HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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Hospital industry pushes back against the RACs

Scrutiny coming from all directions

After years of being frustrated by the Centers for Medicare & Medicaid Services Recovery Audit Contractor (RAC) program and other audit programs, the hospital industry is taking action. Here's the latest:

• The American Hospital Association (AHA) and four hospital systems have filed a lawsuit against the U.S. Department of Health and Human Services, asking the U.S. District Court for the District of Columbia to "set aside CMS's Payment Denial Policy on the grounds that it is contrary to federal law, arbirtrary and capricious, and invalid for failure to undergo notice and comment. Plaintiffs also seek an order that CMS must repay hospitals for the reasonable and medically necessary services they provide to patients," according to the complaint. *(To read the entire complaint, go to http://www.aha.org/content/12/121101-aha-hhs-medicare-com.pdf.)*

• The U.S. Department of Health and Human Services' Office of the Inspector General (OIG) has included a review of the vari-

Coping With CMS Auditors

The alphabet soup of auditors from the Centers for Medicare & Medicaid Services (CMS) has frustrated hospitals for years, but there may be some relief on the way. In the final months of 2012, CMS' audit programs have come under fire from several fronts. In the first of a two-part series, we'll tell you about how the American Hospital Association, the Office of the Inspector General, and a Congressional resolution are tackling the issue. We'll look at other CMS audit initiatives and how you can help your hospital be prepared when it's targeted. Next month, we'll tell you about the current focus of the RACs, what you can do to minimize the financial impact on your hospital, and why it's important to appeal your RAC denials.

ous Medicare contractors in its Work Plan for Fiscal Year 2013. The AHA wrote a letter to Inspector General Daniel R. Levinson supporting the review and asking the OIG to pay particular attention to "the extent to which RAC determinations result in inappropriate denials of payment for services that are medically necessary and reasonable for the care of patients." The AHA also recommended that the auditors be required to improve their accuracy or face financial penalties.

• In October, Rep. Sam Graves (R-MO) and Rep. Adam Schiff (D-CA) introduced the Medicare Audit Improvement Act of 2012 in the U.S. House of Representatives. The AHA supports the bill, which it says would limit the number of medical records the RACs can request, implement financial penalties, require medical necessity audits to focus on widespread payment errors, require physician review for Medicare denials and allow denied inpatient claims to be billed as outpatient claims when appropriate.

"The American Hospital Association is concerned that auditors are overly aggressive, are not following CMS rules in regard to the audits, and that the audit process is subject to persistent operational problems," says **Rochelle Archuleta**, senior associate director of policy for the AHA.

"We believe that there needs to be oversight of the RAC activities. Having checks and balances is very important. We want to see a fair and transparent audit process, and we don't think the agency is there," she says.

It's clear that the audit crisis faced by hospitals and other healthcare providers has caught the attention of the American Hospital Association, the Department of Health and Human Services, and the public in general, says **Deborah Hale**, CCS, CCDS, president and chief

EXECUTIVE SUMMARY

Groups ranging from the American Hospital Association to the U.S. Congress have taken up the issues posed by the Recovery Audit Contractors and other Medicare and Medicaid auditors.

- The high percentage of denials overturned upon appeal and large number of records requests are getting attention.
- Hospitals may get relief, but it's not likely to be immediate so they should continue preparing for the audits.
- Meanwhile, in addition to the Recovery Audit Contractors (RACs), hospitals are facing scrutiny from the Zoned Program Integrity Contractors (ZPICs), Medicare Prepayment Reviews, and Medicare Administrative Contractor (MAC) on-site audits.

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executive officer of Administrative Consultant Service, a healthcare consulting firm based in Shawnee, OK. "Hopefully, we will see some meaningful improvement in the level-of-care determination audit process, but it may be a while in coming. Hospitals that have carefully researched the regulations and have taken time to build a strong infrastructure to support accurate level-of-care determinations at the point of entry into the hospital should 'stay the course,'" she says.

Hospitals of all sizes are burdened by requests from RACs and other auditors, Archuleta says. However, smaller hospitals have greater difficulty because they don't have an in-house counsel or the personnel needed to pull the medical records and prepare for the audit.

For instance, according to the lawsuit filed by the American Hospital Association, Missouri Baptist Sullivan Hospital in Sullivan, a hospital with fewer than 26 beds, has received 418 requests for medical records since Jan. 30, 2010, and the hospital has had to repay Medicare $226,501.

Requests from the various Medicare contractors place real burdens on the healthcare industry, which already operates on narrow margins, adds **Brian Flood**, CHC, CIG, AHFI, CFS, an attorney specializing in healthcare issues and partner with Brown McCarroll, LLP, in Austin, TX. The increased burdens to prepare for and respond to the RACs and other auditors, lower reimbursement amounts, and inefficiencies caused by cumbersome healthcare regulations are a recipe for system failure, he says. *(For information on the Zone Program Integrity Contractor audits, see related article on page 4. For details on one hospital's experiences with the Medicare Administrative Contractor prepayment reviews, see page 5.)*

"There comes a point in every industry in history when they say 'enough' and take a stand for reasonable markets to operate in or they go out of business or abandon their mission to serve in the market. That moment has come for health care and every person who relies on it," Flood says.

The fact that 75% of cases that are appealed are overturned in favor of the hospital is an indication that the RACs are off the mark, Archuleta says. RACs receive as much as 12.5% of the denied claims, which they have to return after a successful appeal, but they get to keep the money in the meantime.

Appeals are costly and time-consuming and take resources away from providing care for patients, she says. Not all hospitals have the wherewithal to develop an efficient process for appealing and don't have the extra resources to fund the appeal, she says. If the appeal goes in the hospital's favor, it will be 18 months or longer before the money taken away by the RACs is refunded, Archuleta adds.

Hospitals have the expense of answering RAC requests, providing documents, then hiring experts to help them argue through three levels of appeals. They pay the costs of going to court, and 75% of the time they win back what they have argued from the beginning was a valid claim, Flood says.

"So far, the RACs are wrong 75% of the time. In what industry would we ever say that it was a success to accomplish your mission one out of four times?" Flood says.

According to data collected by the AHA, in the second quarter of 2012, 55% of the hospitals that participated in the organization's RACTrac Web-based survey "reported spending more than $10,000 managing the RAC process." It adds, "33% spent more than $25,000 and 9% spent over $100,000."

"The hospitals and providers have to create real systems, with real costs, and pull in other resources that could be used elsewhere to respond to RAC requests, litigation, and recovery of funds. It would be interesting if those real costs were allowed to be passed onto the Medicare program and what Congress and the General Accounting Office would think if they had to pay the full bill," Flood says.

The RACs are clearly violating Medicare rules when they use nurses to audit claims retrospectively to determine if they meet medical necessity criteria, Hale says. CMS has emphasized time and again that nurses are not allowed to make the final decision of medical necessity and patient status, she adds.

"This is a fundamental unbalance in the audit process. We recommend that whenever an auditor determines a potential denial that the denial should be determined by physician review. Decisions are being made by second-guessing the physician. CMS should make sure a qualified person conducts the review," Archuleta says.

In theory a claim should not be audited twice, but in some cases, the same claim is

being audited twice for very similar purposes, Archuleta says. There are three types of complex audits: DRG validation, coding validation, and medical necessity. Medical necessity audits make up 80% to 90% of all complex audits.

For instance, a RAC could request records for a claim and review it to make sure the hospital assigned the right DRG. If the RAC denies the claim and the hospital appeals and has the denial overturned, then the RAC may pull the claim again and review it for medical necessity.

This means that two years or more after the hospital supplied medical records for the first audit, it receives a second denial on the same claim, she says.

America's hospitals have a long-standing commitment to establishing programs and committing resources to ensure that they receive only the payment to which they are entitled, AHA executive vice president Richard J. Pollack wrote in letters to Rep. Sam Graves and Rep. Adam Schiff supporting congressional action to rein in the RACs.

The letters state that "[n]o one questions the need for auditors to identify billing errors" but later adds that "[r]edundant government auditors are wasting hospital resources and contributing to growing healthcare costs.

"While the AHA has zero tolerance for real fraud and abuse, these recovery auditors are paid contingency fee payments, a potential conflict of interest, leading to concerns that they focus on claims and services that have the highest likelihood of error, in order to increase their fees. Hospitals are experiencing a significant number of inappropriate denials amounting to hundreds of thousands of dollars in unjust recoupment payments for medically necessary care," the letters state.

The AHA believes that CMS should do a better job of overseeing contracts, addressing operational problems with audits, keeping the level of records requests reasonable, and mitigating confusion caused by multiple auditors, Archuleta says.

"If the RACs continue to cast their nets too widely, they will dilute the effort to ensure accurate payments. The hospital ends up with a tremendous burden, but the end result is the effectiveness of the audits is diluted. If CMS really wants to improve Medicare accuracy, the agency should make sure the RACs are more targeted," she says. ■

ZPICs focus on hospital staff credentials

Keep your licenses up to date

In addition to losing reimbursement when cases don't meet medical necessity, hospitals face additional lost revenue if the credentials of all personnel who provide care for patients are not up to date and the staff are performing interventions for which they are not licensed.

The latest focus of Medicare's Zone Program Integrity Contractors (ZPICs) is credentialing for hospital staff and physicians, says **Brian Flood**, CHC, CIG, AHFI, CFS, an attorney specializing in healthcare issues and partner with Brown McCarroll, LLP, in Austin, TX.

"The ZPICs are sending out letters requesting medical records as usual. Then they are showing up at the hospital and demanding to see the credentials of everyone who provided care for patients in those records. They are essentially cutting off the root of the tree," he says. "If someone who provided care for a patient doesn't have the proper license and credentials, then any service provided by that person can be disallowed. This can affect a vast amount of charges in a big hurry." For instance, if a technician doesn't have the proper credentials and license, the ZPIC could deny care for every patient he or she worked with for an entire year as a condition-of-payment violation or each isolated charge if it is a condition-of-participation violation. "Either way, it can be very expensive to respond to," he says.

Focus on credentialing

The ZPICs' focus on credentialing has caught hospitals by surprise, Flood says. "Hospitals are accustomed to having auditors review documentation and medical necessity. Now the ZPICs are going behind that and reviewing the people who are performing the services," Flood says. The ZPICs are asking for far more than the credentials of the physicians. They also want credentials from the nursing staff and the technical staff such as the radiology technologists and phlebotomists, Flood adds.

"The biggest challenge institutions are facing

is being prepared when the ZPICs ask for the credentials. In the hospitals I've worked with, it's been a challenge to get everything together in the time the ZPIC auditors allow," he says. ZPICs are requesting that all the records be provided to them in a single week, he adds. In many hospitals, records of staff licensure and credentials are not consolidated, Flood points out. In some hospitals, it's not clear whether the hospital, the outpatient facility, or the provider groups are responsible for credentialing, he adds.

Zone Program Integrity Contractors are independent auditors hired by CMS to look for patterns of waste, fraud and abuse. The ZPICs are based on the Medicare Administrative Contractor (MAC) jurisdictions and started by auditing hospitals but eventually will audit all providers of services to Medicare. CMS pays ZPICs a contracted rate plus a contract award at the end of the year that is undefined in the guidelines, Flood says.

Unlike the MACs and RACs, which concentrate on fee-for-service Medicare claims, the Zone Program Integrity Contractors (ZPICs) will review all providers of Medicare and Medicaid services, including managed Medicare and Medicaid, Flood says.

The ZPIC initiative got off to a slower start than the Recovery Audit Contractors (RACs). Now all of the contractors are on board and are fully staffed, and hospitals are going to see much more of the ZPICs in 2013, Flood says.

"The ZPICs have the most authority out of all contractors in the alphabet soup of auditors. They have a mandate to review claims for Medicare fee-for-service, Medicare managed care, and Medicaid and report any patterns of fraud or abuse to the Office of the Inspector General. They are the auditors that hospitals need to pay a lot of attention to if they come knocking on the door and asking questions," he says.

Hospitals should determine where all of the records of staff credentials and licensure are located, that they are current and that the full records are available.

He recommends that case management directors sit down with their staff and make sure everyone has the proper credentials and that every license is up to date, going back three years. Make sure that anyone who works with patients has the right licensure to perform the tasks he or she is assigned, he adds. ■

Nurses scrutinize records before bill drops

Hospital prepares for prepayment reviews

Medical City Dallas Hospital is taking a proactive approach to Medicare's prepayment review process.

When a claim that falls into a category targeted for potential prepayment review has been coded but before the bill has dropped, nurses in the hospital's Medicare Service Center department perform the final review of the medical record to make sure that everything is in order.

"We're trying to get ahead of the process by understanding what they're looking at and making sure the documentation is there before the bill drops. By reviewing the cases proactively, if we have a prepayment review, the documentation is already in place," says **Pat Wilson**, RN, BSN, MBA, case management director at Medical City Dallas.

As part of its efforts to cut improper payments, the Centers for Medicare & Medicaid Services (CMS) launched a three-year recovery audit program prepayment review demonstration project in 11 states beginning in August 2012. Under the program, the Medicare Administrative Contractors (MACs) review and affirm or deny claims before they are paid. Hospitals may appeal the prepayment denials through the normal appeals process.

The pilot project is being conducted in seven states with a high level of fraudulent claims and four states with a high volume of short inpatient stays. States included because of a preponderance of fraudulent claims are Florida, California, Michigan, Texas, New York, Louisiana, and Illinois. Pennsylvania, Ohio, North Carolina, and Missouri are included because of short stays. In announcing the project, CMS said it will initially focus on inpatient claims, particularly for short stays, as they have high improper payment rates.

At Medical City Dallas Hospital, pre-billing reviews by the nurses in the hospital's Medicare Service Center focus on medical necessity criteria for targeted DRGs and procedures that fall under the National Coverage Determination and the Local Coverage Determination.

The hospitals' orthopedic coordinator, bariatric coordinator, and cardiac coordinator, all

of whom are nurses, review scheduled surgical procedures to make sure the documentation is in place before the procedure is performed.

"We know that some procedures will fall under the Medicare Inpatient Only list and will also need to meet the medical necessity guidelines for Medicare," she says.

When targeted procedures are scheduled, a nurse coordinator uses a tool kit with a check-off list to make sure the documentation supports medical necessity. For instance, with total joint replacement surgeries, the documentation in the record should include level of pain, conservative treatment that has been tried, patient mobility, and other indications that the surgery is necessary.

"The hospital partners with physicians to ensure that medical necessity is in place prior to the procedure. Once the procedure is completed, the unit case manager reviews it again for criteria. The Medicare Service Center becomes the final safety net prior to billing," she says.

Orthopedic procedures are the biggest focus of the prepayment reviews, she says.

In those cases, the orthopedic coordinator reviews the supporting documentation that is included with the request for scheduling the procedure. If the documentation is complete, the procedure is scheduled. If the coordinator thinks additional documentation is needed, the physician's office is asked to fax over the information, which becomes part of the medical record.

There was a learning curve when the hospital started the procedures, but the physicians have been very supportive in working with the hospital to ensure all the elements that demonstrate medical necessity are in the record, Wilson says.

"We work closely with the physicians so they understand the requirements. Most surgeons are well-versed in Medicare requirements, and they have provided information to insurance companies for preauthorization for many years. Medicare's move into prepayment review is in many ways similar to the preauthorization required by insurance companies," Wilson points out.

SOURCES

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CMs work overtime in Sandy's wake

Hospital inundated with evacuated patients

Days before Hurricane Sandy roared through the East Coast, the case management staff at Lutheran Medical Center in Brooklyn was working overtime to discharge patients and free up beds for patients injured in the storm or being evacuated from other hospitals and skilled nursing facilities. The hospital also needed beds for staff who were staying over during the storm and its aftermath.

Case management staff worked overtime on Saturday and Sunday — October 27 and 28 — in anticipation of the storm, which hit the area on Monday night, says **Vivian Campagna**, MSN, RN-BC, CCM, vice president, case management for the 462-bed academic teaching hospital. "We discharged a significantly larger number of patients to home or to skilled nursing facilities than we do on a typical weekend. On Monday, we focused on patients who could be moved to skilled nursing facilities that were not likely to be flooded so we would have as

EXECUTIVE SUMMARY

When Hurricane Sandy devastated parts of Manhattan, Lutheran Medical Center in Brooklyn prepared in advance to handle an influx of patients evacuated from nursing homes and hospitals.

• Case management staff worked overtime in advance to discharge appropriate patients and free up beds.

• When evacuated patients came into the emergency department, the staff transferred stable patients to the hospital's own nursing homes and others with available beds, and admitted patients who met inpatient criteria.

• After the storm passed, case managers worked to discharge more patients to free up beds for injured patients and find placement for patients who presented to the emergency department but didn't meet admission criteria.

many beds as possible," she says.

When the New York area experienced Hurricane Irene in August 2011, Lutheran Medical Center accepted patients evacuated from facilities in low-lying areas before the storm hit. "This time those same places had emergency plans in place and generators and did not feel like they needed to transfer patients and disrupt the flow," she says. But Sandy hit with an unexpectedly strong intensity and many facilities were flooded and without power and telephone service.

"With a hurricane on the way and a low pressure area making it a perfect storm, we knew it was going to be pretty severe, but I don't think anybody expected the New York area to take the full brunt of the storm," Campagna says.

Campagna came to work Monday morning with three days worth of clothing and a blow-up bed. "I knew I could get home, but there was a likelihood that I couldn't get back on Tuesday. I knew we needed to have leadership at the hospital so we could keep things going," she says.

Some of the case management staff lived nearby and were able to get back to the hospital. One group got together and hired a car service to bring them in. One social worker spent the night after her shift. "Some people couldn't get back to the hospital. We had a skeleton staff, and everyone worked extremely hard to take care of the patients," she says.

The facility received patients evacuated from a number of skilled nursing facilities and one hospital. The skilled nursing facilities transferred appropriate patients to evacuation shelters but evacuated those with medical issues that might need to be addressed to the hospital, where the emergency department staff assessed them to see if they needed an inpatient stay.

"During Irene, we had good communication between facilities and good patient summaries and documentation. With Sandy, the skilled nursing facilities did not plan on evacuating patients, and often they just send the patients in an ambulance to the emergency department without notifying us," Campagna says.

The hospital received minimal information from the skilled nursing facilities and, in most cases, couldn't contact the facilities because they were without power and phone service and the buildings were empty.

Some of the patients met inpatient criteria. The hospital admitted them and kept them until they were ready for discharge. Case management scrambled to find placements for patients who did not qualify for an inpatient stay.

"We tried thinking out of the box and finding places for these patients. The skilled nursing facility in our system had some vacancies and also created additional space by putting beds in some recreation rooms. We tried to get some of the patients in other skilled nursing facilities that had not been evacuated," she says.

When the storm had passed on Tuesday, the case management staff worked to identify as many discharges as possible and free up more beds. The hospital provided transportation if the patients couldn't get home any other way. If patients couldn't go home because they had no power or no one to take care of them, the hospital transferred them to skilled nursing facilities that had free beds or evacuation shelters.

A variety of patients came to the emergency department after the storm passed. They included patients injured by the storm, older patients who fell because they had no electricity in the home, and patients on supplemental oxygen who had no electricity.

Patients who didn't meet medical necessity criteria were evaluated, treated if necessary, and moved to evacuation shelters or skilled nursing facilities. "Case managers and social workers worked really hard to identify whatever alternatives and options there were. We couldn't relax the criteria for an acute care admission because we needed to keep beds available for patients who needed them. It would have been difficult to say we'd take a patient unless someone sicker came along," she says.

Two weeks after the storm, a handful of patients evacuated from the skilled nursing facilities were still at the hospital because the skilled nursing facility they came from had not reopened and an alternative place was not available.

"The storm created a chaotic situation, but our staff did a yeoman's job. Our response to the storm was a well-choreographed dance," Campagna says.

SOURCE

• **Vivian Campagna**, MSN, RN-BC, CCM, vice president, case management, Lutheran Medical Center, Brooklyn, NY. email: vcampagna@lmcmc.com. ■

Transitions are key in cutting readmissions

Nurses make calls after discharge

A key to the success of Monmouth Medical Center's readmission program is ensuring that patients get the care they need after discharge and understand their treatment plan and medication regimen.

"We moved to a true transitional model of care and work at all levels of care to ensure that patients avoid an emergency department visit or a hospital admission," says **Eleanor Rapolla**, BSN, CCM, director of case management for the Long Branch, NJ, medical center.

The hospital's cardiac RNs, all nurses with a critical care background, call all patients discharged with a primary diagnosis of heart failure on Day 3 and Day 14 after discharge, no matter where the patients are. They ask a series of questions about the patients' understanding of their treatment plan and medication regimen, whether they have gotten their prescriptions filled, and if they have a follow-up appointment.

"The call on Day 14 is important because it a very vulnerable period. Patients may be behind in following their treatment plan or medication regimen. If they are experiencing shortness of breath, the nurse can decide on what action to take," Rapolla says.

The cardiac nurse practitioner evaluates patients on Day 1 of admission and begins educating the patients, answers questions, and makes a follow-up appointment with the outpatient heart failure management program after discharge whenever possible. "We try to book a follow-up appointment within seven days of discharge to home whenever possible," Rapolla says.

The unit-based case managers and heart failure nurse practitioner work together on a discharge plan and engage patients in the outpatient heart failure management program.

When patients come into the program the first time, they spend an hour and a half with the nurse practitioner, who conducts a full assessment and goes over the treatment plan. Then the dietician meets with them for a half hour to go over their dietary plan. "We have found that people often are overwhelmed when they are in the hospital and don't remember what they're supposed to do at home and need a lot of reinforcement in the beginning," Rapolla says.

The nurse practitioner typically sees the patients twice a week after the initial visit, tapering off to weekly and monthly visits as needed.

The nurses from the Visiting Nurse Association who are seeing the patients in their home partner with the nurse practitioner to make sure the patient understands and is following his or her treatment plan.

"When all providers at all levels of care work together, it results in better outcomes for the patients," Rapolla says.

SOURCE

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Culture change improves ED throughput

CMs work 24-7, space redesigned

When Bronson Methodist Hospital in Kalamazoo, MI, examined throughput in the emergency department, it determined that a culture change was needed to shorten wait time and make sure patients meet inpatient criteria and are admitted in the right status.

Among the changes implemented were redesigning the emergency department, developing teams of providers responsible for a particular

EXECUTIVE SUMMARY

Following a revamp of emergency department procedures, wait time for patients to see a provider dropped to 20 minutes and patients are typically triaged into a bed in three to four minutes at Bronson Methodist Hospital in Kalamazoo, MI.

- A dedicated team of providers is responsible for a particular set of beds and specific kinds of patients.
- A triage nurse evaluates patients and assigns them to a team.
- Case managers work with physicians on medical necessity 24-7.

set of beds and specific kinds of patients, and adding case managers who cover the emergency department 24-7 and are dedicated to working with physicians on patient status.

Today, the typical time for patients to be triaged into a bed is three to four minutes, and most patients see a provider within 20 minutes. Only 0.7% of patients leave without being seen.

"When we started this project, our first priority was moving patients through the system in a timely, efficient, and safe manner. This involves far more than just the emergency department staff because multiple areas affect patient throughput. We needed help from everyone in the hospital to achieve our goals," says **Patti Burchett**, CHAM, director of patient access for the 405-bed not-for-profit hospital.

The hospital used the Lean concept to develop 10 to 15 projects to improve patient throughput based on input from the front-line staff in the emergency department.

"Making change is not about doing one big project and getting huge benefits. It's all about developing a series of small projects and having everyone in the hospital look at opportunities to make things work better," Burchett says.

The emergency department has 52 beds and experiences about 96,000 emergency department visits a year in an emergency department designed for 65,000 visits.

"The goal was to improve patient throughput in the emergency department and to improve patient safety. If you do the right thing for the patient first, everything else will follow," says **Carrie Kotecki**, BSN, RN, director of nursing and emergency services.

When the hospital opened a new emergency department, the original plan was for all work to flow out of one central station. "The department was huge and this was inefficient and confusing. Our team looked at using the space in a way that we could more efficiently treat the patients," she says.

The result was to develop four teams, each with a physician, a unit clerk, and a nursing component. The teams include a critical care team, a chest pain team, a fast-track area team, and a medical-surgical team. Each team is responsible for 10-15 beds that are in a specific geographic location. The hospital's fast-track area helps take care of patients with non-emergent needs, leaving the rest of the staff to take care of patients with true emergencies.

"This has improved the turn-around time and increased efficiency because everyone is working in a smaller module," Burchett says.

All patients who come into the emergency department are met by a greeter, a triage nurse, and a member of the registration staff. The nurse determines the patients' chief complaints and triages them into one of four different triage bays. In the individual triage bays, another triage nurse gets more information and puts patients directly into beds in the emergency department as long as beds are available.

To help make sure patients are assigned to the right level of care, the hospital created a case management position dedicated to working with physicians on medical necessity and level of care. The position is staffed 24 hours a day, seven days a week. "These case managers interact with the physicians and facilitate the admissions process. We also have a social worker and another case manager in the emergency department who facilitate discharge plans for patients who are going home and handle transfers to another level of care for appropriate patients," Kotecki says.

It took a while for the case managers to develop a good relationship with the emergency department physicians, Kotecki says, but now the physicians recognize that the case managers are there to make their life a lot easier, she adds. The emergency department case managers review about 60% of admissions.

"The hospital was losing money because patients were being admitted who didn't meet inpatient criteria or who were in observation when they should have been admitted. We know that physicians want to take care of patients, not worry about regulatory requirements. The case managers understand InterQual criteria and can assist the physicians in making decisions," Kotecki adds.

Like many hospitals, Bronson is inundated with uninsured and under-insured patients who use the emergency department for primary care. "Our primary care physician offices are very full. We have a large federally qualified health center that cares for many uninsured patients, but they can't keep up with all the patients who need their services," Burchett says.

The hospital has a close relationship with the community health center and is working with the staff to train them on how to use the LEAN techniques to implement process improvement initiatives. "We are giving them the tools they need so they can become more efficient

and effective in achieving their goal of being a patient-centered medical home for large number of patients. Together, we hope to serve our patients in the most convenient and the least intensive environment for care," she says.

At Bronson Methodist Hospital, the team tested the new processes for three months before asking the administration for additional staff. To justify the new case management positions, they tracked the denials of care for patients coming through the emergency department to show how much money was lost because patients were admitted in an incorrect status and compared that to the cost of the additional case managers.

It's not enough just to analyze a situation and determine what to do to improve it, Burchett points out. "Equally important is changing the culture to make it happen. When improvements are determined by a team, that team should be allowed to implement their recommendations. Otherwise, you'll lose all credibility and the ability to move forward," she says.

SOURCE

• **Patti Burchett**, CHAM, director of patient access, Bronson Methodist Hospital, Kalamazoo, MI. email: burchetp@bronsonhg.org. ■

Hospital flu shot rates entering the public realm

CMS reporting in 2013, public access in 2014

Your influenza vaccination campaign is coming into the public spotlight, and that means more pressure than ever on the logistics of administering and tracking those vaccinations.

Think of this first season of reporting as a test. The Centers for Medicare & Medicaid Services (CMS) will not publicly report the health care worker flu vaccination rates until 2014.

But as of January 1, CMS is requiring hospitals to report the vaccination rates of employees, licensed independent practitioners (non-employee physicians, advance practice nurses and physician assistants) and adult students, trainees and volunteers who are at least 18 years old. (The Joint Commission recommends tracking vaccinations among all contracted workers, but that is not being reported by CMS.)

For many hospitals, calculating the numerator is the easy part. You must count and report the number of individuals who received the vaccine, said they received it elsewhere, declined the vaccine, or who have a medical contraindication of either a severe egg allergy or a history of Guillain-Barre Syndrome within six weeks of a previous influenza vaccination. There is also a category for "unknown."

However, the denominator is causing some headaches. CMS asks you to include all individuals (employees, licensed independent practitioners, etc.) who were in your hospital for at least 30 days between October 1 and March 31. The measure counts a "day" as any part of a day in your facility. (You cannot use data on fulltime equivalent employees.)

Some hospitals plan to count their non-employees in the most liberal way.

"Most places cannot determine how many days their non-employed physicians and other licensed independent providers actually spend in the facility," says **Melanie Swift**, MD, FACOEM, director of the Vanderbilt Occupational Health Clinic in Nashville. "The safest course of action is probably to assume everyone with access and credentials to be in the facility are spending 30 or more days there."

How to count on NHSN

Although for this first year the reporting begins on January 1, you can begin counting from October. The reporting occurs through the National Healthcare Safety Network (NHSN), a surveillance system maintained by the Centers for Disease Control and Prevention.

You can report monthly cumulative totals through NHSN, but CMS will receive the data only once — on May 13, 2013.

Some hospitals are struggling with the logistics of tracking non-employees. Harbor-UCLA Medical Center in Los Angeles can expect to report a high vaccination rate, no matter how it is counted. With a policy that requires those not receiving the flu vaccine to wear a mask during the flu season, Harbor-UCLA vaccinated 89% of employees last year and expects to reach 90% or above this year.

But gathering the data for the denominator will be a challenge, says **Erika Sweet**, RN, MSN, NP, with Harbor-UCLA Employee Health Services.

"Medical students may come in for two weeks rotation, they're off for two weeks, then they come back for another two weeks. We have resi-

dents that do the same," she says. They also have students cycling into the hospital from nursing schools and other programs. "The non-employee category is very difficult because nobody except their instructor knows exactly what time period they're going to be here during any specific rotation."

Some employee health professionals plan to count employees and non-employees who have spent even a day in the hospital, despite the 30-day instruction. **Bruce Cunha**, RN, MS, COHN-S, manager of employee health and safety at the Marshfield (WI) Clinic, notes that hospitals have various types of providers who rotate through or who work in temporary positions. "The best they're going to get out of this is some kind of general ballpark figure," he says.

And some employee health professionals wonder why they shouldn't count people who worked fewer than 30 days during the flu season. "Should it matter how many days they're in your hospital if they're not vaccinated? Aren't they just as much of a risk on any one day they're there?" says Cunha.

Measure may be tweaked

Comments from employee health professionals actually might prompt some minor changes in the measure for future reporting.

"We realize that facilities may have feedback on some issues and difficulties they encounter in meeting the reporting guidelines during this first year of reporting," says **Megan Lindley**, MPH, epidemiologist with the CDC's National Center for Immunization & Respiratory Diseases in an email to HEH. "We will take all of the input that is offered and will reevaluate the specifics of the protocol and measure after this first reporting period to see if there are changes we can make in order to improve the reporting experience for users and the accuracy and reliability of the data."

Some concessions have already been made to make it easier for facilities to comply. For example, employees and non-employees can report in writing (online or on paper) that they have received the flu vaccine outside the facility. They are not required to produce documentation.

Swift called that "the saving grace of the CMS measure … so an electronic survey sent to all licensed independent practitioners is a viable way to ascertain their vaccination status."

[*Editor's note: More information about the influenza immunization reporting criteria is available at* http://ow.ly/felo9 ■

Hospital Report blog

For further analysis and discussion of topics important to hospital professionals, check out **Hospital Report**, AHC Media's new free blog at http://hospitalreport.blogs.ahcmedia.com/. ■

CNE INSTRUCTIONS

Nurses participate in this continuing education program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

CNE OBJECTIVES

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

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

COMING IN FUTURE MONTHS

■ How your peers are preventing readmissions.

■ Case management extends across the continuum.

■ Creating EDs geared to the special needs of seniors.

■ How to cut down on ED boarding.

CNE QUESTIONS

1. According to the American Hospital Association, 75% of denials by the Recovery Audit Contractors are overturned upon appeal.
   A. True
   B. False

2. According to healthcare attorney Brian Flood, CHC, CIG, AHFI, CFS, Zoned Program Integrity Contractors (ZPICs) send out requests for records, then show up at hospitals and demand to see the credentials of everyone who provide care for the patients in the records. How long do the ZPICs typically give hospitals to provide the credentialing information?
   A. One week.
   B. 30 days.
   C. 45 days.
   D. 60 days.

3. According to Pat Wilson, RN, BSN, MBA, case management director at Medical City Dallas Hospital, what has been the biggest area of focus of the Medicare Administrative Contractors' prepayment review initiative?
   A. One-day stays for coronary procedures.
   B. Orthopedic procedures.
   C. Syncope
   D. All of the above.

4. At Monmouth Medical Center, nurses call heart failure patients at what intervals after discharge?
   A. Day 3 and Day 14.
   B. One week and two weeks.
   C. Within five days.
   D. Day 2 and Day 7.

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HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

CMs more appreciated but budgets are tight

Salaries are up, But so are the hours

Healthcare reform initiatives such as value-based purchasing and readmission reduction, and a growing emphasis on quality have heightened awareness of case management, says **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY, and partner and consultant in Dallas-based Case Management Concepts.

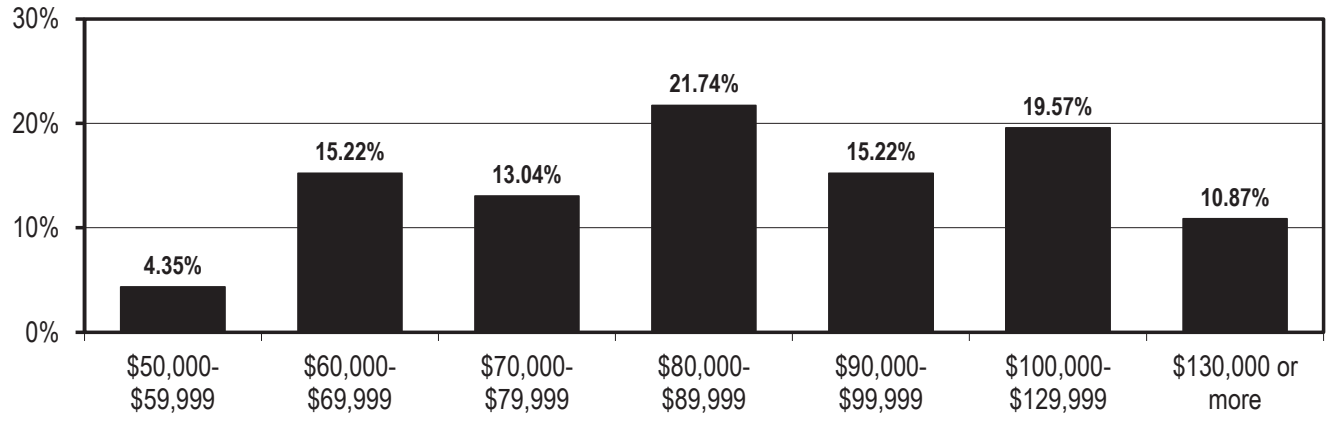
Those factors have also increased appreciation for the role of case managers who, as part of an interdisciplinary team, can help meet the challenges facing hospitals today.

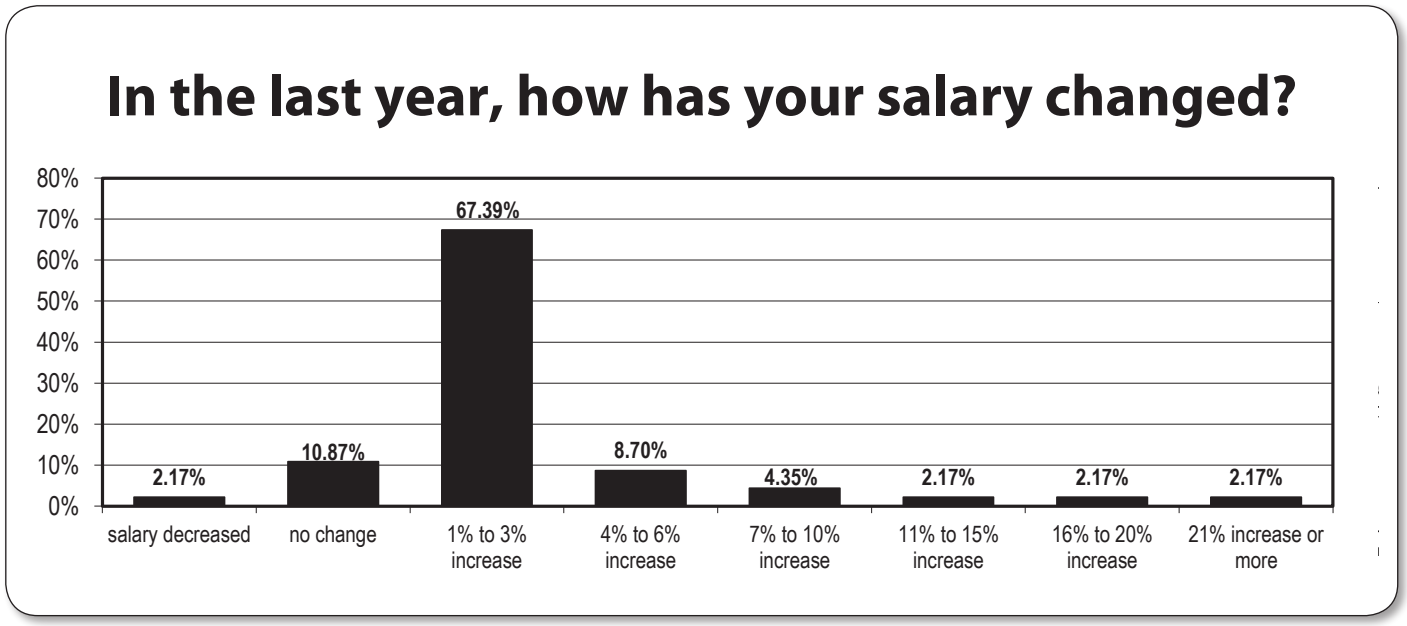
"We have seen many hospitals revisiting their case management infrastructures in an effort to ensure that they are strategically responding to all the challenges that health care reform has placed before them," Cesta says.

As the need grows for case managers across the continuum of care, and as staffing ratios improve, there will be more demand for qualified case managers in both the inpatient and outpatient setting, Cesta says.

B.K. Kizziar, RNC, CCM, CLCP, a case manage-

What is your annual income from your primary healthcare position?





ment consultant based in Southlake, TX, reports that many hospital administrators are just beginning to understand the impact case management can make on the bottom line. "As awareness grows of the value of case management, salaries will also increase," she predicts.

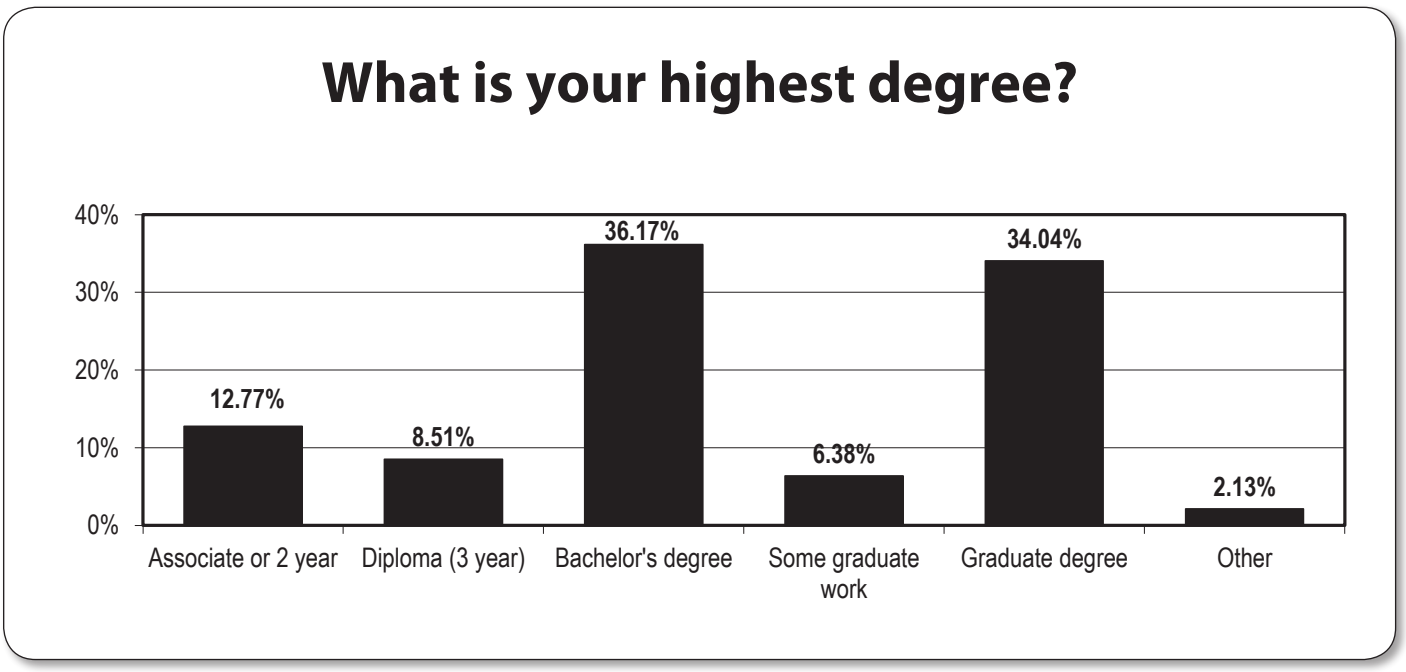
But it hasn't happened yet, she adds. As she works with hospitals around the country, Kizziar hasn't seen much change in salaries in the past several years and doesn't expect to see increases until the economy improves. "Hospitals can't afford to give big raises to case managers in this economy," she says.

Beverly Cunningham, MS, RN, vice president of clinical performance improvement at Medical City Dallas Hospital and a partner and consultant with Dallas-based Case Management Concepts, adds that pay raises and benefits have stayed about the same in her area over the past few years.

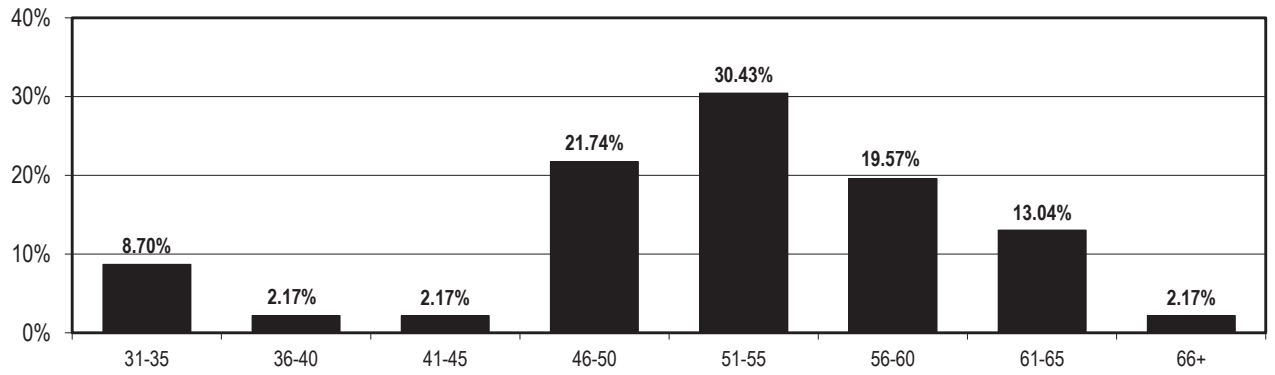
"There doesn't seem to be a lot of turnover. I don't see hospitals hiring a lot of additional case managers, but case managers aren't being laid off either," Kizziar adds.

The majority of case managers responding to the Hospital Case Management 2012 salary survey report making more money last year, but they also say they are putting in long hours.

Most of the respondents (88%) to the 2012 salary survey report that they got a raise last year. Just



What is your age?



12% reported no raise and only one respondent got a pay cut. At the same time, more than 89% of respondents report working more than 40 hours a week, with 23% putting in more than 50 hours.

The majority of raises (67%) were in the 1% to 3% range, with 6% reporting raises of 11% or more. About 68% of respondents report receiving salaries of $80,000 a year or more, with the majority of respondents (25%) reporting an income in the $80,000 to $89,999 range and 31% reporting salaries of $100,000 or more.

Our readers are well-educated. Among respondents to the salary survey, 80% have a bachelor's degree or higher and 34% have completed a postgraduate degree.

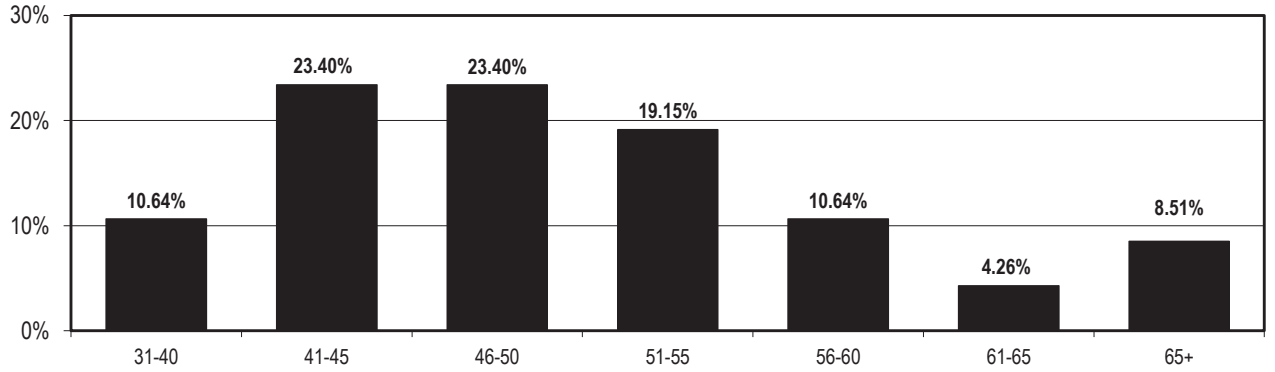
The majority of respondents to the salary survey are older and experienced case managers. More than 75% have worked in case management for 10 years or longer, and 15% have 25 or more years experience as a case manager. More than 70% of respondents have worked in the healthcare field for 25 years or longer.

More than 66% of respondents are over age 50, while 12% report being 61 years or older. Only 11% report being age 40 or younger.

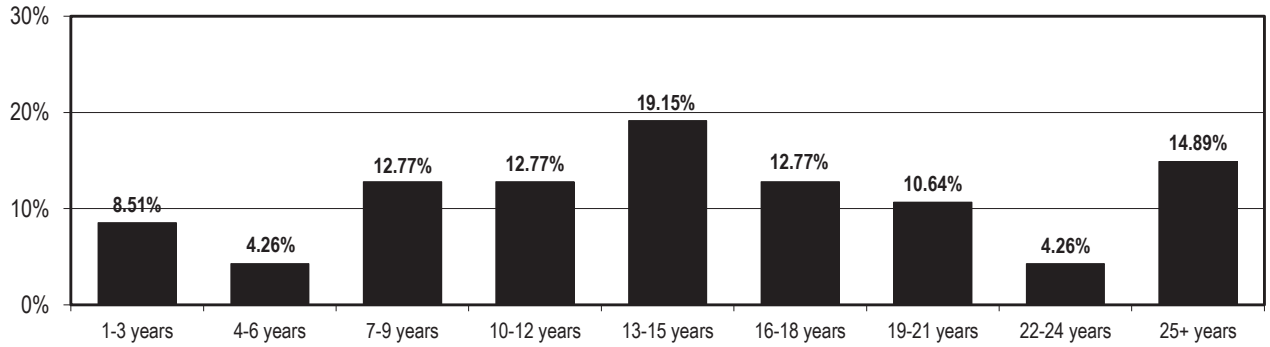
Case managers have to make the case for increasing staff, and that means coming up with ways to show how they can affect the hospital's bottom line, using hard data, not anecdotal information, Kizziar says.

"Case managers have historically been woefully shy about demonstrating their value using hard data,

How many hours a week do you work?



How long have you worked in case management?



and they have never been appreciated for what they do in the hospital setting. People in hospital management want to see data and statistics, not anecdotes, and in many situations, case managers haven't provided it," she says.

While the role of case management is becoming recognized by providers across the continuum, the demand for case managers may make it more difficult to attract qualified case managers to all venues of care in the future, Cunningham predicts.

If case management departments don't staff adequately with clear job descriptions, policies, and procedures, clerical support staff, and case management software, they are likely to lose staff to other organizations that do, Cesta adds.

Her advice to case management directors: "Be sure your staff have the tools they need to be successful." ■