute provider, have them review the patient's clinical needs and determine that they can deliver that type and intensity of care," Birmingham says.

Hospitals must explain in plain language the reason the hospital believes the stay will not be covered by Medicare and include an estimate of the daily cost of care if the patient stays.

Some case managers are reluctant to give patients the HINN 12 because they know many patients can't afford to pay for their care out of their own pocket, Birmingham says.

"Regulations mandate that hospitals will deliver the HINN 12 at the appropriate time. If a case manager lets the patient and family control how long they will stay, they aren't doing them a favor, and down the road, the financial ramifications could be really bad," she adds.

HINN 11 is to be used for noncovered items and services provided during an otherwise covered stay and should be issued by the business office, Birmingham says.

Case management departments should have a process in place for alerting the business office whenever a physician orders a procedure that can be delivered in another setting, she says.

HINN 11 was instituted in 2006 and continues to cause confusion. It is the most intricate of the HINN notices, Birmingham adds.

"Case managers should monitor the professional services rendered and work with the physician advisors to determine whether or not a HINN 11 should be issued," she says.

Hospitals may opt not to charge patients for the noncovered service and should issue the HINN 11 only when they plan to charge the patients, according to CMS regulations.

A hospital representative should go over the HINN 11 with the patients to make sure they understand it before signing it and should give a copy to the patient and to the attending physician.

Other types of notices that the hospital case manager should be aware of are the Advanced Beneficiary Notice (ABN) and the Pre-admission/Admission notice, Birmingham says.

These types of HINNs are given before a stay that is entirely noncovered or a service that may not be covered. These notify the patient that he or she may be liable for the service or hospital stay, Birmingham says.

HINNs may be used when the patient has been receiving observation services and doesn't want to go home, Birmingham says.

The document tells the patient that Medicare is not likely to pay for the stay because it is not medically necessary or because the service can be delivered in another setting and notifies the patient that he or she can appeal to the QIO.

*(For more information, contact: **Jackie Birmingham**, RN, MS, CMAC, vice president of regulatory monitoring for Curaspan Health Group, e-mail: jbirmingham@curaspan.com. For more information on the HINNs, including sample notification letters, visit the CMS web*

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CRITICAL PATH NETWORK™

Follow-up calls help patients adhere to treatment plan, avoid readmissions

CMs identify problems and concerns and work to solve them

In an effort to improve transitions of care, the nurse care coordinators at Brigham and Women's Hospital in Boston make follow-up calls to patients who have been discharged, identify problems and solve them, and answer questions the patients may have about medication, symptoms, or their discharge plan.

"One of the biggest benefits of the follow-up monitoring program is preventing hospital readmissions and visits to the emergency room. By calling the patients shortly after they are discharged from the hospital, we can discover any potential complications and proactively address them. While we don't have statistical data, we do have a lot of anecdotal information that demonstrates we have been able to intervene and solve problems for the patients," says **Christine Dutkiewicz**, RN, MSN, CCM, care coordination nurse manager at the 777-bed hospital.

The hospital has an average of 53,693 discharges and 59,323 emergency department visits each year and had a 30-day readmission rate of 8.79% for medical-surgical patients in 2009.

The Massachusetts Department of Public Health requires hospitals to follow up on patients who are discharged with multiple services or otherwise complex post-hospital needs or lack an informal personal support system.

At Brigham and Women's, nurse care coordinators are assigned by service line and follow the patient throughout the hospital stay. The same care coordinator who made the discharge plan makes the follow-up calls within a day or two after the patient is discharged, Dutkiewicz says.

The nurse care coordinators call any patient who is discharged home with post-acute services, patients who will be home alone after a hospital discharge, first-time mothers discharged to home with their babies, families of babies who are discharged from the neonatal intensive care unit, and any patient the care coordinator is concerned about after discharge.

The nurse care coordinators use their clinical judgment in determining the timing of the call based on past service utilization, access to care, and medical and social complexities.

They also call patients who are discharged from medical oncology and bone marrow transplant and patients who are discharged from thoracic services. The cardiac surgery service handles its own follow-up calls using its own distinct database.

The nurse care coordinators access clinical and demographic information about patients through an ambulatory electronic record. Using a standard template, they ask a series of questions about the discharge process, the adequacy of home care services, family support, pain management, medication, activity restrictions, and follow-up appointments.

They enter the information from the call into a longitudinal database that is accessible by other providers in the Partners Health Care System, which includes Massachusetts General Hospital, Brigham and Women's Hospital, three community hospitals, two long-term acute care hospitals, two rehabilitation hospitals, four skilled nursing facilities, a home care agency, a hospice, and more than 1,000 primary care physicians who

practice throughout the state.

The nurse care coordinators use a follow-up monitoring template that includes the reason for admission, information about how the patient is feeling, pain management, medications, wound/incisions, activities, home care visits, follow-up care, nurse care coordinator follow-up and referrals, and questions or concerns.

Each section has a drop-down menu that includes a series of questions in which the nurse care coordinators enter details about each patient response.

For instance, within the pain management section, the questions include: Is the patient feeling any pain or discomfort? How is the pain on a scale of 1 to 5? Does the pain medication help? Is the level of pain acceptable to the patient?

There is a list of types of medication (antibiotics, steroids, diuretics, etc.) and a list of types of questions (dose, frequency, side effects, duration, etc.) that the nurse care coordinators can record electronically using a check-off or point-and-click method.

Automated e-mails

The system automatically formats an e-mail that the nurse care coordinator can send to the primary care physician, home health nurse, or other providers if they have concerns about the patient. The e-mail includes the reason the care coordinator is asking for the follow-up and all the information gathered during the call.

When the nurse care coordinators uncover problems that might have occurred during the hospital stay, they send a report to the appropriate department leaders of individuals within the hospital, Dutkiewicz says.

"This is important information to share within the hospital to drive improvement activities," she adds.

Originally, the care coordinators documented their follow-up calls using a database that was accessible only to the care coordination department employees. The department has moved to an integrated system to enhance patient transitions, quality, and access, Dutkiewicz says.

The nurse care coordinators print a daily report of patients who were discharged the day before and use that to set up their call schedule. They start calling in the morning, make two attempts to reach the patient, and leave a message asking the patient to call back if the calls are unanswered.

The care coordinators always instruct the patient to call with any questions or concerns but it doesn't always happen, she says.

"Using this system, we take a proactive approach to identifying any questions and problems the patients are having and solving them before the patients are back in the hospital or the emergency room," Dutkiewicz says.

The majority of questions patients have concern medication or symptoms after surgery.

"Often, patients don't understand their discharge instructions. The entire episode of care, including discharge, may be overwhelming. Patients may not feel comfortable calling their doctor's office if they have questions or concerns. They wait for the symptoms to exacerbate before calling," Dutkiewicz adds.

The nurse care coordinators sometimes find that patients haven't filled their prescriptions due to costs or previously unknown preapproval requirements. Other times, the durable medical equipment hasn't arrived or the home health agency hasn't scheduled a visit.

"When we identify these problems, we work to solve them. We've even called 911 for patients when we were concerned about the acute nature of their reported symptoms," she says.

The care coordinators talk to the spouse or caregiver if the patient is unable to come to the telephone. If the patient is sent home with hospice care, they call hospice first, and then call the patient and family.

Calls help other providers

The follow-up calls help other providers in the Partners network coordinate care for the patients after they are discharged from the hospital, Dutkiewicz says.

For instance, if a patient comes into a community hospital's emergency department, staff can access the record and see the patient history and the care coordinator's report after the patient was discharged.

"Many changes need to happen in health care to improve patient outcomes. With public reporting of quality outcomes, payment, and health care reform, there is an additional incentive to conduct integrated follow-up monitoring of patients after they are discharged from the hospital," she adds.

*(For more information, contact: **Christine Dutkiewicz**, RN, MSN, CCM, care coordination nurse manager, Brigham and Women's Hospital, e-mail: cdutkiewicz@partners.org.)* ■

Throughput drive lowers discharge time, LOS

ED time drops, patient satisfaction soars

When Henrico Doctor's Hospital in Richmond, VA, launched a hospitalwide initiative to improve patient throughput, the team was able to shave 2.5 hours off the average discharge time and decrease the average length of stay on the medical unit from almost 10 days to five days in the first six months of the project.

Before the project was initiated, the hospital's emergency department was frequently on diversion, says **Patrick McGrady**, RN, MBA, director of med-surg services at the 767-bed hospital with three campuses.

At that time, Henrico's average emergency department length of stay was 270 minutes. Patients who were admitted to the hospital stayed in the emergency department for more than 470 minutes. Bed-hold hours for patients waiting for transfer to an inpatient bed were about 1,500 a month. The percentage of patients who left without being treated was at 4%, twice the national average.

"We knew we had to change the way we were doing things and improve emergency department throughput. The hospital administration enlisted the help of a consulting firm to develop a plan to deal with the issue," McGrady says.

At the end of the improvement process, arrival to treatment time in the emergency department dropped from 77 to 21 minutes and patient satisfaction increased 563%.

When beginning the project, the hospital assembled a process improvement team of more than 90 people including hospital administration, physicians, case managers, bedside nurses, ancillary unit directors, and housekeeping staff.

When the team drilled down to look for the cause of emergency department delays, it determined that one of the biggest issues affecting throughput and bed availability was length of stay on the medical-surgical units, McGrady says.

The team began its initiative to decrease length of stay by investigating the discharge process from various points of view and outlining the roles that physicians, nurses, case managers, patients, and their family members play in the discharge process, looking for barriers to a timely discharge and ways to overcome them, McGrady says.

The team examined physicians' role, including what time of day they make rounds and what kind of communication they need to support the discharge process.

They looked at what kind of rounding the case managers were doing with the staff nurses or charge nurses on each unit or if they were making rounds at all.

"We considered what would be the best time to make rounds, the charge nurse role and how it impacts the length of stay, and the link between the physician and the case manager," he says.

The team also scrutinized what kind of communication various members of the treatment team had with patients and family members about discharge plans from the day of admission to the time of discharge.

One of the goals was to improve communication between the case managers and the charge nurses so both were on the same page about patients being discharged.

Now the case managers meet with the charge nurses in the morning and update them about potential discharges. They look for barriers that might slow down the discharge, such as home health referrals or durable medical equipment, and collaborate to ensure that services are in place and that the barriers are overcome.

The charge nurse team makes regular rounds to keep family and friends of the patient informed about the patient's condition.

The hospital's average discharge time was 5 p.m. when the initiative started. The team set a discharge goal of 11 a.m. for all patients on the medical and surgical units and almost immediately moved the average discharge time up to 2:16 p.m.

"We're still moving toward the 11 a.m. goal, but it's not set in concrete. If patients have extenuating circumstances, we're not going to push them out on the street," he says.

The team put up signs in the patient rooms informing patients and family members about the target discharge time.

"This helped facilitate the conversation about discharge with patients early in the stay. It alerts the patient and family members that they need to start planning their transportation and other discharge needs," he says.

The team also created a flier to educate patients about what they can expect during their stay, including that the discharge target time is 11 a.m.

The nurses give patients the flier and talk with them about what they may need when they go

home and what discharge services are available. They can determine from the conversation whether patients need a case manager or social worker to help them prepare to go home.

"The flier helps open up the discussion about discharge planning and helps us plan for the patient's post-discharge needs early in the admission process instead of waiting until the day of discharge to set it up," McGrady says.

The case managers review the charts of patients who exceed the geometric mean length of stay on a case-by-case basis and drill down to find out why patients stayed longer than the expected length of stay.

"Some patients stay longer than expected because of complications or change of DRG. But sometimes patients stay because it's convenient for the family or because the post-acute services are not in place in a timely manner. We looked at all the reasons for the delays and ways we could speed up the process. We did a lot of communicating with physicians and a lot of work instituting culture change," he says.

The case management department tracks patients who have longer stays than expected and follows up with the physicians to address the issue. If the patient is ready to be discharged, they try to make sure the patient is discharged within two hours after the physician writes the discharge order.

"We have been looking at physician-specific data and having a conversation with physicians who might have been keeping patients in the hospital longer than necessary to find out why," McGrady says.

For instance, in the past, lab work for med-surg patients typically was the last drawn and the last to be completed.

"The physicians knew this so they came in late to check on the results and determine if the patients were ready for discharge," McGrady says.

The team created a process that notifies the labs in advance if the patient's discharge or transfer is pending.

"Now physicians get the labs in a timely manner, and patients are not waiting to go home because the lab results aren't in the chart," he says.

When the process began, case managers were seeing the patients only if the physician wrote orders for a consultation. Now, the nurses can call the case manager or social worker in when needed.

*(For more information, contact: **Patrick McGrady**, RN, MBA, director of med-surg services, Henrico Doctors' Hospital, e-mail: Patrick.mcgrady@hcahealthcare.com.)* ■

Hospital created simple, effective discharge tool

Patient discharge process now much smoother

An effective and simple discharge checklist is the ideal tool for hospital nurses and others who handle the patient discharge process.

The University of New Mexico Hospital in Albuquerque has developed one that meets both of these goals and has received high marks from nurses who use it.

The hospital developed the tool after becoming involved in Project BOOST (Better Outcomes for Older adults through Safe Transitions), which is sponsored by the Society of Hospital Medicine in Philadelphia.

"One of the things we've had some success with is our discharge checklist for nurses," says **Percy Pentecost**, MD, assistant professor of medicine at the University of New Mexico Hospital.

"What we found is there is not a lot of consistency in the way discharges were done, so we tried to make that more consistent," he explains. "The way we've done that is to come up with a discharge checklist that all the nurses on our trial floor utilize every time they discharge a patient."

For example, if a patient has his or her prescriptions in hand or has a way to obtain his or her prescriptions before arriving home, this will improve the patient's discharge process.

"If you hand somebody prescriptions at 8 p.m., it doesn't do them any good because the pharmacies are all closed," Pentecost says. "So we're trying to anticipate the details needed for discharge."

Another example of a discharge detail involves making certain patients understand and can repeat back all of the warning signs of problems.

"So, if they're admitted with pneumonia, they should be able to articulate to the nurse before the discharge that they know to call their medical provider or return to the emergency room if their breathing gets more difficult or if they develop a cough or fever," Pentecost says.

"The checklist is implemented on our trial floor, and the nurses are quite pleased with it, and they feel it adds consistency and helps them organize their thoughts," he adds. ■

(Continued from page 6)

site at: http://www.cms.hhs.gov/BNI/05_HINNs.asp#TopOfPage.) ■

Hospital appeals, receives about $2 million in denials

System uses external physician advisor

Bon Secours St. Francis Health System received nearly $2 million in denials and successfully appealed the vast majority of them during the few months the Greenville, SC, hospital was part of the Recovery Audit Contractor (RAC) demonstration project, says **James T. Jones**, PhD, RN, administrative director, case management and patient documentation for the Bon Secours St. Francis Health System.

South Carolina became part of the Recovery Audit Contractors demonstration project on July 1, 2007.

"We were part of the RAC demonstration for only a few months but we received 650 requests for medical records. Out of several million dollars of initial denials, the recovery rate under the appeals process has been an overwhelming success in that all but a small percentage of denials were overturned," says Jones.

The secret to success was the hospital's decision to contract with an outside physician advisor firm, which reviews patient records before the admission occurs when there is a question about medical necessity or patient status.

When the hospital administration asked Jones for his opinion on contracting with an outside physician advisor firm, he readily agreed to contract one.

"I thought this was something that would work well because CMS requires the second-level review process under the Medicare Conditions of Participation. In my opinion, it's always best to have an escalated process where the physician who reviews the case has the authority to make a determination but is not an admitting physician and does not have a personal relationship with the physician whose orders he or she is reviewing," Jones says.

Under the arrangement, the hospital has its own dedicated team of physician experts who work with the case management staff and the medical staff. Jones has a monthly telephone conference with the firm to discuss how the referral process is going and any issues or concerns.

When case managers have any questions about a case meeting inpatient criteria, they call the physician advisor for a review while they are still on the telephone. In most cases, the case managers have the chart in front of them and can provide the information the physician advisor needs to make a determination.

If the case managers can't have the chart available when they make the call, they use a sheet that outlines all the information they need to gather in order for the physician advisor to make a medical necessity determination, Jones says.

"The staff understand that it is extremely important to check with the outside physician advisor firm if there is any sort of gray area. If the patient is clearly meeting inpatient criteria, they don't call. But they do call in situations where lab values may be abnormal or the patient is on a slow IV fluid drip and may be more appropriate for observation services," he says.

The case managers ask for review of about 30% to 40% of Medicare patients.

"These calls are so important because only the second-level physician reviewer has the authority to override the criteria and say that, based on other comorbid conditions, that may place the patient at higher risk the patient meets admission criteria," he says.

"The case manager documents in the medical record that the case was reviewed by the physician advisor and the patient did or did not meet medical necessity," he says.

The physician advisor firm then e-mails a determination letter in an encrypted secure zip file that only four people can access. That includes Jones, his administrative assistant, the lead case manager, and an RN case manager on the surgical unit.

"We make the letters accessible to four of us to make sure that someone is on site when the letters arrive and can get them printed and sent to the medical records department in a timely manner," Jones says.

The medical records department scans the letter into the electronic medical record.

"Once we receive the letter of determination from the physician advisor firm, it is available in the electronic medical record within two hours," Jones adds.

The hospital retains the letters of determination from the firm as part of the permanent patient record.

"Now if there is ever any question from an auditor or if the case ever goes to court, we have it in the record that we have a process in place and that we followed it," he says.

Before signing the contract with the outside physician advisor firm, Jones presented the idea to the hospital's medical executive committee and utilization management committee and got their buy-in.

"We conducted extensive education with the physicians in meetings and one on one in the hallways. We told them that what we were doing would not only help the hospital, but would help them to document the correct severity and status that will affect their MEDPAR data," he adds.

Physicians accept admissions reviews

Physician acceptance to having their admissions reviewed by an outside firm was a challenge at first, but it's improved now that physicians face the same level of risk as the hospital and are subject to having their professional fees recovered if the hospital receives a Medicare denial, Jones says.

"During the demonstration project, it was difficult to get most of the medical staff to buy into what a RAC denial means, but now, I have physicians calling me to ask how they can comply," he says.

When the process started, the physician advisor firm's trainer met with Jones and the case management staff to describe how the process would work.

During the educational sessions, Jones emphasized the importance of making the telephone call to the physician advisor company and ensuring that their letters of determination are included in the patient chart.

"We're not looking for them to agree with us. The whole secret to compliance is to get it right the first time," he says.

The actual referrals are about 70% above the projected referrals, Jones reports.

"This tells me that all the education and coaching is paying off. Now the case managers understand the importance of making referrals to the physician firm when there is a question of medical necessity," he says.

Jones receives regular monthly reports on compliance issues, which he uses to educate his case management staff.

"We have conducted extensive education with the staff on the use of Condition Code 44. If Medicare determines that a hospital invokes Condition Code 44 frequently, it opens the hospital up to more scrutiny. Our Condition Code 44 rate is extremely low, due to the education the staff have received from the physician advisor firm," he says.

The hospital uses the outside physician advisor firm for about 70% of its payer mix. It's used primarily for Medicare and Medicaid cases since commercial insurance reimbursement is primarily driven by the contract, Jones says.

"We treat any self-pay or uninsured patients the same as we do Medicare patients. We have to manage them well because we don't want to add to the cost to the self-pay patients or to the hospital," he says.

The hospital had been using the new system to determine admission status for nearly a year when it became part of the RAC audits.

"We had the process down very well by then and were very successful with compliance and the RAC process," he says.

St. Francis appealed all of its denials with the help of the outside physician advisor firm.

When the records requested by the RAC included a letter from the physician advisor company explaining medical necessity and the medical reasoning for making that determination, the denials were automatically overturned at the first appeal level.

"That told me that our process was working very well to lower our exposure to the RAC denials," he says.

The appeals process can take up to two and a half years to recover any money that Medicare takes back if the hospital has to appeal through the entire five levels of appeal, Jones points out.

Of the 38 cases that St. Francis appealed to the administrative law judge level of appeal, 99.8% of denials were overturned in favor of the hospital.

Jones already was knowledgeable about the demonstration project after moving to Greenville from Florida, one of the initial states in the RAC demonstration project.

"The hospitals here weren't as familiar with the RAC process. I was able to educate our staff about what the RACs mean and the kind of processes we must define and follow," he says.

Jones recommended that the hospital's RAC steering committee have senior administrators as part of the team so the committee could make decisions immediately and go forward with them.

"The RAC team needs to be widespread and high-powered. At St. Francis, the chief medical officer and the chief financial officers are members of the RAC team and strong supporters of the process," he says.

*(For more information, contact: **James T. Jones**, PhD, RN, administrative director case management and patient documentation, Bon Secours St. Francis Health System, e-mail: Jim_jones@bshsi.org.)* ■

Studies show decrease in senior care continuity

End-of-life discussions should be reimbursed

If the discharge planning community's ideal is to begin the discharge process at the door, when patients are admitted to the hospital, then community provider input is necessary for a smooth care transition.

But care continuity has been low, and it's decreasing for older adults, recent studies show.[1,2]

A study that examined the proportion of patients who are seen by their primary care physician during their hospitalization found a significant decline in this continuity of care, says **Gulshan Sharma**, MD, MPH, an associate professor at the University of Texas Medical Branch in Galveston.

"The proportion declined from 50.5% to 44.3% between 1996 and 2006," Sharma says.[2]

The study showed an even greater decrease in continuity in cases where patients were admitted to the hospital on weekends and for those living in large metropolitan areas.[2]

The results were not too surprising, given the changes that have taken place in the delivery of health care over the past two decades, Sharma notes.

"To improve efficiency of care, you have primary care physicians managing patients in very busy practices, and it's hard for them to go see patients who are hospitalized," he explains. "So there's been a large growth in hospitalists' positions, and these are the people who provide care for patients when they're hospitalized."

The older model of having one physician follow patients through the trajectory of their illness and care no longer is followed.

"The health care system is getting more efficient, with physicians spending more time at their part of this system, but the price you pay is fragmented care," Sharma notes.

"There's a lot of disruption in care, and there's no major effort to have a physician make sure the transition is smooth in either direction," he says.

Similarly, there are no practice or economic incentives for hospitalists to follow up with patients

CNE *questions*

1. The Medicaid Integrity Contractors (MICs) are chosen by CMS but contract with each individual state's Medicaid integrity program. This means that MIC audits could be different in every state.
A. True
B. False

2. When the MICs request records, the time the hospitals will have to comply with vary according to state law, but generally it can be expected to be between:
A. 30 and 45 days.
B. 15 and 30 days
C. 15 and 45 days.
D. 20 and 30 days.

3. When a hospital requests a QIO review because the attending physician does not agree with the discharge decision, which HINN should be issued?
A. HINN 10
B. HINN 11
C. HINN 12
D. All of the above

4. During the few months that Bon Secours St. Francis Health System was part of the RAC demonstration project, how many records did the auditors request?
A. 400
B. 450
C. 600
D. 650

Answer key: 1. A; 2. C; 3. A; 4. 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 **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

once they've returned to the community, Sharma adds.

"That's where a major discussion is going on: How do you make this transition smooth?" Sharma says. "One way would be through an electronic health record."

Hospital systems and community providers who can connect electronically can provide follow-up care and a smoother transition through electronic communication, he says.

But research suggests that having a primary care provider attend a patient in the hospital can improve health care outcomes. In one study, investigators found that patients with terminal lung cancer who were visited by community physicians while in the hospital were less likely to spend time in the intensive care unit (ICU) before death.[1]

"So it might be good for discharge planners to have a primary care physician visit patients," Sharma notes, "and discharge planning should include communication with a patient's primary care physician, so they'll know what's going on."

One reason those primary care physician visits to hospitalized patients are decreasing is that there is no reimbursement for them, he says.

"Medicare won't reimburse for two physicians for the same specialty," he explains. "So, if you have an internal medicine doctor providing care and a primary care physician who also sees the patient, then whoever sends in the claim first gets paid."

Health care reform discussion has included a discussion of paying primary care providers for visiting at least terminally ill patients when they are hospitalized, but this possibility may be eliminated from any final Congressional bill because of the summer's emotional debates about insurers covering end-of-life care discussions.

Still, there has to be some discussion between hospital staff and community physicians about the patient's end-of-life care plans, whether this is via the telephone or e-mail, he suggests.

"It's possible there already is some communication occurring over the phone, and our research hasn't captured that in the billing information we used from Medicare," Sharma says. "But we need a better way of reimbursing the primary care physician for helping the hospital doctor in better decision making."

Primary care physicians should be reimbursed for having these discussions with patients, Sharma adds.

"We need to improve care transition communication and building patient-physician trust," Sharma says. "Once patients trust their physicians, they can make more appropriate decisions."

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Discharge often difficult at children's hospitals

Too few post-acute pediatric options exist

A researcher and pediatric physician who has studied insurance and immigration issues related to medical care has found that several myths create an emotional response that complicates the medical and political issue of who should pay for health care for undocumented immigrants.

For example, the average costs of medical care for immigrant children is considerably less than the cost of medical care for children who are not immigrants, says **Susmita Pati**, MD, MPH, senior co-director of the Children's Hospital of Philadelphia (CHOP) and director of research programs for FOCUS, which is a program supported by the dean of the University of Pennsylvania's School of Medicine.

Pati also is an assistant professor of pediatrics at CHOP and the University of Pennsylvania in Philadelphia.

Pati's research has shown that what is spent on health care for an immigrant child is one-third as much as the average spent on children who are not immigrants.[1]

And immigrant children are far less likely to be insured, particularly through public health insurance, since immigration reform in the late 1990s.[2]

"The prevailing misconception in the general populace is that immigrants are draining our health care system because they don't have insurance and that it costs more to take care of them," Pati says.

"Another myth is that tons of immigrants are on public insurance rolls, and the study I published shows that also is not true," Pati says. "Immigrant kids are much more likely to be without coverage."

However, discharge planning for hospitalized children is challenging regardless of the child's insurance or immigration status, she notes.

"We might have trouble finding an appropriate

home care provider when children need antibiotics via IV or if they need additional therapy for a head injury in an accident," Pati explains.

There are too few long-term care or rehabilitation facilities for children, she says.

"It's a chronic problem, and for children who have mental health needs, inpatient psychiatric facilities are incredibly lacking, as is reimbursement for those types of services," Pati says.

"Some things are easier to arrange than others," she adds. "But in general, long-term types of care like rehabilitation are very poorly reimbursed when compared with antibiotic administration, and those are inherent challenges we have in the system."

Group finds coverage for uninsured kids

At CHOP, there is a dedicated group of people who work to find coverage for children who don't have it, Pati says.

"When a family doesn't have insurance coverage, they work with the family to apply for whatever they might be eligible for or to arrange for a payment plan or for charity care," she says. "Those are the three options."

Many hospitals do not provide this service, Pati notes.

"Unfortunately, there are cases where no post-hospital care can be worked out very quickly, and children sometimes stay in the hospital a few extra days," she adds. "But that's obviously not ideal for anybody."

This is one of the situations where hospitals and discharge planners cannot fix the problem through their own individual efforts.

"Almost no solution can be handled singly by providers," Pati says. "We need public policy changes."

Children can languish in the hospital while medical providers cope with finding an appropriate skilled facility, ensuring post-acute medical care will be covered, and communicating with families who often do not speak English as their primary language, Pati explains.

"There are plenty of cultural and ethnic community-based organizations you can tap into as resources. But if you talk about a child who needs long-term rehabilitation, they're not able to do that; they can provide someone with a ride to a grocery store, but they can't give a child physical therapy," she notes.

"Children are where an ounce of prevention is

CNE objectives

Upon completion of this educational activity, participants should be able to:

- identify the particular clinical, administrative or regulatory issues related to the profession of case management;
- describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the health care industry at large
- discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities. ■

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- ■ Promoting interdisciplinary harmony at your hospital
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- ■ Finding a case management model that works for you
- ■ Should CMs cover the house 24/7?

worth a pound of cure; if we don't invest in children from birth to three years of age, we end up paying for it many times over," Pati adds.

Reference

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2009 SALARY SURVEY RESULTS

HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

Salaries on the rise — but so are the hours

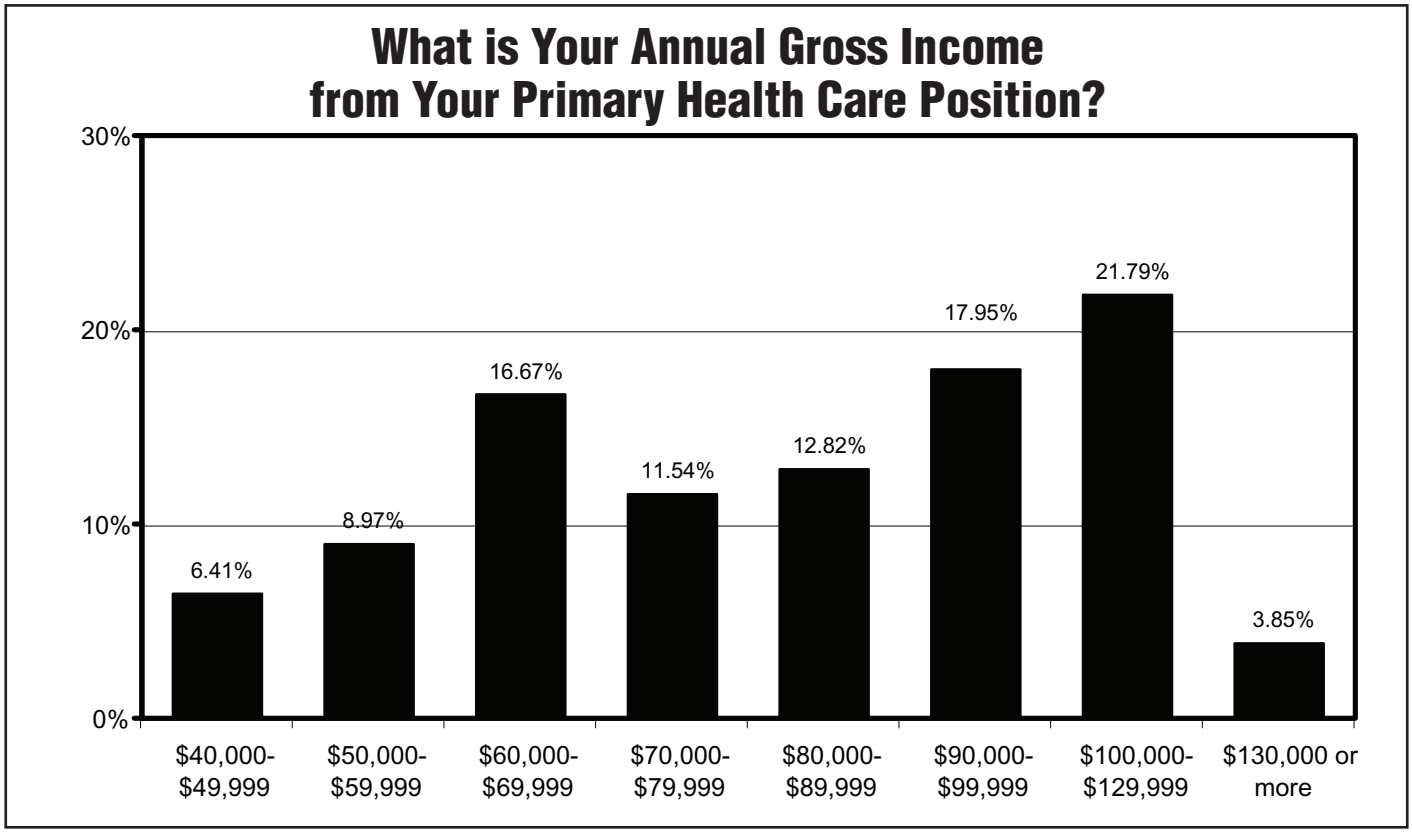
Economy, perks are slashing turnovers

Salaries for case managers are increasing, but the vast majority of case managers are working far more than the typical 40-hour week, according to the 2009 *Hospital Case Management* Salary Survey.

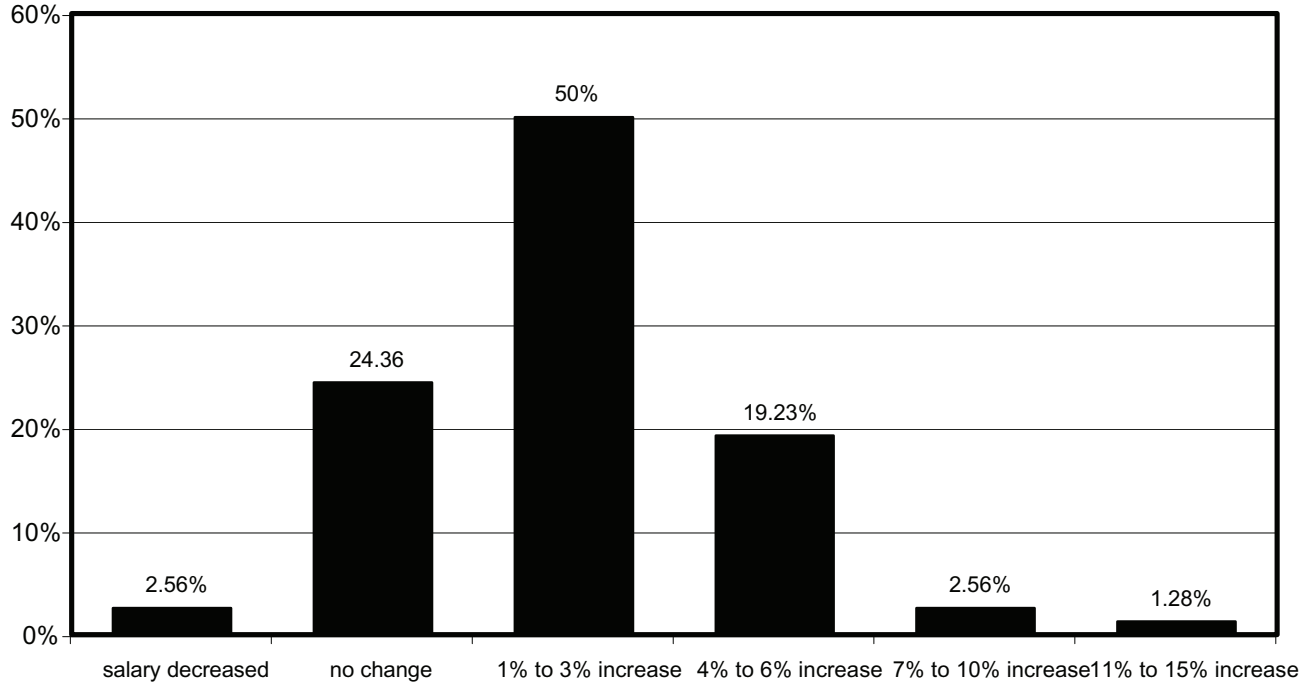
The 2009 Salary Survey was mailed to readers of *Hospital Case Management* in the June issue. About two-thirds of the respondents (67%) were case management directors. The rest were case managers, utilization managers, social workers, or had other titles.

The majority of respondents (73%) to the survey report that they got a raise last year. About half were in the 1% to 3% range, with 23% reporting raises of 4% or more. Nearly 3% reported a salary decrease for the year.

About 85% of respondents reported receiving a salary of $60,000 a year or more, with 28% of



In the Last Year, How Has Your Salary Changed?



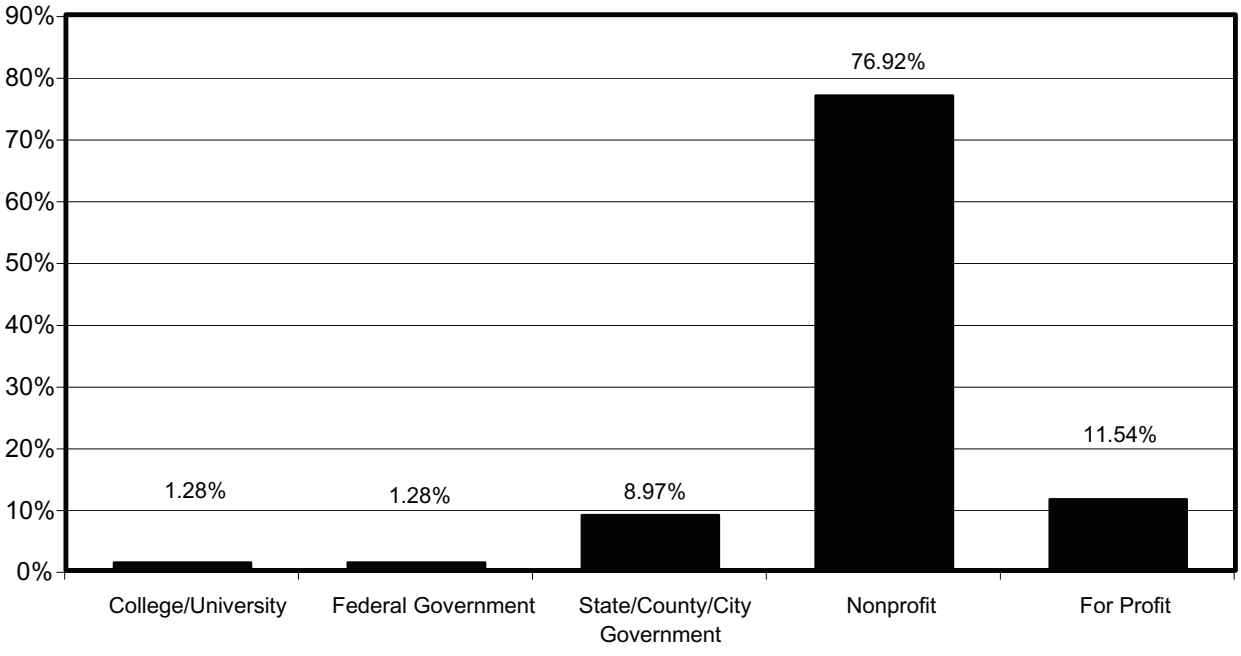
respondents reporting an income in the $60,000 to $80,000 range and 26% reporting salaries of $100,000 or more.

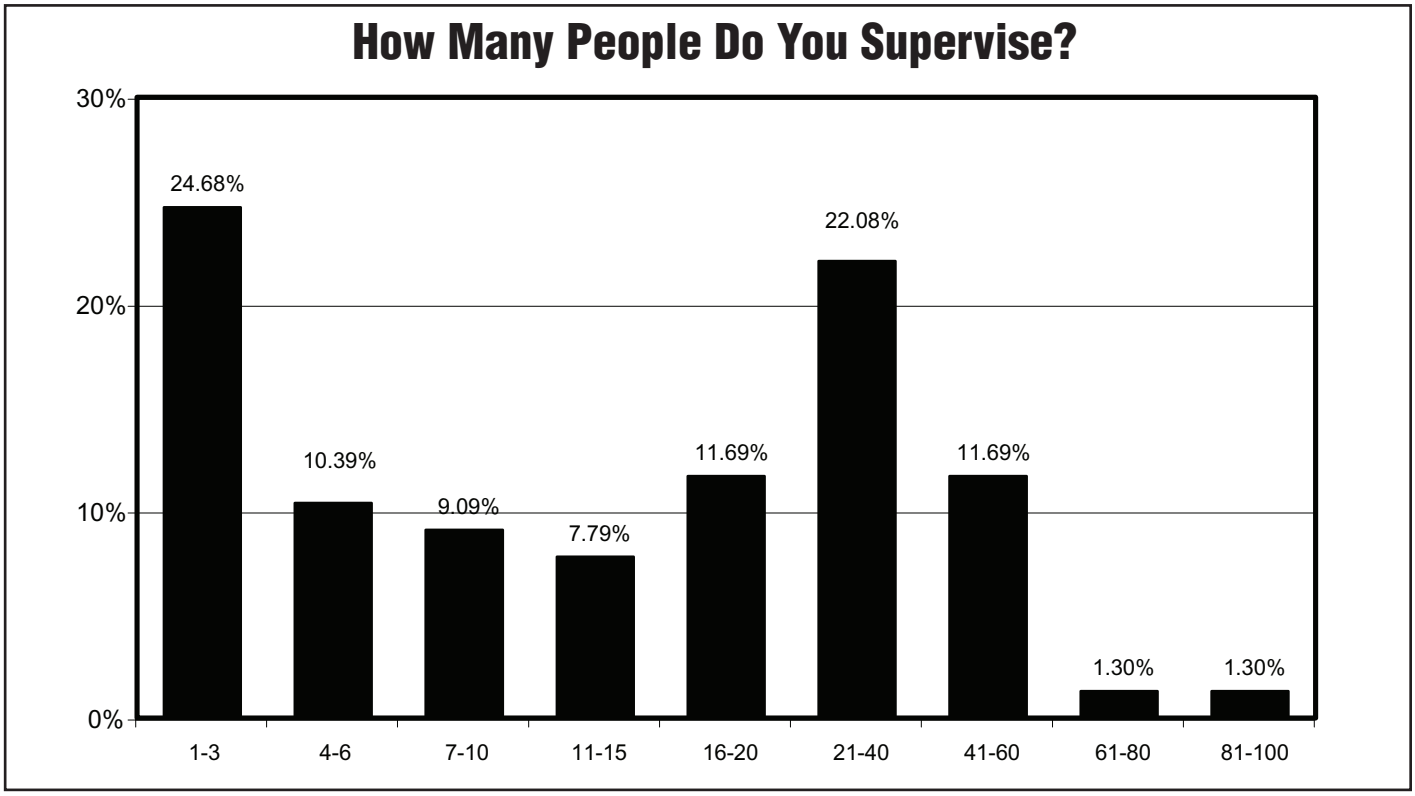
At the same time, case managers reported putting in long hours. Nearly 76% of respondents reported working more than 40 hours a week, with 28% putting in more than 50 hours.

Today's case managers are well educated. Among respondents to the salary survey, 81% have a bachelor's degree or higher, and 34% have completed a postgraduate degree.

The majority of respondents to the salary survey are older and experienced case managers. More than half (56%) have worked in case management

Which Best Describes the Ownership or Control of Your Employer?





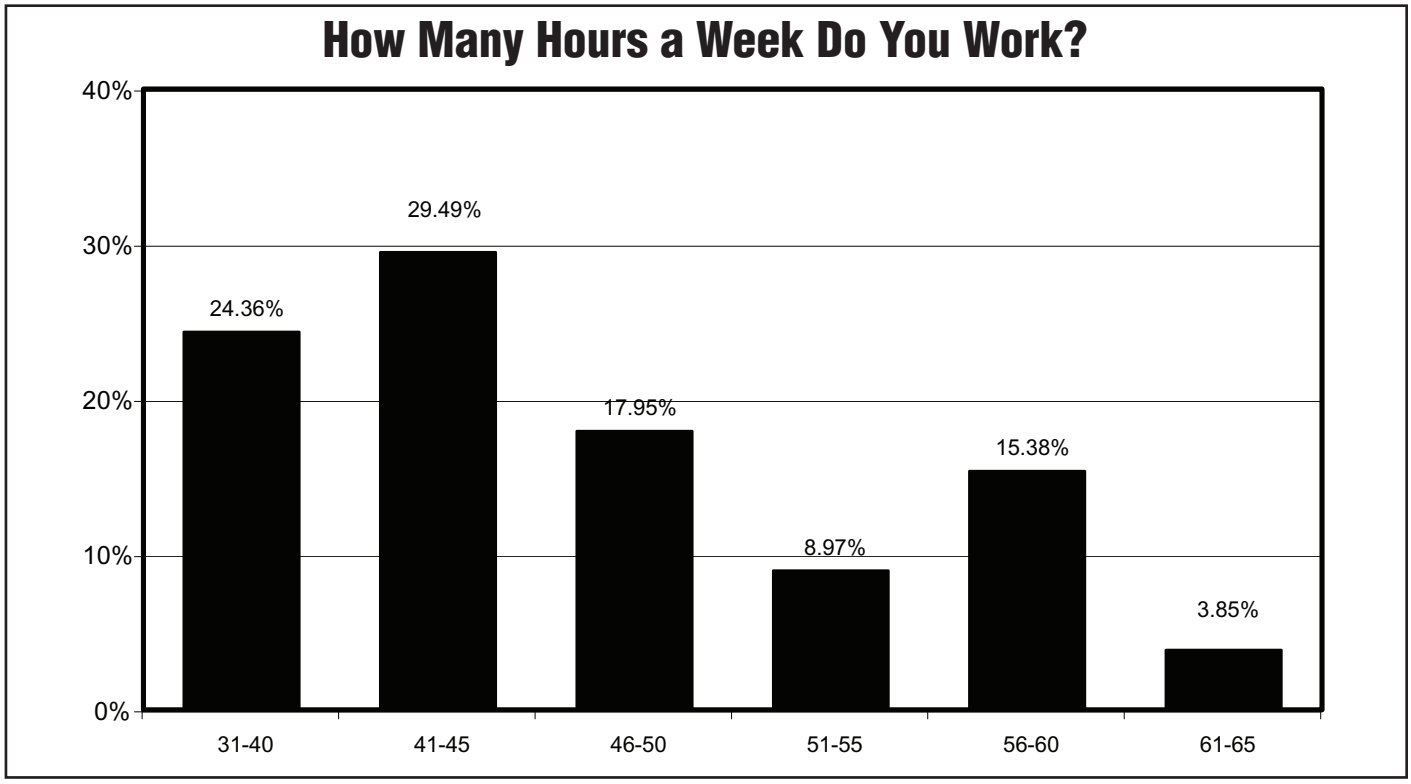
for 10 years or longer, and 68% have 25 or more years experience in the health care field.

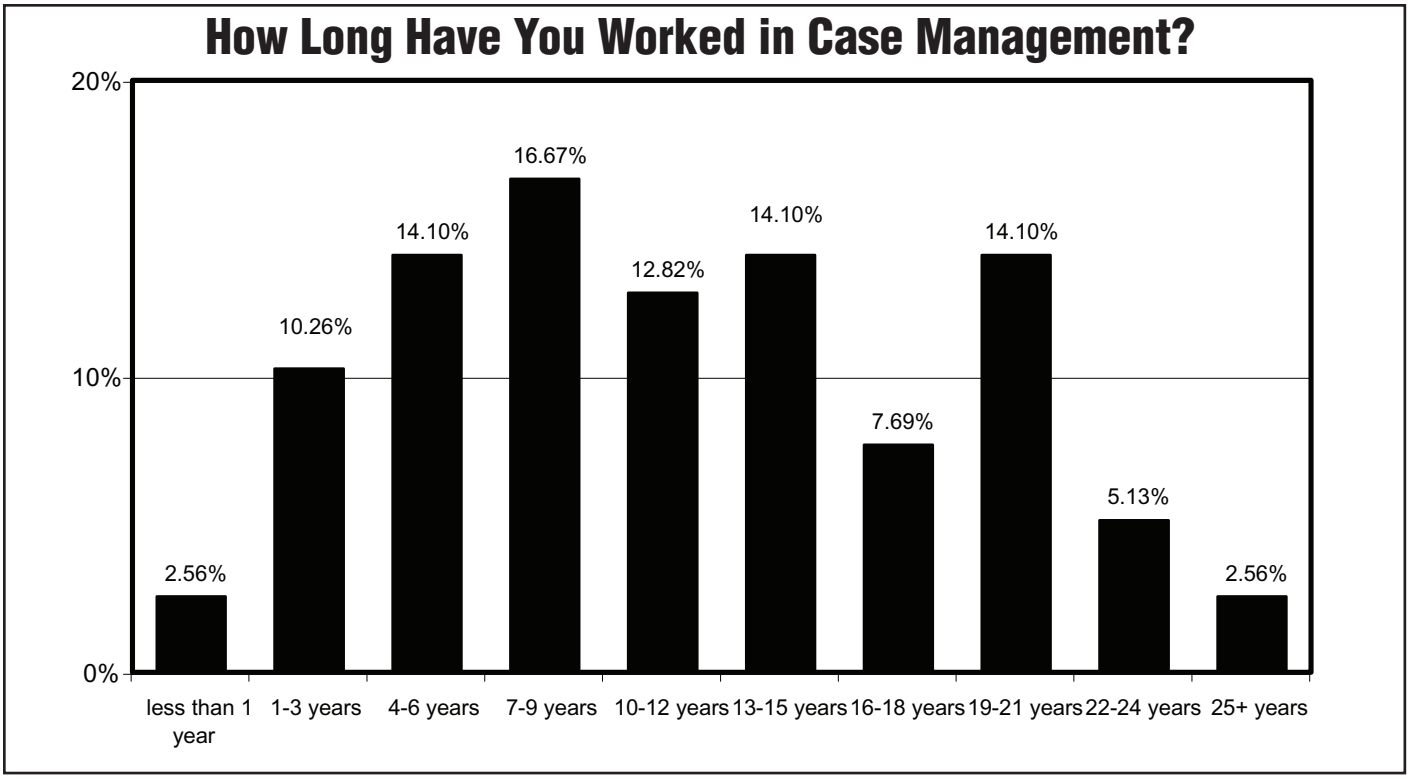
Ninety-two percent of respondents are over age 40 while 13% reported being 61 years or older. Only 8% reported being age 40 or younger.

Case managers seem to be staying on the job longer than in recent years, thanks to economic conditions, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy & Associates, a case management training and consulting company.

The U.S. economy has changed the employment outlook for nurses and is affecting the number of case management jobs available, she adds.

"Times are changing a bit. Many nurses aren't retiring early. Some nurses who were working





part-time are now working full-time," she reports.

As Mullahy presents workshops for case managers around the country, she frequently encounters nurses who are looking for jobs.

"I don't hear many people talking about the nursing shortage anymore. Now I'm hearing about the shortage of nursing positions," she says.

Case management turnover is low among many hospitals, which may be attributable in part to the economy but also to training and incentives that hospitals offer their case managers.

"I don't have an issue retaining care managers. When I have a vacant position, I have more applications than I can screen," adds **Jamie Buller**, LCSW, director of case management for St. Vincent's Health Care, a two-hospital health system in Jacksonville, FL.

When the Recovery Audit Contractors demonstration project cranked up in Florida, Buller was able to justify adding FTEs for the new position of admissions case managers. The admissions case managers work from 1:30 p.m. to midnight seven days a week and review all new admissions that are likely to be one- or two-day stays.

At St. Vincent's new case managers are assigned a proctor and work side by side with him or her for 90 days, gradually assuming a full caseload.

Most of the new hires have been from within the system, Buller reports.

"I have more success hiring internally because of the learning curve. Nurses who have worked here know all the hospital systems. What they have to learn is InterQual and the care coordination piece," she says.

When he arrived at Bon Secours St. Francis Hospital System in Greenville, NC, as director of case management, **James T. Jones**, PhD, RN, worked with the hospital system's human resources department on a salary survey of the Greenville market.

"I discovered that at the time, we were probably below the market. The case managers might not realize it at the time, but word travels fast. I didn't want my staff to go to work at the hospital across the street," says Jones, now administrator director for case management and patient documentation.

Working with management, Jones raised case management salaries above those offered by the competition and reduced the case management caseload. The department has gone two years without a resignation.

In the past, case managers were responsible for 30 to 40 beds on their own. Now a case manager-social worker team covers 30 beds. Each team member has a 19-inch laptop he or she can use throughout the day.

"I constantly poll the staff to ask what they need to do the job. We also have a strong rewards and recognition program. We have the Cadillac of case management departments and models," Jones says. ■

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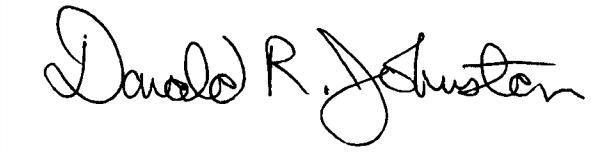

Donald R. Johnston
Senior Vice President/Group Publisher
AHC Media LLC

N #4005

3525 Piedmont Road NE
Building Six, Suite 400
Atlanta, Georgia 30305-1515
Tel (404) 262-7436
Fax (404) 262-7837
www.ahcmedia.com