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HOSPITAL CASE MANAGEMENT™

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

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IN THIS ISSUE

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Case management and compliance: What every CM needs to know

Failure to act could result in jail, civil penalties

As the federal government, private payers, and accrediting agencies crack down on overutilization, underutilization, fraud, and abuse, hospital case managers need to keep an even closer eye on what is going on in their hospitals, experts say.

Case managers have the same obligation that every employee in the health care industry has — to take appropriate steps when they see inappropriate care, underutilization, or overutilization, points out **Elizabeth Hogue**, a Burtonsville, MD, attorney in private practice specializing in health care.

If a case manager knows something is wrong and ignores it, he or she could end up facing serious consequences. Those could include losing your job, losing your license, going to jail, and paying huge civil monetary penalties, Hogue says.

"The stakes are very high," she adds.

Case managers can create liability for their hospitals if they don't do their job efficiently and point out problems with overutilization, fraud, and abuse, adds **Alice Gosfield**, JD, of Alice G. Gosfield and Associates, a Philadelphia law firm.

At the same time, they can help their hospitals avoid liability by going through the proper channels to report incidents that may be in violation, she adds.

"As fraud and abuse moves more and more into quality and medical necessity issues, the role of case managers is far more linked to what compliance is all about," Gosfield says.

Case managers' clinical expertise gives them the ability to look at situation and see compliance issues or unethical practice, assess them, and understand what steps need to be taken to correct them, adds **Mindy Owen**, RN, CRN, CCM, past chair of the ethics committee and a member of the executive board of the Commission for Case Management

Certification and principal of Phoenix Health Care Associations in Coral Springs, FL.

"Our clinical expertise, even prior to case management experience, builds us a foundation by which we can look at situations and issues and see this compliance issue or unethical practice and acknowledge the concerns we have about it," Owen says.

While compliance standards may vary among accrediting bodies and government agencies, the overall perspective is that if case managers and case management organizations come across potential fraud and abuse cases, they are obligated to address them.

"This goes right along the lines of the code of ethics for CCM [the certified case manager credential]. If a case manager observes a fraud or abuse situation, a medical error, or an incidence of underutilization, it is their duty and responsibility to report it and to ensure that the next steps are taken to correct the situation and make sure it doesn't happen again," Owen says.

Case managers need to be acutely aware of the clinical validity of what they are doing, Gosfield points out, adding that the best defense is to follow national practice guidelines.

"Case managers need to be looking at trends in diagnoses or procedures that don't meet the medical necessity criteria, and if they notice something that seems abnormal, they should report it," says **Beverly Cunningham**, RN, MS, director of case management at Medical City Dallas Hospital. Look for overutilization and underutilization of care, she adds.

"Case managers need to look at quality outcomes as well. As responsible case managers, we need to balance the clinical and quality scale," Cunningham says.

For instance, if a patient has a three-day length of stay with poor outcomes and another patient with a similar condition has a five-day length of stay with good outcomes, the first patient may not have gotten the care he or she needs.

Take into account the criteria for admissions and medical necessity based on the criteria of each payer, she adds.

In many states, Medicare criteria and Medicaid criteria are different. Each commercial payer may have its own criteria that must be taken into account for its particular patients. Private insurance companies also have active programs to take legal action on fraud cases, rather than just not paying the claim, Hogue adds.

"We are accustomed to thinking about fraud and abuse in Medicare, Medicaid, and other federal and state programs. Private insurance companies have begun to take action because they have been supported and encouraged because of actions taken in federal and state programs," she says.

Every state has a Quality Improvement Organization that is assigned to make sure health care providers do the right thing for Medicare patients, and they regularly scrutinize hospitals and other providers.

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Editorial Questions

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For instance, the Texas Medical Foundation is studying one-day stays, an area where there is some question about whether hospitals are putting patients in the right status, Cunningham says.

Admissions for one-day stays are getting increased scrutiny, she says. "With Medicare, hospitals are paid by the diagnosis-related group [DRG], and if it's just a one-night stay, Medicare is questioning whether the patient should have been on observation status."

The one-night stays are becoming more common as procedures make it possible for patients to have shorter lengths of stays, Cunningham points out. For instance, many patients who once had open-heart surgery now receive stents, a procedure that involves only an overnight stay.

Compliance issues sometimes pose a Catch-22 situation for case managers. Do you do what you know in your heart is right? Or do you do what you know is going to keep you employed?

"This is uncharted territory and will present some very gray areas for case managers to navigate," Owen says.

For instance, one potential problem for case managers is admission vs. observation status.

Case managers have the hospital — their employer — telling them they need to get the patient admitted because it's a better status for the hospital and they will be reimbursed more than for an observation stay. On the other hand, the family or patient may be refusing admission and want the patient discharged.

Additionally, Medicare is cracking down on the number of patients who are admitted instead of being kept on observation status.

"The issue comes down to what, in the case manager's expert opinion, they feel is best for the patient. As a case manager, their role is to be the advocate for the patient," Owen says.

On the other hand, admitting the patient may be in the best interest of the hospital, which pays the case manager.

There may be conflicts of interests for case managers: For example, the employer wants a patient admitted, but the patient doesn't want to be. The case manager needs to balance which public he or she is serving, Owen says.

"I'm not saying that a case manager will be doing anything wrong if he or she goes one way or another. It's an issue that case managers may have to grapple with in their own practice," she adds. ■

Act cautiously if you see a compliance problem

Take your information through proper channels

If case managers see a problem in their hospital, they have a responsibility to report it, asserts **Alice Gosfield**, JD, of Alice G. Gosfield and Associates, a Philadelphia law firm.

"Most institutions should have a compliance program. In addition, virtually every hospital has a quality improvement process. Case managers can report through that process," Gosfield says.

Case managers should be familiar with what constitutes a compliance problem and the steps they need to take to report an incident of noncompliance, overutilization, or underutilization.

The steps you should take will vary from facility to facility, but it is advisable for all hospitals to have a compliance program and a chain of command. Some areas where problems might occur are inappropriate care, under- and overutilization, kickbacks and rebates, and honoring patient choice of providers.

Look for patterns

Look for a pattern of conduct, not just isolated incidents, suggests **Elizabeth Hogue**, a Burtonsville, MD, attorney in private practice specializing in health care.

Don't be tempted to investigate by yourself. Instead, take your information up the line to the appropriate people in the hospital. "If a case manager thinks he or she sees a pattern of inappropriate care or underutilization, he or she should go ahead and make the report to his or her supervisor and let someone else investigate. That's what the compliance officer is required to do," she says.

Start by reporting your suspicions to the case management director, says **Beverly Cunningham**, RN, MS, director of case management at Medical City Dallas Hospital.

"If staff case managers see things that are going on they think may not be right, it is their responsibility to report it to me, and my responsibility as director is to study and see if it is happening or is an anecdotal incident, then to report it through the chain of command in the hospital," Cunningham says.

The organization is more likely to pay attention to problems if they are pointed out by the

case management department as a whole, rather than by just one person, she adds.

When you do report a problem, make sure you approach the issue in a professional way and in a spirit of cooperation. Don't sound like you have an ax to grind with whomever you are reporting, Hogue says. Emphasize that you know you have an obligation to point out the problem.

Most compliance plans promise anonymity when someone makes a complaint, but it's not always possible to maintain confidentiality while you are investigating and taking action, Hogue adds.

"Part of any good compliance plan is protection of confidentiality. A good compliance plan should indicate that retaliation is not allowed," she explains.

If you report fraud and abuse and nothing happens, you have an obligation to go outside of the facility, Hogue says.

She suggests calling the federal Office of the Inspector General. "There again, there should be no ax to grind. Case managers should report what they see and say that they are satisfying their obligations to bring it to the attention of the authorities," she adds. ■

Educate yourself on compliance requirements

Know the steps to follow to report problems

As **Mindy Owen**, RN, CRN, CCM, travels around the country for the Commission for Case Manager Certification (CCMC), she's always surprised to find how few case managers are familiar with the standards of practice under which they operate.

"Case managers should become very familiar with and follow the standards of practice for their profession. They are the foundation for the practice of case management," says Owen, past chair of the ethics committee and a member of the executive board of the CCMC and principal of Phoenix Health Care Associations in Coral Springs, FL.

Case managers who work for an organization that has been accredited by an accrediting body or that is looking at accreditation should be familiar with the standards from that accrediting body as well, she explains.

For example, the Joint Commission on Accreditation of Health Care Organizations, the National Committee on Quality Assurance, and the URAC all have compliance standards that health care providers must meet for certification.

All case managers, whether they have been certified by the CCMC, are held to the code of conduct that has been established by that organization, Owen points out. "In a court case, if an attorney asks case managers about the code of conduct, the fact that they have not been certified does not exempt them from culpability."

Case managers also should be familiar with compliance guidelines for Medicare, Medicaid, and other federal and state programs as well as those from commercial health insurance companies, says **Elizabeth Hogue**, a Burtonsville, MD, attorney in private practice specializing in health care. Some sources for education include professional organizations, professional journals, and publications, she adds.

Be very clear about and able to articulate the philosophy and mission of the organization with which you are employed, and make sure your case management efforts are aligned with the mission of your organization, Own suggests.

"Ethical, legal, and noncompliance issues often come from nonalignment. If employees and their organizations have the same philosophy and the same understanding of the ethical process, they're not as likely to get into trouble. But when the organization is going in one direction and the case manager in another, that can lead to a breakdown in communications and possible noncompliance consequences," she says. ■

Include case managers in hospital's disaster plan

Trained clinicians can provide vital help

Case managers can provide vital assistance during a disaster, **Toni Cesta**, PhD, RN, FAAN, knows from first hand experience.

When the August power failure hit Saint Vincent's Hospital Manhattan (NY), where Cesta is the director of case management, the case management department spent 36 straight hours providing hands-on care for traumatized patients.

In the case of a disaster, Saint Vincent's case managers are assigned to go to the cafeteria and

care for the patients who have been discharged but can't go home.

During the blackout, those patients included people who had been injured in the subway when the lights went out and people suffering from heat exhaustion and respiratory problems. Included in the mix were psychiatric patients, three newborns and their mothers, and patients who had been discharged from the hospital that day but couldn't go home.

The social workers in Cesta's department were called on to provide emotional support to the patients who had been through a traumatic event and to help others locate their family members.

"The bottom line is that experienced nurses and social workers can add a lot of value to a disaster plan," she says.

As soon as the power outage hit, the Saint Vincent's disaster plan went into effect and the case management staff went to their assigned place in the hospital cafeteria and set up a discharge area for patients who had been released from the hospital or emergency department (ED) and had no transportation home.

During a disaster, New York City does not allow any emergency vehicles to transport patients out of hospitals. They are to remain free for casualties and only can transport patients to hospitals, she says.

Limousine services and other transportation companies couldn't help because the power outage also made it impossible to pump gas into their vehicles. Family members couldn't come and get the patients because the bridges and tunnels were closed and the traffic signals were out.

Within a short time, the Saint Vincent's ED was jammed with patients. "It became clear that the [ED] was overloaded. They were seeing and releasing people and because the city wouldn't allow us to transport them out, we had to put them somewhere," Cesta says.

Case managers put their ingenuity to work assembling what was needed to care for the patients. The patients with head wounds needed antibiotics; diabetics needed insulin; and people with respiratory problems needed inhalers.

"The patients we had there, technically, had been discharged, but many of them still were very sick. Some were sicker than they should have been, and we returned them back to the [ED]," Cesta says.

The hospital had a supply of cots that had been purchased for the staff to sleep on in emergencies, but they weren't suitable for the patients because there was no way to keep them from falling off. The staff brought in hospital beds, but all of them had been raised for cleaning, and there was no electricity to lower them. The solution was to use the big chairs from the dialysis clinic. The staff brought oxygen tanks into the cafeteria for patients who needed oxygen.

Eventually, the Salvation Army brought in bottled water and food. Staff already had gone to the supermarket to buy sandwich materials. The news reports downplayed the severity of the power failure, Cesta says.

"They showed people camping out, laughing, and coping, but for our hospital and the patients, it was a disaster. The case managers essentially were up for 36 hours taking care of patients. It was dark and hot, and if you turned on the tap, you got brown water," Cesta recalled.

Don't forget to plan for outpatients

Based on her experiences of 9/11 and during the blackout, Cesta recommends that hospitals come up with a means to care for outpatients during a disaster.

"Now we know we have to beef up the concept of the discharge lounge and equip it with medications and supplies as well as red plugs hooked up to our generator system," she says.

When creating a disaster plan, Cesta recommends looking for a clinically appropriate location in which to set up a discharge area. The area should be large enough to handle the influx of patients you might expect and should include hookups to the emergency generator system. She offers the following advice as well:

- Don't expect to be able to transfer people out of the hospital.
- If your hospital uses electronic medical records, come up with a paper system for admissions and orders when there is no power.
- Think through everything necessary to accommodate the patients' needs. Establish a supply of medication, oxygen, and dressing changes — anything that patients might require for any period of time.
- Develop a system to get medication orders from the ED and to get the medication the patients need from the pharmacy.
- Line up sources for appropriate food and water.
- Secure appropriate places for people to sleep or lie down.
- Set up a system to accommodate patients who have been released from the hospital and ED who need continuing care. ■

GUEST COLUMN

Do patients get uniform case management?

Perform assessment of CM practices to make sure

By **Patrice Spath**, RHIT
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Forest Grove, OR

The leadership standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) require that hospitals provide "one level of care" for all patients. The intent of this standard has been clearly defined by the Joint Commission to mean that patients who have the same health problems and health care needs will receive the same level of care or resource allocation regardless of time of service, place of service delivery, or ability to pay.

For case management departments, this requirement can be problematic. Case manager staffing patterns and screening criteria may need to be adjusted to ensure availability of case management services to all patients needing such services.

Understanding the intent of the standard is key to a successful survey as well as success in providing consistent and uniform case management services to all patients. The Joint Commission clearly recognizes that different patients have different health care needs and that each patient's individual circumstances dictate the level of case management services needed for a positive outcome.

Response times for case management assessments and interventions should be the same for patients with similar needs, regardless of whether they are admitted on a weekday, weekend, or holiday. An approach case management departments can use to meet this requirement is through the development of a strategy and plan for the provision of patient care. The plan must be consistent with the mission of the organization, be expected to produce consistent and positive patient outcomes, and take into consideration the specific skill levels and competencies of the case managers who will provide the services.

In determining the departmental plan for case management, a delivery model should be selected.

The model for providing case management services may involve assigning case managers to particular units or patient populations in order to efficiently deliver services to the appropriate patients. Once the delivery model is determined, the department must clarify how patients needing case management will be identified and how resources will be allocated to meet those needs. Policies that specify all patients will be assessed at specific frequencies based on the day of the week are outmoded and inappropriate. Do your case management policies state, for example, that patients admitted Monday through Friday will be assessed within 24 hours of admission and others will be assessed within 72 hours? If so, you clearly are not providing consistent care based on patient needs. The time frames must be the same for patients with the same needs.

It is acceptable to have different assessment time frames for different populations based on the real needs of patients in those groups. For example, patients admitted to the critical care unit may not require an assessment of their discharge needs within 24 hours of admission, but this time frame may be appropriate for patients admitted to a medical unit. For specific patient populations, such as orthopedics, it is appropriate to have a policy that states that acute care patients with a given set of diagnoses will receive an initial assessment within a shorter time than patients with the same diagnoses who are admitted to a long-stay unit.

It is imperative that the time frames for initial case management assessment be established without consideration for the case manager staffing schedules. A policy that specifies that patients will be evaluated within "24 working hours" implies that the needs of the staff have been considered rather than the needs of patients. Likewise, time frames for initial assessment should not be linked to the patient's ability to pay or type of insurance coverage. All patients with similar clinical or psychosocial needs must receive timely and appropriate case management services.

When faced with limited case management resources, there may be situations where all patient needs cannot be met. It is acceptable to prioritize patient needs based on an acuity system that allows for high-priority needs to be addressed more quickly than lower ones. Variables of illness severity can be used to establish a system for prioritizing case management services. These variables include age, specific complications and comorbidities, level of effect of complications and

(Continued on page 175)

CRITICAL PATH NETWORK™

Checkoffs play key role in SICU improvement

Checklist helps team follow care plan

A patient daily goals checkoff form used twice daily during rounds has helped the surgical intensive care unit (SICU) team at Hartford (CT) Hospital achieve a 25% drop in its mortality rate, while cutting lengths of stay and ventilator days.

The 800-bed hospital, a level one trauma center and urban teaching/tertiary care facility, is a major affiliate of the University of Connecticut School of Medicine and one of the original participants in the "Transformation of the ICU," or TICU Project, sponsored by the Veterans Health Administration to help improve the organization and delivery of care to the ICU.

One of the outgrowths of the project was the concept of a goals form for rounds, first employed at Johns Hopkins in Baltimore under the direction of Peter Pronovost, MD.

"It seemed to work there, and they asked if other teams would try it; we took that challenge," recalls **Eric Dobkin**, MD, director of the 12-bed SICU at Hartford.

The hospital actually formed two different teams in the surgical and medical ICUs and came up with two different goals forms.

"We [the SICU] clearly had outstanding outcomes, and I think the main reason for that was the way our form was structured," he says.

The form Hartford uses **(see checklist, p. 168)** differs not only from the original Pronovost model but from many others Dobkin has seen implemented — including some in his own facility. "The real key is that to some extent, the others miss the point," he asserts. "Their focus is to use this as a to-do list, and I'm sure that is very beneficial. However, we chose a different path."

One of the key elements of the TICU project, he notes, is improving patient safety. "We felt [with our form] we could improve quality *and* patient safety," Dobkin says. "That's why some of our questions are attributable to patient safety. They not only reflect the clinical concerns of the patient, but also their safety and psychosocial concerns."

But the key take-home message, he underscores, is that, "We decided to design not just a to-do list, but something modeled after an airplane takeoff checklist." That's why, he says, not only is every item on the list expressed in the form of a question, but each question is designed with a default answer of yes.

The decision on the questions themselves was, like the SICU team, multidisciplinary. The team includes nurses, a physician leader (Dobkin), respiratory therapist, social worker, and midlevel practitioners (nurse practitioner and physician assistant). "We have a multidisciplinary care philosophy in the SICU, and we primarily developed the form by mirroring the way we presented patients on rounds," Dobkin explains.

"We have rounds twice a day, and they had been more or less formalized verbal presentations of the patient, going in systems order — pulmonary, cardiovascular, neurological," he says. "Traditionally, this had been given from [memory] or from notes. Since we were multidisciplinary, this would include issues around the whole patient. We thought about this and formalized the areas we routinely discussed into questions [for the checkoff]."

Multiple versions of the form were used before the final version was selected. "We asked for input from our nursing staff, so they could incorporate

(Continued on page 169)

SICU Patient Daily Goals Sheet

Why is the Patient here?	No	Plan : Morning	Revisions: Afternoon	Night
Appropriate level of sedation?				
Appropriate level of pain control?				
HOB elevated 30 degrees?				
Weaning/extubation assessment performed?				
Current vent support needed RWP candidate?				
Tissue perfusion adequate?				
Arrythmias treated/controlled?				
Optimal BP control?				
Volume status appropriate?				
IV fluids appropriate?				
Adequate nutritional support?				
Bowels regular?				
PUD prophylaxis?				
Electrolytes WNL?				
Glucose controlled?				
H/H appropriate?				
Coags appropriate?				
DVT prophylaxis?				
Cultures checked?				
Wounds checked?				
Skin intact?				
Antibiotic appropriate?				
Lines/tubes necessary?				
Tests /procedures ordered?				
Tests read/reviewed?				
Δ meds PO, adjust dosing?				
Consults ordered/contacted?				
Patient mobilized, OT/PT/ST?				
Primary service/consults contacted, plan discussed?				
Team aware of end of life plan?				
Family feels informed?				
Cont. Care/ Soc. Serv involved?				
		RN ___ MLP ___ MD ___	RN ___ MLP ___ MD ___	RN__MLP__MD__

Source: Hartford (CT) Hospital.

questions they felt were important, too," Dobkin explains. His team started with a small "test of change," using one or two patient rooms, then four, then half the unit.

"Each time, the form changed," he notes. The compilation of the questions in their final form was handled by the nurse practitioner, Denise Lawrence.

Communications improved

Dobkin says that one of the additional benefits of this form has been the elimination of a problem he has seen in every ICU in which he has worked. "Every day on rounds, the residents present the patients the same way, by system," he says. "At the end, the resident inevitably says the plan for the day is 'ABC.' Yet, when you ask the nurses, they inevitably will say there is no plan. I don't know if this is a delivery issue or a reception issue; but since we implemented this, we have had total buy-in from the nursing staff."

Dobkin has the data to back up this assertion. At the outset of this program, nurses were provided with blank goals forms after rounds and were asked to write down the plan for their patients. "We found when we measured that the nurses truly did only know about 50% of the goals planned," he points out. "But after we instituted the [checkoff] procedure, they knew 98% to 100%. We have tested this for a year and a half, and it has been consistent."

While there is no baseline for the residents, the current data show that 98% to 100% of them also know their goals every day, Dobkin adds.

It also provides reinforcement for the nurses that this form helps them know the goals for the day, he says. "Nurses feel better organized about their day." And even though it is not the form's primary function, it also *does* function later on as a to-do list for the nurses.

"Plus, it is a communication form," Dobkin explains. "We print it on fluorescent yellow paper, and we put it in clear plastic sleeves on the breakaway door to the ICU, so everyone involved with the case can see it." Finally, he says, it serves as a safety and quality "force multiplier."

Of course, it is the change in outcomes that is "truly impressive," Dobkin says. The SICU has decreased its mortality rate from about 11.4% to about 8.3% since the checklist began being used, he reports. "We also decreased [average] length of stay by 1½ days and ventilator days on by one day," he adds.

Scientifically, of course, it is impossible to attribute the entire change to the checklist. "However, we have had no change in patient population, no new technology implemented, nor have we been doing any other studies during this time," he asserts. Could other hospitals duplicate Hartford's results? "Yes and no," he says. "This is very low tech, simple, and cheap to do. The high cost is the commitment by the staff, including physicians, to use it."

The checklist is done for every patient every morning, and revised in the afternoon. Then at night, the resident and the fellow make sure every goal is being followed. "What's necessary is the absolute devotion and leadership by clinical care physicians," Dobkin says. "How did we do it? We have a great team, and I had the support of the director of the section of surgical critical care and chief of surgery."

The nurse practitioner and the physician's assistant also played a crucial support role. "When I was not there, they reminded the others to adhere to the plan," he adds.

Even so, there was resistance in the beginning, both from nurses and physicians. However, notes Dobkin, "they persisted only until they saw the results." ■

Proper patient ID focus of hospital initiative

Effort targets intentional fraud, human error

With patient safety a heightened imperative from the Joint Commission on Accreditation of Healthcare Organizations, and facing its own duplicate medical record problem, Truman Medical Center in Kansas City, MO, launched an initiative aimed at ensuring proper patient identification.

The challenges are myriad, explains **Nancy Stringer**, director of patient access. "Some [of the problem] has to do with patients coming in and being one person one time and another the next time."

A man who knows he needs a particular medical procedure may use his brother's Medicaid card to try to make sure the cost will be covered, she adds.

"Or a person is in the country illegally, and someone loaned him a visa to use." Then there are the cases in which someone is Willie Williams

on one hospital visit, William on the next, and Billy in a later encounter, Stringer says. Adding to the mix — which of course also includes normal human error — are cases in which people give inaccurate Social Security numbers, she notes.

The hospital is addressing the problem on several levels, Stringer says, with educational efforts targeting registrars, clinical personnel, and patients.

"We are making sure registrars understand proper search criteria," she adds. "For example, we probably have 40 or 50 Bob Smiths. We're telling them to use multiple criteria when they put that name into the system. If there's no match using name and birth date, don't give up and add a new patient. Try the Social Security number — maybe the [patient's existing file] is under Robert Smith."

In addition to educating registrars, Stringer notes, the hospital also is looking at getting registration software with a feature that searches for names that sound like the one being entered.

The idea behind educating care providers, she explains, is that they often are privy to information that patients may hide from registrars. "Sometimes, the person is afraid because, for example, they may have [outstanding] tickets or warrants against them and feel we might notify someone about that," Stringer says. "So they use their brother's name or birth date."

When the care provider begins taking the person's history, but is looking at the brother's chart, she adds, the deception may eventually be uncovered during their conversation. Other times, she says, the patient may have trouble communicating for one reason or another [during registration], but when the family comes in later, the family clears up the confusion.

With these kinds of scenarios in mind, clinicians are being urged to share such revelations with registration personnel, she notes. "It's everybody's responsibility to make sure we have accurate information."

Patients, meanwhile, are being targeted with an effort called Operation Identification, Stringer says. "We will do a campaign about why [proper identification] is important."

The hospital's public relations department is working on a flyer — using the colors red and black to make it stand out — that stresses the connection between proper identification and good medical care, she says.

The flyer will encourage patients to bring along information to verify identity, and to give the same form of their name on each visit, Stringer adds. "It will be displayed at registration sites for patients to pick up," she says, as well as being handed out by registration staff.

In conjunction with the new emphasis by the Joint Commission on patient safety, Stringer notes, the proper identification focus will extend throughout the organization.

For example, she adds, "When clinicians do a procedure, they will use dual identifiers, such as [checking] the armband, [checking] the birth date, to verify that this is 'Suzie,' as well as going over it verbally with the patient." ■

CE *questions*

17. Case managers cannot be held legally liable for failing to report an instance of fraud or abuse that has come to his or her attention.
    A. true
    B. false

18. Which of the following organizations has compliance standards that health care providers must meet for certification?
    A. Joint Commission on Accreditation of Healthcare Organizations
    B. National Committee on Quality Assurance
    C. URAC
    D. all of the above

19. What was the first action of the case management staff at Saint Vincent Catholic Medical Centers of New York when the August power blackout hit New York City?
    A. They evacuated the hospital.
    B. They went to the hospital cafeteria and set up a discharge area.
    C. They went to the emergency department to assist in triage.
    D. They maintained their normal routine.

20. Which standards from the Joint Commission require that hospitals provide "one level of care" for all patients?
    A. environment of care standards
    B. medical staff standards
    C. leadership standards
    D. nursing standards

Answer Key: 17. B; 18. D; 19. B; 20. C

ACCESS MANAGEMENT
QUARTERLY

CMS hopes final EMTALA rule will ease burden

New rule is both good and bad news

There is much to rejoice about in the final rule of the Emergency Medical Treatment and Active Labor Act (EMTALA), with many of the most vexing parts of the law either clarified or eliminated altogether, but there still is plenty to keep you busy. The new rule will lessen risk in some areas, but it also may increase liability from a longstanding problem — the difficulty of getting enough physicians to take call for EMTALA coverage.

The final rule is "good news, some more good news, and continued bad news," says **Mark Kadzielski**, JD, head of the West Coast health practice in the Los Angeles office of the law firm of Fulbright & Jaworksi and an expert on EMTALA. He says Centers for Medicare & Medicaid Services (CMS) administrator Tom Scully was on target when he announced the new rule by saying that it "carries out EMTALA in a common-sense and effective way."

EMTALA applies to all hospitals that participate in the Medicare program and offer emergency services and covers all patients treated at those hospitals, not just those who receive Medicare benefits. Hospitals that violate EMTALA may have their Medicare participation terminated and may be subject to civil money penalties of up to $50,000 per violation. Individuals who have suffered personal harm and hospitals to which a patient has been improperly transferred and that have suffered financial loss as a result of the transfer also are provided a private right of action against hospitals that violate EMTALA.

One of the most difficult parts of EMTALA essentially was eliminated in the final rule, says Kadzielski. The "250-yard rule," which was prompted by an infamous case in which emergency department staff did not leave the hospital grounds to render aid to someone nearby, was made moot by new definitions outlining when EMTALA applies. Instead of the previous interpretation, which stated that the hospital was responsible for anyone who was within 250 yards of the hospital campus (and "campus" was defined broadly), the final rule now makes clear that EMTALA applies only in specific areas that meet one of three definitions.

In effect, CMS is stating that EMTALA applies only when people come to an area in which they could reasonably expect to receive emergency treatment, Kadzielski says. There no longer is any need to try to figure out where your campus begins and what falls within 250 yards.

EMTALA does not apply to inpatients

And to make things even better for hospitals, CMS declared that EMTALA does not apply to inpatients. That severely limits how much of a hospital's operations are subject to EMTALA. "If I take my daughter to a doc-in-the-box affiliated with a hospital and they don't screen her properly, in the old days, I could have sued for an EMTALA violation," he says. "Here the new rules say no, not unless it is specifically licensed as an emergency room, or held out to the public as a place that provides emergency care, or unless emergency cases made up a third of all cases for the prior year."

The bad news involves CMS's final word on the difficulty of getting doctors to take calls for EMTALA coverage, Kadzielski says. This has been a difficult part of complying with EMTALA for years, as hospitals find it difficult to keep enough physicians on call to ensure that an emergency patient can get a proper screening or treatment by a specialist. Hospitals, especially risk managers, had hoped the final rule would help them force doctors to take call, but that didn't happen.

"The government hasn't done anything to help hospitals get physicians to take call," he says. "They just said, 'It's up to you. Work it out however you want to, but the hospital has to provide coverage.'"

CMS decided to stay out of the fight and simply give doctors and hospitals maximum flexibility to work out their disagreement, Kadzielski says. "The final rule also allows doctors to be on call at more than one hospital and to do elective surgery while on call, so they're effectively not available," he says. "It makes it easier for doctors to take call, but it doesn't give any hints to the hospital as to how to provide coverage."

One part of the rule related to physician coverage may seem like good news, but Kadzielski cautions that there is a hidden risk. The rule clarifies that it now perfectly legitimate for a hospital, for instance, to have orthopedic coverage on Monday, Wednesday, and Friday, and to have neurosurgery coverage only on Thursday. That often is the best a hospital can manage when specialist physicians are too few or just won't take calls.

So that's good news, right? Not entirely, Kadzielski says. The final rule will give you a defense if you were unable to provide enough physician coverage, but it's not an ironclad defense. "If I'm a plaintiff, I'm going to sue and argue that the way you limited this call is not rational, not appropriate, and is a violation of EMTALA," he says. "The hospital will argue that the final rule says it's up to our discretion and that was our decision. But the patient will argue you abused your discretion, knew that was inadequate call coverage, and therefore, you should have liability. It's going to get crazy like that.

"Not only did they make the on-call situation worse by not providing any guidance, they made it worse by leaving it all up to the hospital to decide," Kadzielski says. "That means that when someone disagrees with your decisions about on-call coverage, it's all in your lap."

With that kind of hands-off approach from CMS, the nationwide on-call crisis is not likely to improve any time soon. Kadzielski says the final rule is likely to exacerbate the situation and lead to more patient transfers when the emergency department can't find a specialist.

George Molzen, MD, president of the American College of Emergency Physicians in Irving, TX, agrees and conjures up images of patients being driven all over town in search of the one hospital that has the right specialist on call.

"Hospitals also can allow specialists to opt out of being on call to the emergency department." Molzen notes. "This means that patients in need of specialty care may need to be transferred to other hospitals. But the question is where? We already have a shortage of on-call specialists because of the medical liability crisis. This rule could exacerbate an already difficult situation."

And if your hospital is the one that managed to keep specialists on call, guess what? All those transfers will be coming to your emergency department. The new rule potentially could leave only a few hospitals left with medical specialists, which means those hospitals may be flooded with emergency patients, Molzen says. It could result in conflicts between hospitals over who will provide specialty care and result in delayed care or more transfers of patients, exacerbating the ambulance diversion problem.

Don't think EMTALA is toothless now

Aside from the on-call issue, the EMTALA final rule is largely good news for health care providers. But according to one CMS official, don't assume the government is going soft. CMS still has every intention of enforcing EMTALA diligently, says **Charlotte Yeh**, MD, FACEP, CMS regional administrator in Boston.

"No one should look at this as a wholesale change or weakening of EMTALA," she says. "It's just really a much better balance and assurance that patients will get the necessary care without being overly burdensome to hospitals. This makes it more manageable."

CMS intended to clarify much of the EMTALA rule that had made compliance difficult, and to codify some court rulings over the past years that affected how the law was interpreted and enforced. In particular, Yeh says, CMS wanted to eliminate the need for "defensive" EMTALA compliance in those gray areas in which providers had a hard time knowing whether the law applied. In many cases, providers played it safe by using EMTALA protocols, and that led to an unnecessary burden, she adds.

For instance, some providers thought the rule applied to patients who came to the hospital for outpatient care such as lab tests. They were in the hospital, so some providers interpreted EMTALA to mean there was an obligation to provide screening. The final rule makes clear that such practices are not necessary, Yeh says.

"If you develop an emergency on your way to the appointment or need emergency help, then EMTALA applies," she says. "But if you're being treated in rehab and develop chest pains, then the other hospital outpatient conditions of participation apply and you don't have to apply EMTALA." ■

Some finer points of the updated EMTALA

These highlights of the final Emergency Medical Treatment and Labor Act (EMTALA) rule were summarized by the Centers for Medicare & Medicaid Services (CMS):

- The new rule changes the definition of emergency department to mean any department or facility of the hospital, whether situated on or off the main hospital campus, that: 1) is licensed by the state as an emergency room or emergency department; 2) is held out to the public as providing care for emergency medical conditions without requiring an appointment; or 3) during its previous calendar year, has provided at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis.
- CMS clarified the circumstances in which physicians, particularly specialty physicians, must serve on hospital medical staff on-call lists. Under the revised regulations, hospitals will have discretion to develop their on-call lists in a way that best meets the needs of their communities. In keeping with traditional practices of "community call," CMS says physicians will be permitted to be on call simultaneously at more than one hospital, and to schedule elective surgery or other medical procedures during on-call times.
- The rule confirms that hospital-owned ambulances may comply with citywide and local community protocols for responding to medical emergencies and thus be used more efficiently for the benefit of their communities.
- Hospital departments that are off-campus now can provide the most effective way of caring for emergency patients without requiring that the patient be moved to the main campus when this would not be best for the patient.
- The final rule clarifies that EMTALA does not apply to individuals who come to off-campus outpatient clinics that do not routinely provide emergency services or to those who have begun to receive scheduled, nonemergency outpatient services at the main campus — for example, routine laboratory tests. Other regulations and state licensing laws already cover the hospital's obligations to patients in such circumstances.
- The rule clarifies that EMTALA does not apply after a patient has been seen, screened, and admitted for inpatient hospital services, unless the admission is made in bad faith to avoid the EMTALA requirements. This provision was adopted to conform to the decisions of five circuits of the United States Courts of Appeals. ■

EMTALA Q & A

'Just the facts' not enough if patient asks about bill

Question: Is it true that we can violate the Emergency Medical Treatment and Labor Act (EMTALA) by not encouraging a patient to stay for treatment when he wants to leave? We've been told, for instance, that if a patient asks about financial liability for treatment, we must actively encourage the patient to stay until he can be examined rather than just stating the facts about payment.

Answer: You're right. You can violate EMTALA this way, says **Susan Lapenta**, JD, a partner with Horty Springer, a law firm in Pittsburgh that specializes in health care issues. This facet of EMTALA is particularly confusing to health care providers, who often are surprised to learn that they violated the law when they merely answered a patient's question honestly and politely, she says.

To fulfill the intent of EMTALA — ensuring that people who need urgent care are not turned away from hospital emergency departments (EDs) — the government expects providers to go beyond simply answering a question about possible financial liability. ED staff should actively encourage people to stay for treatment even if they are concerned about the ability to pay, Lapenta says. "It's not enough to answer a question about payment factually and accurately. The government is looking for the hospital to reassure patients, to say, 'Don't worry about payment. We'll take care of you.'"

The concern is that if you simply provide the facts about payment, a patient will leave the ED because of payment concerns when he or she actually has a medical condition that needs to be treated, Lapenta says. "The government considers [it] your responsibility to prevent" this from happening, she adds.

The issue can trip up ED staff because they often think of EMTALA violations as overt acts in which the staff purposefully turned the patient away. That is a dangerous misconception, warns Lapenta. ED staff might not understand this point, she says. "I suspect they know in a general sense that they're not supposed to talk about payment, but I'm not sure they fully understand that the government expects them to actively encourage people to stay for treatment. It confuses people when they know they meant no harm and didn't initiate the conversation about payment to try to scare people off."

The government has spelled out what it expects of ED staff in this situation, Lapenta says, and the bar is set pretty high. In an advisory bulletin issued in 1999, the Health Care Financing Administration — now the Centers for Medicare & Medicaid Services (CMS) — explained exactly what the ED staff should do in response to a question about financial liability. (Financial inquiries are addressed in item 4 in the bulletin.)

In a nutshell, she explains, the government expects ED staff to gently reassure people that they will be treated as needed without regard to payment, going to great lengths if necessary to avoid answering the question directly.

If the patient is insistent and keeps pushing for a straight answer, the government does allow the ED to respond, but only after a verbal tango in which all attempts to elude the answer are exhausted. The staff member has to work through a series of steps choreographed to reassure the patient and deflect payment inquiries. No matter how reasonable and serious the question sounds at first, she adds, you just can't blurt out the facts and let it go at that.

The Bush administration is sending signals that it is more flexible in investigating such slip-ups, Lapenta notes, whereas the previous administration took more of a hard-line approach.

Of course, an EMTALA investigation is bad news even if you prevail in the end. Thus, she advises taking the necessary steps to educate ED staff, especially those involved with patient triage and intake, about this particular risk with EMTALA. Some hospitals script out what employees can say, which she says can be a good idea.

Lapenta suggests a script that goes something like the following in response to the first question, with parts repeated as necessary if the patient persists in asking: "You need to be taken care of first. That's our first concern. We can talk about money and what you might have to pay for later, after we make sure that you're safe. We have to do this screening examination first to make sure that you're OK, and then we can talk about payment later. We'll answer all your questions about that soon, but we really need to concentrate right now on making sure you're OK," she adds.

Educating staff is a key concern with EMTALA because, if a complaint arises, investigators will take a hard look at whether a patient was illegally diverted intentionally or because staff weren't adequately trained in EMTALA compliance. Either of those conclusions is much worse than staff simply making a mistake with one patient. "The government is usually more concerned with whether staff are trained properly than whether they slipped up one time," Lapenta says.

[For more information about EMTALA, contact:

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(Continued from page 166)

comorbidities, direct clinical and physiological observations, need for life-support or therapeutic interventions, admission status, and anticipated discharge status. Look at having a case manager on call to respond to specific needs on weekends and have criteria that trigger case management interventions. By triaging patient needs based on established policy, the case management department is able to assure consistent levels of service.

Review a representative sample of charts and determine what level of case management intervention was provided to meet the high-priority patient needs that were identified during the initial assessment. Determine what your staffing requirements would be to provide just these interventions on a 365-days-a-year basis and make this your core staffing level. This would be the staff you schedule every day. Determine what medium- or low-priority case management interventions you could provide with additional staff on a certain number of days and flex staffing up and down as appropriate.

Assess your current activities

Perform your own assessment of case management practices to determine if a uniform level of services is being provided. Start this assessment by examining the language in your policies. If you find that you use language that suggests different case management coverage on different days of the week or that you refer to time frames as "working hours," it's time to critically evaluate your policies. While having coverage policies that relate to the weekend may not always be problematic, this type of language could trigger a more intensive review of your coverage practices by a JCAHO surveyor.

Look at your staffing to determine if it meets JCAHO requirements for uniform performance of patient care processes. Suppose you work in a 65-bed rural hospital and you are one of two RN case managers. There also is one part-time social worker who is available two days a week.

Case management services routinely are provided only on weekdays, with one of the two case managers on call each weekend. This staffing pattern would appear to show a different level of service based on the day of the week and could put your department at risk for not providing uniform care if patients routinely required the services of both a case manager and a social worker. A review of case mix and patient needs would be needed to determine if patient needs are being met. If, for example, the patient mix is generally low-risk medical and all high-risk patients are being transferred elsewhere, the staffing may be adequate as long as patients meeting your department's criteria for case management intervention are being seen.

Of particular concern might be how patients with psychosocial problems are being assessed and appropriate discharge planning initiated. If the RN case managers are cross-trained to conduct social work assessments, staffing may be adequate. If the department has criteria for selecting high-priority patients for case management or social work interventions, an audit may reveal that all of these patients are in fact receiving necessary services in a timely fashion.

Another area of potential problems is case management based on the patient's payment source. Patients covered by insurance that is expected to adequately reimburse the facility for an entire hospitalization should not be considered low priority for case management services. Decisions about whether a patient requires case management services must be based on the patient's needs, not expected payment. Some of the case manager's struggle is to find sufficient time for every patient; however, providing a uniform level of care means seeing all patients who meet criteria for case management interventions. If the workload is too high to ensure compliance with the department's policies, it may be necessary to revise the case management triage criteria or add additional staff.

The JCAHO survey team will expect to see that your practice actually follows the policies you have in place. If you find your policies and practices are different, assess the cause of this disparity. Often policies become outdated and new practices are accepted without updating written policies. At other times, policies are appropriate, realistic, and effective but staff members require education and

COMING IN FUTURE MONTHS

- Departmental design issues in case management
- The challenges of case managing the uninsured
- The evolving role of discharge planning
- A case management credentialing update

feedback to ensure compliance. Take time to evaluate whether case management is provided uniformly to all patients based on their needs and whether actual practices reflect your department's policies.

If your department is in compliance with the JCAHO standard for uniform patient care, continue to monitor staff adherence to policies. If you find areas out of compliance, take steps to remedy the problems. ■

CE objectives

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

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

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2003 SALARY SURVEY RESULTS

HOSPITAL CASE MANAGEMENT™

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

How do your salary and benefits stack up against your case management peers'?

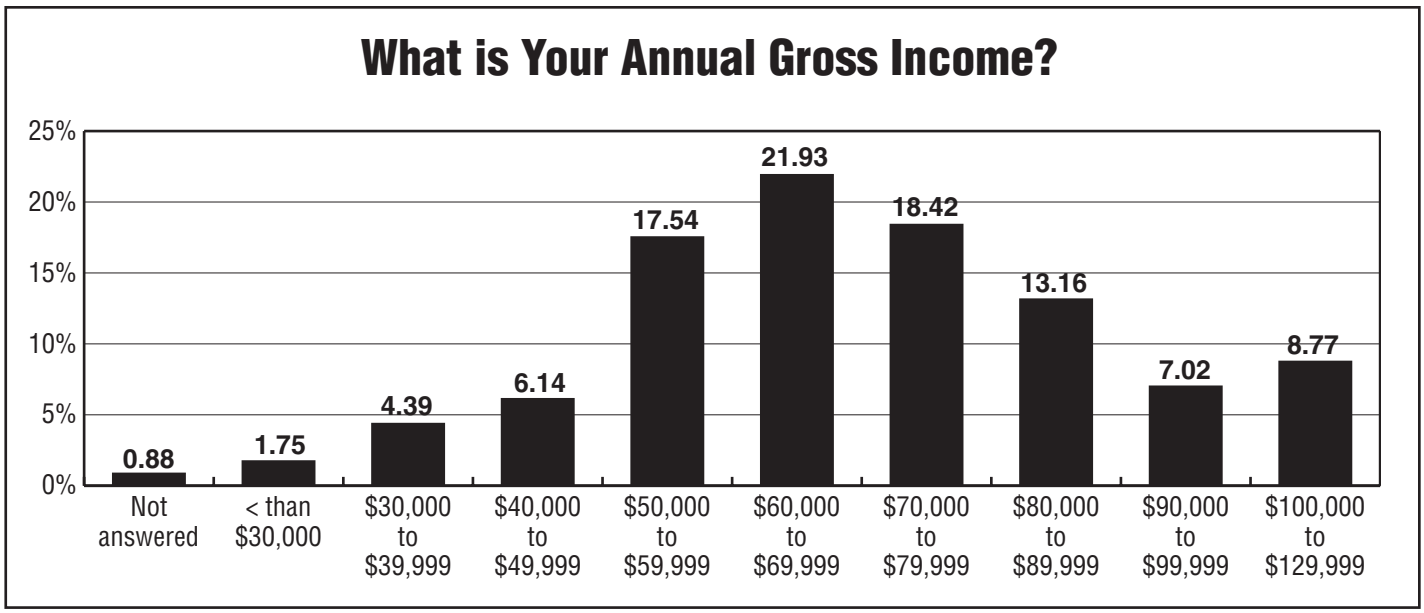
Hospital Case Management's annual salary survey was mailed to readers along with the April 2003 issue. Questionnaires, response forms, and postage-paid envelopes were inserted into that newsletter. The responses contained no names unless readers wished to include them along with special comments. The surveys were compiled and analyzed by Thomson American Health Consultants in Atlanta, publisher of *HCM*.

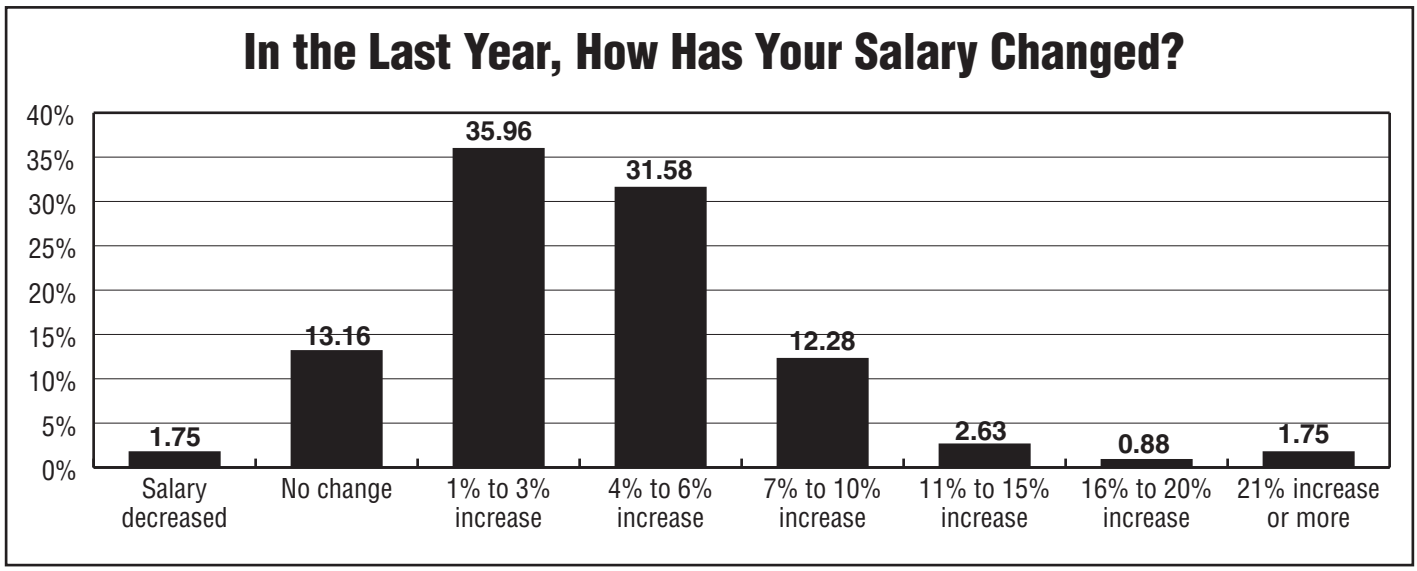
Getting right to the point

Annual gross income for *HCM* readers generally clustered between $50,000 and $80,000. More than one-fifth of respondents (21.93%) earned between $60,000 and $69,000. Another 18.42% earned between $70,000 and $79,999. The third highest group was $50,000 to $59,999, with 17.54% of respondents. Only 2.63% earned less than $40,000, and 8.77% earned more than $100,000.

Most (61.4%) work between 41 and 50 hours per week, although more than a quarter (26.31%) work even longer hours. Only 12.28% work less than 40 hours per week. About 36% received a salary increase of between 1% and 3%. Another 31.58% had a salary increase of between 4% and 6%. About 15% had either no change in salary or (1.75%) a salary decrease.

The greatest percentage of respondents — 24.56% — have been working in hospital case





management for between seven and nine years. Another 22.81% have been working in the field between four and six years, while only 9.64% have worked in case management for 16 years or more. Sixteen percent have worked in case management three years or less.

Meanwhile, nearly half (48.25%) of our respondents have been working in health care for 25 years or more, and a full 81.58% have worked in health care for 19 years or more. The most common titles are director of case management (56.14%), case manager (14.91%), and utilization manager (5.26%).

Nearly all of our case management respondents are women (96.49%). About 42% are in their 40s, but there are a good number in their 50s (37.72%) and 30s (9.65%) as well. About 42% have completed at least some graduate work, and another 25.44% have bachelor's degrees.

When it comes to the number of people supervised, responses again ranged widely. About 28.1% supervise six or fewer people; 29.83% supervise between seven and 15 people; and 31.58% supervise between 16 and 40 people. About 8.7% of respondents supervise more than 40 people.

A plurality of *HCM's* readers (37.72%) hail from the southern United States, while 21.93% live in the northern central states running from Ohio on the east to the breadbasket states on the west.

About 21.05% live in the Northeast, and 19.3% are from the West or West Coast. About 29.8% come from hospitals in an urban area. Another 28.95% are from medium-sized communities, 24.56% are from rural areas; and 15.79% work in a suburban setting.

As usual, most of respondents, 67.54%, work in nonprofit institutions; 16.67% work in for-profit organizations; 8.77% work in either federal facilities or academic institutions, and 7.02% work for state or county government facilities.

For the first year, the highest percentage of our respondents (24.56%) work in hospitals with fewer than 100 beds. The next largest group — 23.68% — work in hospitals with between 101 and 200 beds. Another 21.93% work in hospitals with between 201 and 300 beds, and 9.66% work in hospitals with 500 beds or more. ■

Creativity helps with CM recruitment, retention

Nursing shortage has intensified staffing problems

Each year, Covenant Health System in Knoxville, TN, has a "Case Management University" for nurses in the system who are interested in becoming case managers.

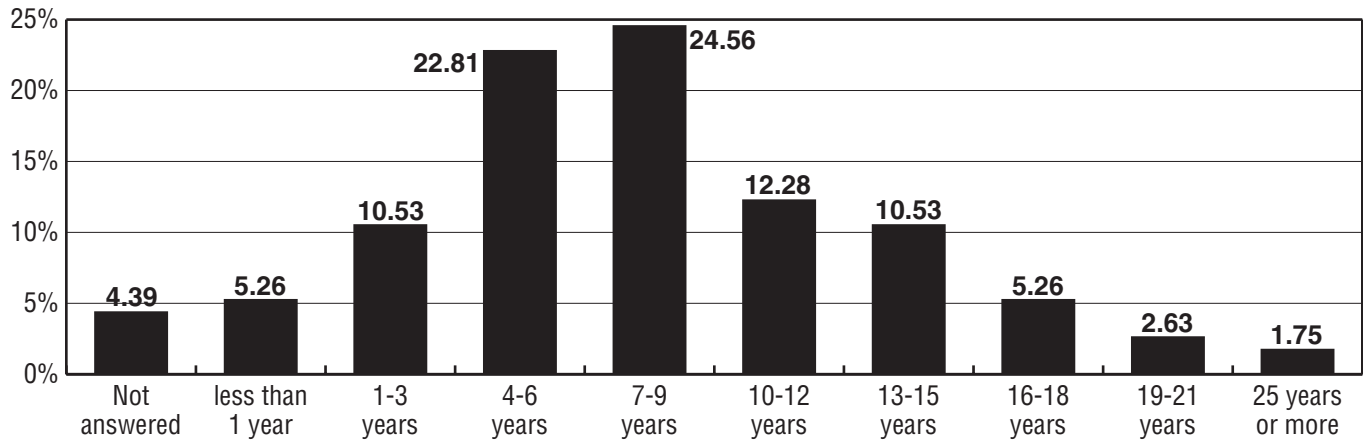
"The nurses who participate get basic education about case management and our model. When there is an opening, they have that certification," says **Sandra Marshall**, RN, MSN, senior vice president of organizational effectiveness/clinical outcomes for Covenant Health.

At Sarasota (FL) Memorial Hospital, the case management department has done such a good job of proving its value to hospital administration that a hospitalwide budget cut had minimal impact on case management.

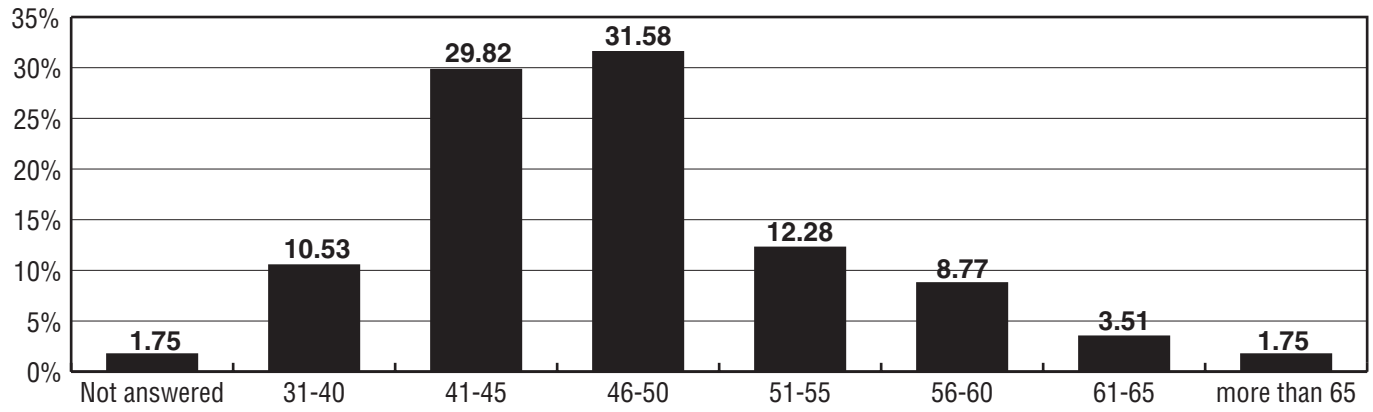
"This is our biggest retention and recruitment strategy. We have been resourced well because we have performed well. Case managers who apply

(Continued on page 4)

How Long Have You Worked in Case Management?

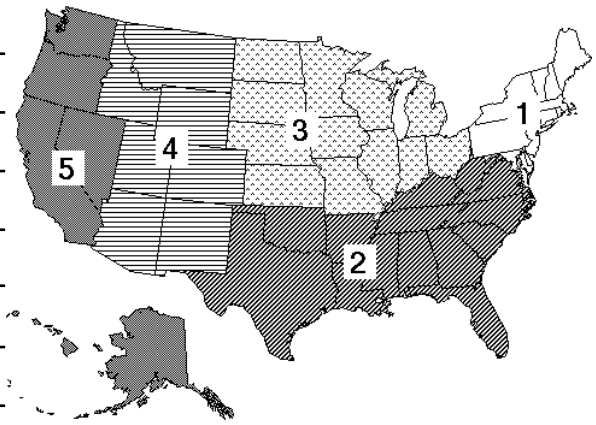


On Average, How Many Hours Do You Work Per Week?



Salary by Region

Income	Region 1	Region 2	Region 3	Region 4	Region 5
Less than $30,000	8.7%	0%	0%	0%	0%
$30,000 to $39,999	0%	2.33%	16%	0%	0%
$40,000 to $49,999	0%	11.63%	4%	16.67%	0%
$50,000 to $59,999	13.04%	23.26%	24%	0%	6.25%
$60,000 to $69,999	30.43%	18.6%	16%	50%	18.75%
$70,000 to $79,999	8.7%	18.6%	32%	16.67%	12.5%
$80,000 to $89,999	13.04%	11.63%	4%	16.67%	31.25%
$90,000 to $99,999	13.04%	4.65%	0%	0%	18.75%
$100,000 to $129,999	13.04%	9.3%	4%	0%	12.5%



to the hospital are usually very excited about our staffing ratios," says **Judy Milne**, director of integrated case management and quality improvement at Sarasota Memorial.

Those are two examples of how case management departments are rising to meet the challenge of recruiting and retaining staff as the nursing shortage grows more acute.

Case management departments across the country face difficulties in finding experienced staff, reports **Teresa Fugate**, RN, BBA, CPHQ, CCM, manager at Pershing Yoakley & Associates, a Knoxville, TN-based health care consulting firm.

The problem is compounded by the fact that hospitals are offering nurses who work the floor incentives such as shorter shifts, sign-on bonuses, and higher pay but don't offer the same benefits to case managers. Case managers put in long hours and now have to work weekends and possibly evenings to meet insurance company mandates, she adds.

Part of the reason for the differential is that hospital administrations on the whole have not understood the value that case management brings to the organization, Fugate adds.

That's why case managers need to start collecting the data they need to show the value of the program.

"Hospital administrators are financially focused, and case managers should be showing how they can affect the bottom line. Until case managers start collecting the data they can use to show the value of their services, the nursing shortage can hurt their programs," she says.

According to Marshall, when she started working at her position at Covenant two years ago, she immediately tackled retention and recruitment of case managers.

"At the time, salaries for case managers weren't what I expected them to be, nor did their responsibilities meet what needed to be met for that level of nursing practice," Marshall says.

She has required that her case managers be at an advanced practice level and become certified. When they meet those requirements, they get a significant pay increase, she adds.

Marshall got approval from the administration for increased pay for the case managers by showing the value that case management brings to the organization.

"We looked at length of stay and cost per case and were able to show that we got a low denial rate because of the case managers working closely with the utilization review staff," she says.

Because of the respect that case managers receive in the Covenant organization, staff nurses have been stepping forward and aspiring to be case managers, Marshall says.

The challenge is recruiting RN case managers who have experience in clinical case management and utilization review, Milne reports.

"We get a lot of applicants who have insurance case management experience but not hospital experience, and that is a different skill set," she adds.

Her hospital has created special pay incentives for bedside nurses since they are considered a critical need, a move that sometimes causes resentment among the case management staff.

"Nurse case managers don't have to deal with infectious diseases. We don't have to transport patients; we aren't as likely to have to work on weekends and nights; and we don't typically get tapped for overtime," she adds.

The case management department does have support from the hospital administration who realize the value the case managers bring to the hospital, she adds. For instance, the hospital has been ranked No. 1 in the country for Medicare efficiency, a rating largely due to the efforts of case management, she adds. ■

Salary by Title

Income	Case Manager	Director of Case Management	Utilization Manager
Less than $30,000	11.76%	0%	0%
$30,000 to $39,999	23.53%	0%	0%
$40,000 to $49,999	11.76%	3.13%	33.33%
$50,000 to $59,999	29.41%	10.94%	33.33%
$60,000 to $69,999	11.76%	26.56%	16.67%
$70,000 to $79,999	11.76%	21.88%	16.67%
$80,000 to $89,999	0%	20.31%	0%
$90,000 to $99,999	0%	7.81%	0%
$100,000 to $129,999	0%	9.38%	0%