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A Season for Gratefulness

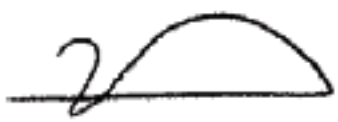
SINCE THE HOLIDAY season is upon us, and we begin to reflect on those things that are most important to us, let us remember to give thanks to those whose support and encouragement have helped us in our daily lives. At Thanksgiving, most gather with family and friends to commemorate a harvest festival dating back to the Pilgrims. But more than a day of turkey and football, this can be thought of as the beginning of a season of gratitude—a time when we reflect not on our future dreams and aspirations, but rather a time to be grateful for where we are and what we have, for the relationships we strive to maintain, and the freedoms which we all enjoy. I hope that this gratefulness can extend beyond a one day celebration to become a theme for the season.

First, as physicians, we need to remember all of the preparation required for entering the medical profession—the dedicated teachers and instructors during our schooling, the help we received from classmates as we studied for exams, our preceptors during clerkships, and certainly to the patients who were willing to spend the time to help us learn and hone our communication and physical diagnosis skills. Let us remember and thank our parents, siblings, spouses and children, who all have sacrificed something for our profession, whether it was financial support for our education or the time we might have spent with family and loved ones had we not pursued our mission to help those who needed our services. Let's not forget to be grateful for the dedicated staff in our offices who help us run our practices and help us stay focused on our task of caring for those in our community. And, this holiday season, let us acknowledge our colleagues on the healthcare team, including the nurses, nurse practitioners, and physician assistants, technicians, medical assistants, social workers, physical, occupational and speech therapists, phlebotomists and the many others involved in patient care.

Next, let us, as physicians, acknowledge and be grateful for our relationships with each other. We all have been guided, shaped and molded partly by the interactions we have had with colleagues and peers throughout our careers. We learn from each other, collaborate, and share ideas on how to best care for our patients. I am reminded of the adage I learned in residency, which said, "see one, do one, teach one," and think of my colleagues and the wisdom they have imparted upon me throughout the years.

Now, think of the collective strength we could have if we, as physicians, could speak with one voice on topics pertaining to the delivery of healthcare and the well-being of our patients. In order to achieve this, we all must recognize and convey the value of membership in the Chicago Medical Society and all of organized medicine. When our colleagues sit on the sidelines and don't join our organization, they are not simply abstaining from participation. Inaction negatively impacts our efforts and our advocacy. This is why your leadership is working on creative ways to attract and retain physicians who have not understood our mission or who don't see the value in speaking collectively for our profession. I welcome any ideas from you or your colleagues on making your membership in the Chicago Medical Society more valuable. I encourage you to speak often of our organization's value and relay the benefits of membership in organized medicine.

With the stress that is often associated with this time of year, I hope you can all find your true meaning of the holiday season. Demonstrate to those around you how grateful you are to have them in your life. A smile, a "thank-you" and a touch can help show them how you truly feel. And try to remember this when asked to mentor a student or resident, or contribute to your organization or medical staff or a committee at the CMS. Be grateful and be involved. May you have a meaningful holiday season. With gratitude.



Howard Axe, MD
President, Chicago Medical Society

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Get More Value from LinkedIn

10 easy tips **By Lonnie Hirsch and Stewart Gandolf, MBA**

LinkedIn is the premiere social media website for professional networking.

IF THERE'S ONE social media platform that medical doctors, hospital and healthcare executives should be using to showcase themselves, it's LinkedIn. LinkedIn is mainly for and about professionals and business networking. And as the trend toward hospital employment for doctors grows steadily upward—along with many other changes in healthcare delivery dynamics—LinkedIn is one online space to park your CV.

Most of what LinkedIn has to offer is free with a basic account. Some more aggressive users may want to upgrade to a Business, Business Plus or Executive account. The cost for the extra bells and whistles ranges from about $20 to $75 per month, which is reasonable, but only when you have a well-established "basic" account and are ready to move to the "power user" category. Paid ads are another option, but only for certain situations.

Think of LinkedIn as a dynamic process, and not a static page. The primary fuel of networking is in activity and interaction. And the single most important way to get more value and benefit from LinkedIn is in making regular changes.

This "secret" is no surprise. Like many other social media platforms, it is the connections and interactivity that propel the process of networking. The LinkedIn system recognizes when change occurs and often that triggers a notice to others. What's more, change is important to search engines and the algorithms of stronger search listings.

Call them updates or revisions—adding (or subtracting) content is what causes others to notice your pages. Here are ten tips to bring more activity to your profile and get more value from your LinkedIn pages. There's no cost involved, except for a bit of time.

1 **Refresh your descriptive Summary**. Likely you've done something new, attended a conference, been a presenter or earned an award. Add the new details, remove the dated ones, and occasionally rewrite the description to be relevant and timely.

2 **Update your photograph.** Use a photo that is less than a year old. Take a new photo if needed. Switch between a "business casual" photo and a formal pose from time to time.

3 **Add titles** to your Reading List. LinkedIn makes this easy to do, complete with book cover.

4 **Join LinkedIn Groups** or start your own. Consider LinkedIn's suggestions for Groups You May Like and/or search for other options.

5 **Integrate LinkedIn and Twitter.** List your Twitter account on your LinkedIn profile and use #in and #li to send tweets to your LinkedIn page.

6 **Rearrange the sections** of your profile. New on LinkedIn is the ability to present your profile sections in the order you choose. (Click on draggable handles and drop in your preferred order of presentation.)

7 **Make contact** or contribute comments. Add your note to the discussions of others. Better yet, begin a conversation. Send brief notes of thanks, congrats, etc.

8 **Recommend others** (and vice versa). LinkedIn notices the connectivity between and among individuals.

9 **Add connections.** You may not know it, but you likely have friends, colleagues and college alumni who are already LinkedIn members. (LinkedIn will tell you who is listed.) It's easy to check your list, make invitations or invite non-members to join in.

10 **Post your presentations.** LinkedIn and SlideShare work together. Include the PowerPoint or other visual materials from your most recent talk or professional presentation.

Lonnie Hirsch and Stewart Gandolf, MBA, are Founding Partners for Healthcare Success Strategies, a full-service healthcare marketing company. You can find them at www.healthcaresuccess.com.

Your Practice Management Colleagues

MEMBERSHIP in the Chicago Medical Society's Practice Manager Section is an excellent way to expand your professional networking horizons. Practice managers employed in the offices of CMS physician members enjoy a discounted dues rate of only $99 per year. The nonmember rate is $395. To download a membership application, please go to *www.cmsdocs.org* or call 312-670-2550.

How to Get the Most Out of a First Patient Visit

Six important things to do **By Susan Keane Baker**

A **FIRST PATIENT** visit is the best opportunity you ever have to develop a mutually rewarding relationship. Most patients arrive with high hopes for a positive experience. It's up to you to manage the first visit in a way that leaves your patient convinced that he or she made the right decision in choosing you.

Create some positive anticipation through advance contact. Send a letter that answers the questions patients want to know. "How do I get there? Is it difficult to find parking? Is there a charge for parking? Which entrance should I use? Is there a long wait? What happens while I am there?" Or you might call to confirm an appointment and make that call patient-focused by asking "Are there any questions I can answer for you now?"

Be glad to see your new patient. You, and everyone on your team, should know when someone is a first-time patient. Make the time to introduce the first time patient to others. Find out what his or her past experiences have been in healthcare settings.

Assess expectations. Ask "Can you tell me three things that are most important to you in your relationship with us?" Your patient will think about what she liked and disliked most in her previous relationship. It's the same phenomenon you experience when you hire a new employee. If the person who held the position before loved to gossip all day and took lots of personal phone calls, a desire to focus on work will be an important characteristic for you in evaluating job applicants. If the person who held the position before was chronically late, punctuality will rise right to the top of your "most desired characteristics" checklist. When you ask your patient about her top three expectations, it's likely that you will be able to satisfy two, if not three, of them. If you can't meet all three, it's an opportunity for you to manage her expectations. "I hope two out of three will work for you. I wish that we could provide prescription refills on the weekends, but our policy is that because physicians don't have access to your medical record when they take weekend call, they don't order refills then. However, we do routinely ask patients if they need any prescription refills when they are here."

Explain your rules and systems early. If you explain a rule before a patient violates it, that's education. If you explain a rule after a patient violates it, that's perceived as scolding.

Find something to like about your patient. Compliments must be sincere. Don't bother with admiring the patient's shoes unless you are truly interested. Notice pins. They are often added to attire because they hold special meaning. "Can you tell me about the pin you are wearing?" will convey that you are interested in your patient as a person. If you are a specialist, compliment the patient's choice of primary care practitioner. Compliment good health habits or lifestyle choices. "I wish more of my patients understood the importance of eating well."

Help patients remember what to do after the visit. Written or audiotaped instructions are essential, no matter how simple the information might be. Consider providing a checklist of items that the patient is to follow through. You help your patient be successful by providing the information he or she needs to take the next step. "Schedule mammogram 504-555-3300, ext. 2453" Leave space for appointment dates, and patient notes.

The impressions that patients form during their first encounter are long lasting. How do you want them to feel about you and your organization? With a little bit of planning, you can create the experience that will accomplish your goal.

Reprinted with permission of the author, Susan Keane Baker. Source: www.susanbaker.com.

"Written or audiotaped instructions are essential, no matter how simple the information might be."

"My doctor told me to stop having intimate dinners for four. Unless there are three other people."

–ORSON WELLES

Usability and Electronic Health Records

The importance of effective technology **By Enid Montague, PhD, and Abel Kho, MD**

UNDER the Health Information Technology for Economic and Clinical Health Act of the 2009 American Recovery and Reinvestment Act, the United States Department of Health and Human Services invested billions of dollars to expand the adoption of health information technology. The initiative has led to a widespread transformation of health care systems by promoting rapid adoption of electronic health records.

The goal of the HITECH Act was not limited to implementing EHRs—it extended to the concept of Meaningful Use, which is being released over three stages. Meaningful Use Stage 1 focuses on improved documentation, Stage 2 focuses on improved care processes, and Stage 3 will focus on improved outcomes. Increasingly, there is interest in understanding how to design systems that complement provider and patient needs and contribute to high-functioning healthcare systems. The Stage 2 Meaningful Use regulations address this for the first time by requiring that EHR vendors demonstrate how they have incorporated user needs (for example, usability) into the design of their products.

Practical Usability

What does this mean for physicians in Chicago? Usability is about making it easy for people to accomplish goals and do their jobs well while benefiting from technological advances that improve efficiency and effectiveness. After all, technology should make us smarter, faster and more capable. For example, a well-designed mobile phone calendar can help you schedule meetings efficiently and remind you of important deadlines. This tool can remember complex information like dates, times and locations far better than the average human brain, therefore freeing up mental energy for other tasks such as problem solving, empathy and creativity—activities technology doesn't do nearly as well as humans.

A tool designed with user needs in mind can increase productivity and satisfaction. However, a version of the same technology that does not include user needs can add time to a everyday activities and decrease productivity and satisfaction. If technology is not easy to use, people may find themselves working less effectively overall. Going back to the calendar example, imagine how frustrating it might be for a busy person to struggle to add dates and locations to a system that is poorly designed, requires too many steps, or shows you appointments that don't match the way you typically think about dates. If the calendar is very different from other calendars you're familiar with, you might get frustrated when you try to view dates and times. Poorly designed products can cause errors and are potentially unsafe. In practices, EHRs help physicians care for patients better. However, in some cases, these systems could benefit from usability studies so they can be updated to better assist physicians with their workflow.

Usability Research

Now you can see why usability research is so important. Healthcare is a complex system that involves many types of users, teams, needs, goals and environments and, of course, patients with equally diverse needs. Developing designs that work for everyone is not easy, and the lack of research on healthcare system user needs and capabilities poses a challenge to achieving optimal use.

To emphasize that point, the Agency for Health Care Research states, "Scant basic research has actually been conducted to better capture how clinical work (i.e., cognitive workflow, task distribution) is performed, who performs it (e.g., physician, nurse, therapists, administrative staff), and how it could be performed, with and without the support of health IT." Those working to increase this research are part of the discipline of human factors ergonomics engineering, which is concerned with understanding human, group and system needs, and capabilities and limitations.

Research initiatives are particularly important as lack of usability is cited as a significant barrier not only to the adoption of EHR systems, but to their effective use. To design better EHR systems, more research is needed about how physicians provide care while using new technologies. For example, human factors engineers are skilled at understanding thought processes and answering questions such as, "Exactly how many alerts can a person attend to reliably?" and, "Which aspects of a person's workflow can be automated, and which should remain under human control to avoid error?"' Designing while considering knowledge of human capabilities and work contributes to systems that are easier and more pleasant to use, and maximizes the potential benefits of EHRs. The important thing to think about is that technologies designed with user needs in mind help physicians focus their attention on the important goal of providing care.

Practically, understanding usability can help practices communicate needs to vendors and develop more effective EHRs, implementation and training programs. The result is more efficient, effective and safer use of EHR.

Participate in Testing

To prepare for the usability component of Meaningful Use Stage 2 and to learn about your HIT needs, you might consider participating in usability testing. This is particularly important for practices with diverse providers and patients or for those that have experienced decreased quality after implementation of an EHR. Formal usability testing can provide an individual or a practice with ideas to maximize use of EHRs and can improve HIT for the greater physician community.

As Chicago's federally funded resource for health IT assistance, the Chicago Health IT Regional Extension Center offers support for obtaining usability testing. We have the tools, testing facilities, and information on finding trained usability consultants to help you get started.

Contact Dr. Enid Montague at *enid.montague@northwestern.edu* or 312-503-6461 to receive information about usability, to learn about testing at your practice, or for a personalized consultation. For information on participating in one of our usability studies, visit *chitrec.org/research/usability-testing*.

Dr. Enid Montague is an assistant professor in the Division of General Internal Medicine and Geriatrics at Northwestern University and director of CHITREC's Research Initiative for Human Factors Research and Usability Testing. Dr. Kho is an internist and co-executive director of CHITREC.

Start with Your Staff

Look to your staff if you want to set a foundation for top-notch patient care **By Alina Baban**

PRACTICE managers constantly strive to provide ever-better care to patients by focusing on better patient communication and education. Still, keep in mind that every goal has a clearly defined foundation. Most managers err in making the patients the foundation of the practice. Yes, satisfied patients are the ultimate goal, but they are not the building blocks that will drive your practice to where you want it to be—your staff is. Here are three key elements to create a successful staff foundation:

1 Staff Morale. Only satisfied and happy staff members can take *excellent* care of patients. Standard patient care is expected and can be provided by any staff member. To stand out from the practice next door, your staff members must feel valued and understand the importance of their role. Remember to reward and thank staff members for the exceptional care they provide. A simple thank you note expressing your appreciation is important, and doesn't require much time.

2 Staff Development. Transition to a more structured training format. It's normal to feel too busy to train new staff members, and instead let them follow existing staff members around to learn their job. Take a look at other industries and note the amount of time and energy they spend on staff training. It doesn't make sense that the hotel or fast food industry spends more time training their staff members than we do in healthcare. What is the excuse for not providing as much training as the other industries? Overly busy schedules? Too busy focusing on patient care? Set aside the excuses and realize that staff development will lead to higher levels of competency, increased job proficiency, and overall better patient care.

3 Staff Accountability. Staff members are competent, well-intended, and responsible individuals, and should be held accountable for their actions. Accountability has to be measurable in order to be effective. Have each staff member list a couple of goals they want to attain, and ask them how you can help. Let your staff know they can hold you as well as each other accountable. As leaders, we are the example that drives the morale and development of the practice.

Once you realize that your foundation should be your staff, the goal of building a practice that delivers superb care becomes easy to attain. With staff morale, development, and accountability intact, you can build a strong and trusting foundation of staff that will drive your practice to the forefront of excellent patient care.

Alina Baban is chair of CMS' Practice Management Section.

Stroke in Native Americans

A new study shows a higher incidence rate in this population group

By Neelum T. Aggarwal, MD, and Shyam Prabhakaran, MD

"Current and past smokers had more than 2 times and 1.5 times higher risk of incidence stroke respectively compared to participants who had never smoked."

CEREBROVASCULAR disease and stroke are the leading causes of long term disability in the United States. More than 900,000 hospital admissions are attributed to stroke related illnesses and it ranks as the fourth leading cause of mortality with annual costs of care and treatment estimated to be $18.8 billion. Recent trends demonstrate decreasing death rates for Caucasians and African American patients who have a stroke; however relatively little is known regarding stroke incidence, risk factors and mortality among Native Americans.

The *Strong Heart Study* is a population-based study of cardiovascular disease and its risk factors in 13 Native American communities in southwestern Oklahoma, central Arizona, and North and South Dakota. The initial exam of over 4,500 participants occurred in 1989-1992, and in 2004, 306 participants suffered a first stroke at an average age 66.5 years. The incidence of stroke increased with older age in both men and women in all communities. Overall the 30-day case fatality from the first stroke was 18 percent with a one year case fatality rate of 32 percent.

Those participants with incident stroke were older, had higher systolic and diastolic blood pressures, fasting glucose, HbA1c and were less physically active at baseline compared to participants who remained stroke free. Hypertension, diabetes, microalbuminuria and macroalbuminuria were more common in persons at baseline who developed a subsequent stroke, and those with incident stroke were more likely at baseline to be past alcohol users. Persons with higher levels of blood pressure and HbA1c had higher incidence of stroke than those with normal levels and baseline LDL cholesterol levels were not significantly related to stroke incidence. Current and past smokers had more than 2 times and 1.5 times higher risk of incidence stroke respectively compared to participants who had never smoked.

The most common subtype of stroke was cerebral infarcts (86 percent); hemorrhagic stroke occurred in 14 percent of subjects. Intraparenchymal hemorrhages were more common in the youngest age group (45 to 54 years of age) with relatively few cases of subarachnoid hemorrhages noted. Among those Native Americans who had a first stroke, the percentage of subtypes of strokes were similar to that noted in other large studies such as the Framingham study, Cardiovascular Health study and Atherosclerosis Risk in Communities Study.

Although the risk factors that predict stroke appear to be similar between Native Americans and other populations, this study (which was comparable to other studies in Caucasian and African American populations) suggests that Native Americans have a higher overall stroke incidence rate than Caucasians or African Americans. Another important finding was that both the 30-day and 1 year case fatality rates after first stroke were higher in both Native American women and men as compared to the comparable national data for Caucasians and African Americans.

Further studies are needed to examine the differences in stroke incidence and risk factors among Native Americans. Understanding the potential mechanisms to explain differences in stroke should lead to the development of more efficient and effective stroke prevention strategies in this group.

Dr. Aggarwal is a cognitive neurologist at Rush University Medical Center, and the clinical core co-leader of the NIA-funded Rush Alzheimer's Disease Research Center. Dr. Prabhakaran is an associate professor at Northwestern University, Feinberg School of Medicine. His research focuses on acute ischemic stroke, transient ischemic attack, and intracranial stenosis.

Q&A

Q: In complying with HIPAA regulations, do I have to obtain my patient's authorization to use or disclose his or her protected health information to an interpreter?

A: When you use an interpreter to communicate with your patient, you do not have to obtain an authorization if one of these conditions is met:

- The interpreter is a member of the covered entity's workforce—for example, a bilingual employee.
- The interpreter is a business associate.
- The interpreter is the patient's family member, close friend, or any other person identified by the patient as his or her interpreter for that health care visit.

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A Citywide Effort

Public health efforts have led to a 47 percent reduction in HIV in Chicago

By Bechara Choucair, MD

ON DECEMBER 1, World AIDS Day, people from around the globe unite in the fight against the human immunodeficiency virus. An estimated 33.3 million people in the world are living with HIV. The U.S. Centers for Disease Control and Prevention estimates that 1.1 million people in the United States are currently living with HIV; in Chicago the epidemic has affected our families, disparate populations and our children.

Thirty-one years ago, in 1981, the first case of acquired immune deficiency syndrome was reported in Chicago. Since then, 37,617 cases of HIV and AIDS have been reported in the city. Today, 22,172 people in Chicago are living with HIV. However, an estimated 20 percent of people infected with HIV are unaware of their status, suggesting that more than 27,000 people might be living with HIV in our city.

Fortunately, HIV is preventable. Effective counseling and testing are essential components to a comprehensive HIV prevention strategy, which is why the Chicago Department of Public Health is focusing its efforts around prevention. At the CDPH, our goal, which is aligned with the National HIV/AIDS Strategy goal, is to reduce new HIV infections in Chicago by 25 percent by 2015.

"Thirty-one years ago, in 1981, the first case of acquired immune deficiency syndrome was reported in Chicago."

So far, we've had great success. Our HIV prevention efforts have led to a 47 percent reduction in the number of new HIV infections since 2000. This decline is due in part to collaborative efforts between the CDPH and many local and national community partners. As one unit, we are committed to preventing the spread of HIV by implementing a comprehensive system of prevention, care and support services.

For example, on World AIDS Day, the CDPH organizes a citywide STI/HIV prevention effort to distribute 20,000 free condoms to Chicagoans during their morning commute. This is also a year-long project that allows us to distribute 10 million free condoms a year through city clinics, community-based organizations, community health centers and local businesses such as nightclubs, barbershops and churches.

The project is aligned with the National HIV/AIDS Strategy, the U.S Department of Health and Human Services and CDC's Enhanced Comprehensive HIV Prevention. It also is part of the National Female Condom Coalition and a partner with the Chicago Female Condom Campaign to increase access and availability to female condoms.

All of these efforts are working together to reduce the burden of disease in our city, but there is still much work to be done. We are faced with the same challenges observed nationally, such as racial disparities and a younger population affected by HIV and other sexually transmitted infections. In Chicago, non-Hispanic Blacks have an AIDS case rate that is four times greater than that of non-Hispanic Whites, an HIV infection diagnosis rate three times higher than non-Hispanic Whites and an HIV infection prevalence rate twice that of non-Hispanic Whites.

Hispanics have a considerably lower prevalence rate than non-Hispanic Whites and non-Hispanic Blacks, and a slightly higher AIDS diagnosis rate than non-Hispanic Whites. Compared to the U.S. population overall, the HIV prevalence rate is higher in Chicago for all racial/ethnic groups but the magnitude of difference varies. Most notable, is the difference for non-Hispanic Whites who have a prevalence rate five times greater than the rest of the U.S. population.

Men who have sex with men continue to be disproportionately affected by the epidemic. In 2010, two out of every three diagnoses were among homosexual males. Also, we are now seeing considerable differences in HIV trends by age group. A younger population is more affected by HIV than ever before. In the last decade (2001-2010), the number of HIV infection diagnoses actually increased for ages 13-19 (30 percent) with only small declines for ages 20-29, while the older age groups all experienced declines of more than 45 percent. Adolescents and young adults up to age 29 represented 38 percent of HIV infections diagnosed in 2010 alone.

The mission of CDPH's Division of STI/HIV/AIDS Public Policy and Programs is to use the best public health practices for the prevention and treatment of HIV and sexually transmitted infections. By continuing to build partnerships in the community and effecting systems of change, the CDPH aims to eliminate the spread of HIV and its related illness and death.

To learn more about our prevention efforts and to stay informed about the status of HIV in Chicago, visit our website at *www.CityOfChicago.org/Health* or follow us on Twitter @*ChiPublicHealth* and Facebook at *www.facebook.com/ChicagoPublicHealth*. As always, I am happy to respond to any emails at *Choucair@cityofchicago.org*. I am also available on Twitter @*choucair*.

Dr. Choucair is commissioner of the Chicago Department of Public Health.

Fresh, Innovative and Tasty Menu Items

They're coming to a restaurant near you! **By James M. Galloway, MD, MPH**

CHICAGO IS often noted as one of the best food cities in the world. Unfortunately, dining out may contribute greatly to the U.S. obesity epidemic. Americans spend nearly half of their food budget on meals away from home, which can lead to diets higher in calories, sodium, saturated fat, and cholesterol.

In light of this, Building a Healthier Chicago has developed the F.I.T. (fresh, innovative and tasty) City Initiative to encourage restaurants to include healthy offerings—and to recognize those that do. The program is a collaboration among the Chicago Medical Society, Chicago Department of Public Health, the Office of the Regional Health Administrator of the U.S. Department of Health and Human Services and Institute of Medicine Chicago focused on making Chicago the healthiest city in the nation. Many restaurants are already taking a deeper look into their menu items, so the time is right for the initiative to have an impact.

F.I.T. City is working with some of Chicago's top chefs, including Pam Smith, an internationally known chef and nutritionist and the lead for Disney's Food and Wine Festival, to promote the initiative and generate efforts to support the health of Chicago. The group has put together a set of criteria that restaurants can adopt to ensure healthy menu items. The F.I.T. City designation is given if a restaurant meets the following criteria:

- A minimum of two menu items, other than salad, whose main ingredients are fresh, non-deep fried selections of fruits and vegetables.
- A minimum of two menu items, at least one of which is an entrée, whose main ingredients include whole-grain selections.
- No menu items with artificial trans fat.
- Only plant-based cooking oils, containing predominantly monounsaturated or polyunsaturated fats (including oils such as olive, canola, peanut, grape seed, rice bran, corn, sunflower or safflower) are used for frying entrées and side dishes.
- A non-deep fried fruit or vegetable is offered as an option for all meals that include french fries or chips.

The initiative also recommends that restaurants support local sustainable agriculture, meat, and seafood. F.I.T. is working with restaurants, chefs, culinary institutions and community groups to implement this important work. Visit *www.healthierchicago.org*. To learn more about F.I.T. City, or recommend a restaurant that may want to participate, contact Lesley Craig at *Lesley.Craig@hhs.gov*.

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The Medicare Recovery Audit Program

Top strategies to overcome a backdoor attempt to save the Medicare trust fund

By Leon Huddleston, MD, JD

EVERY YEAR the federal government struggles to obtain the revenue it needs to meet its funding obligations and priorities. In its October monthly budget review, the Congressional Budget Office projected that the federal budget deficit for fiscal year 2012 was $1.1 trillion and it will be nearly $900 billion in fiscal year 2013. This unsustainable trend makes true the adage: "If your outlays exceed your income, your upkeep will be your downfall." Congress has at long last attempted to heed this ominous declaration.

Congress passed—and several presidents signed—legislation that created an abundance of acronymically named federal programs designed to recoup money paid for legitimate and illegitimate medical claims. These programs include MACs, ZPICs, CERT and RACs. The list does not include programs conducted by the Department of Health and Human Services' Office of Inspector General. The OIG runs its programs through the Offices of Audit Services, Evaluation and Inspection, Investigations, and Counsel to the Inspector General. On June 8, 2010 President Obama announced that his administration would cut the improper payment rate in the Medicare Fee-for-Service program by half in 2012. The goal was to eliminate more than $20 billion in payment errors in 2012.

This article reviews the Recovery Audit Contractor program. The RAC program is broad in that it touches nearly every aspect of medical care and it is deep because of the methods the program uses to obtain data and determine improper payments. The Centers for Medicare and Medicaid Services has noted that the RAC program's goal is to eliminate improper payments and it has listed the recovery auditors on its website at www.cms.gov. This should give you the theoretical hope that the program's success will be its demise.

The CERT Program

CMS implemented its Comprehensive Error Rate Testing program in 2003 to measure the Medicare Fee-For-Service improper payment rate. The program monitors payment decisions made by claims processors. CERT considers any claim that was paid when it should have been denied or paid at another amount (including overpayments and underpayments) to be an improper payment. CERT evaluates a random sample of Medicare FFS claims to determine if they were paid properly under Medicare coverage, coding and billing rules.

CERT obtains a random sample of claims stratified by service selected from all claims submitted to processing contractors (for example, MACs). The sample is comprised of claims paid or denied. In 2011 CERT sampled 51,000 claims (less than the previous year due to increased efficiency). The improper payment rate calculated from the sample reflects all paid claims for the year. Because CERT uses random claim selection, reviewers cannot label a claim fraudulent.

Once the medical records are received, CERT medical professionals conduct a review. The team may include physicians, nurses and certified coders. Before reviewing the documentation, medical reviewers examine the Common Working File and the CMS eligibility system to (1) confirm that the patient is an eligible Medicare beneficiary; (2) ensure the claim was not a duplicate; and (3) verify that Medicare was the primary insurer. CERT must ensure compliance with Medicare statutes, regulations, billing instructions, NCD, LCDs, and coverage provisions in the CMS instructional manuals. The Social Security Act is the primary authority for all coverage provisions and policies.

Recovery auditors cannot use claims history information to make a payment determination—each claim must stand on its own. Recovery auditors may use the claims history for data mining and to detect duplication and overutilization of services. They perform two types of reviews: automated (also known as non-complex), which involve no documentation requests and complex, which requires the review of medical records. Recovery auditors may re-open a claim for good cause. Reasons may include high error rates or potential overutilization based on data analysis.

In *Palomar v. Sebellius,* a recovery auditor re-opened a claim that was more than a year old. Under Medicare regulations, a claim can be re-opened if it is less than one year old. If the claim is more than one year, but less than four years old the claim can be re-opened only for "good cause."

Palomar went through the administrative appeals process and an administrative law judge found that Palomar was overpaid, but that the recovery auditor did not show good cause to re-open the claim. The decision was overturned by the CMS administrator. The district court found for the HHS. The Ninth Circuit ruled that given the goals of the RAC program and the Secretary's regulation, the decision to re-open a claim is final and not appealable. The court stated further that the issue of good cause for re-opening a claim could not be raised after an audit's conclusion and the revision of a paid claim for medical services.

Once a claim has been re-opened CERT assigns error categories to each claim. They are labeled:

- No documentation
- Insufficient documentation
- Medical necessity
- Incorrect coding (different codes, billed service as unbundled)
- Other—unallowable service, etc.

CERT notifies the claims processing contractors about the improper payment. The contractors are only allowed to recover the actual overpayments. Projections made to the universe of claims by CERT cannot be the basis for recovering projected overpayments nationally.

The 2011 Medicare FFS improper payment rate was 8.6 percent or $28.8 billion. This is out of $336.4 billion paid in FY 2011. Most of the improper payments were in the form of Part A payments for acute inpatient hospital care. They tallied approximately $10 billion. A large portion of the 2011 improper payments (over 20 percent) were inpatient claims that were denied but would have been payable if billed in the outpatient setting. The RAC program focuses on essentially four claim types: Part A (acute inpatient services); Part A (excluding acute inpatient services); Part B (outpatient services); and Durable Medical Equipment, Prosthetics,

Orthotics, and Supplies. DMEPOS suppliers have the highest rate of improper payment rate at 61 percent though Part A claims have the highest dollar amount of improper payments at $15.1 billion.

RAC auditors have homed in on inpatient admissions because they represent the greatest cost to the Medicare Trust Fund. An inpatient is one who is admitted to a hospital for bed occupancy to receive inpatient hospital services for 24 hours or more. Medicare will cover an inpatient stay only if the hospital care is deemed medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient. Hospitals must meet all documentation requirements noted in the LCDs, NCDs, and issued by the processing contractors.

The issue is whether or not the patient is sick enough to require the intensity of the inpatient setting. Furthermore, CMS has determined that certain surgical procedures should be done in the inpatient setting. This means that many other procedures must be done in the outpatient setting. Even so, there are exceptions to the inpatient-only procedure rule. The physician's clinical judgment is considered as well.

RAC auditors have seized upon short inpatient stays because they tend to violate the inpatient admissions rules that services be provided in the proper setting. Statistics have shown that the frequency of claim errors is positively correlated with decreasing length of stay—the shorter the inpatient stay the more likely it is to be inappropriate. For instance, stays of one day or less had an improper payment rate of 34.4 percent, whereas, two day stays had an improper rate of 17.3 percent, and three-day stays had a rate of 11.8 percent. The concern is that providers may trend toward placing patients in 23-hour observation when those patients should, instead, be admitted as inpatients.

CMS has identified a number of services and settings that should be reconsidered. For instance, joint replacements without documentation indicating functional limitations and the exhaustion of conservative treatment have been denied. CMS has noted also that the placement of cardiac stents and cardiac pacemakers should be performed in outpatient settings unless there is a good medical reason for the patient to be admitted. In addition, all improper payments for cardiac pacemakers occurred because dual-chamber pacemakers were placed instead of single-chamber pacemakers. These factors underline the need for providers to consider Medicare coverage guidelines in addition to the best practices guidelines of their various societies and their own clinical judgment.

Inpatient care is not the only setting that the CMS is scrutinizing. Services provided in skilled nursing facilities are being denied primarily because of insufficient documentation to support the patient's stay. Patients should be admitted for nursing care and therapy services, not for custodial care. Home health services had an improper payment rate of 7 percent. As with the denial of care in nursing facilities, home health services are denied because of insufficient documentation and medical necessity errors. If home health agencies do not submit therapy notes, the physician certification of homebound status, and the Outcome and Assessment Information Set, their claim for services provided will be denied.

Those who provide DMEPOS items have suffered the greatest losses under the RAC program. More than 60 percent of their claims were denied by recovery auditors. Many DMEPOS providers fail to submit complete medical records and a physician signature, which may help to ensure payment. The documentation supplied by the DMEPOS supplier is not enough to warrant payment. Recovery auditors are questioning beneficiaries' need for oxygen and glucose monitoring supplies, nebulizer machines, power mobility devices (power wheelchairs) and, positive airway pressure devices.

CMS is now working to increase its pre-payment medial review by using enhanced analytics.

There are three demonstration programs designed to reduce improper payments:

1. Recovery Auditors Prepayment Review

Recovery auditors recovered $939.4 million in improperly paid claims in fiscal year 2011. The demonstration project will allow RACs to review claims before they are paid. This, of course, is more onerous than a post-payment audit because the provider never receives the payment that may later be disputed. Prepayment review will therefore affect hospitals' and physicians' cash flow, making it harder to maintain a healthy practice.

2. A/B Rebilling Demonstration

This demonstration is limited to a select number of hospitals that will be able to re-bill denied claims that would have been payable in outpatient settings. The stated purpose of this project is to allow reimbursement for medically necessary services, while protecting beneficiaries, encouraging proper inpatient admissions and reducing appeals. It appears that CMS recognizes that the denial of all reimbursement for medically necessary services could make the agency responsible for the denial of future services.

3. Power Mobility Devices Prior Authorization

A limited demonstration project is being established to determine if prior authorization for power mobility devices can reduce fraud and improper payments. Since this is not a random sampling (as with CERT) and a relatively small number of power mobility devices are received, the program may be used to detect fraud.

To offer further evidence of the depth of RAC audits, the recovery auditor for Region C has been authorized to inspect physician billing of office visits. This kind of scrutiny had not been allowed previously. The recovery auditor, Connolly Inc., will be authorized to review claims from Oct. 1, 2007 forward. CMS has taken this action because it is suspicious of physicians who bill the higher-level E&M code 99215, even though in May 2010 the OIG reported that fewer than 1,700 physicians consistently bill at this level out of 442,000 physicians who billed E&M codes. Physicians whose electronic medical record systems allow them to cut and paste or auto-fill the patient's record should be aware that HHS and the Department of Justice believe the systems can be used to up-code office visits and allow physicians to bill more than they should.

These concerning trends will lead to more audits that will have to be appealed.

Appeal of RAC Audits

The RAC audit appeals process is the same for the original Medicare program, which was fee for service. The process does not apply to Medicare Advantage (Part C) programs. Section 1869 of the Social Security Act and 42 C.F.R. Part 405 sub-part I outlines the appeal process for Medicare Part A and B claims.

There are five levels of appeal as listed below.

1. Redetermination by a CMS contractor

When a Medicare claim is denied, the redetermination is performed by contractor staffers who were not involved in making the initial claim determination. If the redetermination is unfavorable for the appellant, the appellant may request reconsideration.

2. Reconsideration

The reconsideration is performed by a Qualified Independent Contractor. The QIC will conduct an independent review of the CMS contractor's initial determination, including the redetermination, which may include a review of medical necessity by a panel of physicians or other qualified healthcare professionals. If the appellant once again fails to prevail, the appellant may appeal the QIC's decision to an administrative law judge within 60 days of the reconsideration.

3. Adminstrative Law Judge Hearing

If at least $130.00 remains in controversy after the QIC's decision, the appellant may request an ALJ hearing within 60 days after the QIC's decision. The minimal amount in controversy changes annually based on the percentage increase in the medical care component of the Consumer Price Index.

4. Appeals Council Review

If the ALJ's ruling has failed to satisfy both parties, the matter may be brought before the Appeals Council for review. CMS or one of the contractors may refer a case to the Council if they believe that the ALJ's decision contains an error of law that is material to the outcome of the claim or if the outcome presents a broad policy or procedural issue that may affect the public interest. CMS may request the Council to review on its own motion if CMS participated in the ALJ proceedings, and if in its view the ALJ's decision was not based on the preponderance of evidence or the ALJ abused his or her discretion.

No minimum monetary amount is necessary for a review to occur. The request for a review, however, must be submitted in writing within 60 days of the ALJ's ruling. The Appeals Council's decision should be expected within 90 days thereafter and it qualifies as the final decision of the Secretary for judicial review purposes.

5. Judicial Review in U.S. District Court

If at least $1,350 remains in controversy after the Appeals Council's decision, the dissatisfied party may request a judicial review in federal district court. This must be done within 60 days after receipt of the Council's decision. The amount in controversy required for a judicial review is increased annually based on the increase in the medical care component of the Consumer Price Index for all urban consumers.

Recommendations for Mounting a Defense

The good news in all of this is that physicians and hospitals win almost half of the recovery audit appeals. According to an analysis by CMS for fiscal year 2010 physicians and hospitals appealed 5 percent of their cases and 46 percent of those cases were overturned in favor of the providers.

The starting point for a RAC defense is to first determine if the overpayment claim is appropriate. If the answer is yes, the provider should learn from its mistake and probably forgo an appeal. If the answer is no, the provider must weight the risk against the benefit of pursing an appeal. The provider should considering the following:

1. Was the claim coded properly?

Recovery auditors have successfully obtained repayment from providers because of coding errors such as the following:

- Incorrect code
- Unbundling
- Incorrect discharge status
- Non-covered, non-allowed services
- Multiple error code values
- Incorrect number of units

Providers can successfully defend recovery audits if they abide by CMS billing guidelines.

2. Was the care medically necessary?

RACs have focused on the correct setting of care and whether or not a procedure was necessary at all. If a procedure was necessary, but performed in the wrong care setting, the claim will be denied. Treating physicians should be involved in the defense of those claims with which they are associated.

Attorneys who want to mount a successful RAC appeal should look to the Medicare Appeals Council rulings for guidance on developing a strategy.

King's Daughter Medical Center (Appellant) v. RAC Auditor CGI Federal, Inc.

One issue in this hearing was CMS' contention that the ALJ's unfavorable decision contained errors of law and was not consistent with the preponderance of evidence. In particular, CMS alleged that the ALJ gave presumptive weight to the treating physician's medical opinion contrary to CMS policy. The appellant provided medical services for a beneficiary over a 24-hour period that immediately followed a left heart catheterization and angioplasty and stenting of a right coronary artery. Prior to then, the patient had complained of chest pain and received a diagnosis of unstable angina. A RAC audit determined that the services were not covered because the medical record did not establish the need for acute care hospitalization at the inpatient level.

On review of the medical record, the ALJ noted that the patient had a history of diabetes, hypertension, COPD, and chest pain. In addition, the medical record documented the patient's current crescendo angina/unstable angina, severe peripheral vascular disease resulting in the insertion of two stents in the femoral artery and CT of the thorax. The ALJ determined, based on multiple medical factors, that the inpatient hospitalization subsequent to the surgery was medically necessary.

CMS homed in on the ALJ's statement "based on the overall record, the undersigned gives *greater weight* to the position of the admitting physician and finds the inpatient admission of the Beneficiary was medically appropriate...." The Appeals Council held that the ALJ did not afford presumptive weight to the admitting physician's opinion but afforded his opinion greater weight based on the ALJ's consideration of the entire record. Attorneys defending a recovery audit may be able to assert that the ALJ should give greater weight to the admitting physician's medical opinion if the record does not present any evidence of a violation of CMS policy.

Indiana University Health Methodist Hospital v.

National Government Services

This hearing involved the Appeals Council's decision to overturn an ALJ's determination that the provider was liable for non-covered services and not without fault for the overpayment under section 1980 of the Social Security Act. The appellant billed Medicare for services rendered to a beneficiary after he was admitted for acute renal failure, dehydration, and viral gastroenteritits. More than one year after the services were rendered, the recovery auditor denied the claim, stating that the patient could have been treated in an outpatient setting. The denial was upheld on redetermination and by the QIC. The ALJ affirmed the lower determinations.

The Appeals Council performed its review. It noted that there are no binding statutes, regulations, or NCDs that establish criteria for coverage and payment of inpatient services; however, the Council affirmed the ALJ's ruling that the beneficiary's care could have been provided in the outpatient setting. The Council overturned the ALJ's ruling that the appellant was liable for the cost of the care. The Council reasoned that the medical care provided was necessary and appropriate; therefore, the services furnished to the beneficiary qualified for Medicare coverage under Part B as outpatient services. The Council relied on the Medicare Benefit Policy Manual for its decision. The Council's ruling and its reference to the Manual should provide attorneys with strong arguments during their appeal.

Challenging CMS

Some entities have now gathered together to challenge CMS' refusal to abide by its own policies.

The American Hospital Association in concert with several medical centers have filed suit against HHS Secretary Kathleen Sebelius, alleging the Medicare program has refused to pay hospitals for hundreds of millions of dollars worth of care even though all parties agree that the treatment was reasonable and necessary as the Medicare Act requires. The AHA has put forth several arguments. It asserts that CMS violates it policies when it does not pay hospitals for the care they provide because CMS acknowledges that services not paid under Medicare Part A must be paid under Part B. The AHA maintains that CMS Payment Denial Policy should be set aside on the grounds that it is contrary to federal law, arbitrary and capricious and invalid for failure to undergo notice and comment. Furthermore, the AHA requests that CMS be required to repay hospitals for reasonable and necessary services whether they were inpatient or outpatient.

Creating Protective Protocols

Physicians should develop a process to help ensure that they do not provide services that may not be reimbursed because they are not deemed reasonable and necessary. For example, at Provena St. Joseph Center for Wound Care and Hyperbaric Medicine in Joliet, we have developed a protocol over the past two years based on Medicare LCDs and NCDs. Our clinic offers a range of state-of-the-art treatments for patients with diabetic wounds, including hyperbaric oxygen therapy and the placement of bioengineered skin substitutes. These treatments are effective, but expensive. Medicare LCDs and NCDs lay out the diagnoses that qualify for these services. Because these are not emergency treatments, we are able to ensure that the proper pre-treatment testing and documentation is done before proceeding. If the patient does not qualify for treatment based on Medicare guidelines, we do not provide the treatment. This simple process has helped ensure we will not suffer any loss if we are audited. However, this approach is unlikely to work for those physicians who have urgent or emergent decisions to make.

Recommendations for Physicians

The recovery audit program is a permanent part of the regulatory scheme. The stated goal of the program is to eliminate improper payments. Currently, the program is not designed to detect fraud. Medical necessity is at the core of the program and usually concerns the setting of care. Physicians must decide if they wish to appeal a recovery audit. They should consider the expense versus the reward. Physicians and hospitals have had moderate success in winning recovery audits on appeal. Attorneys and those involved in the appeals process should look to the Medicare Appeals Council's rulings to develop a defense strategy. And if physicians appeal a greater percentage of their cases, they may chasten the recovery auditors into denying only the most egregious claims.

Dr. Leon Huddleston is the medical director of the Provena St. Joseph Center for Wound Care and Hyperbaric Medicine in Joliet. He also holds a faculty appointment at Rush University Medical Center and is an attending physician at Advocate South Suburban Hospital. In addition, Dr. Huddleston is a 2012 Graduate of Depaul University College of Law.

Legislative Mandate

THE MEDICARE Fee-For-Service improper payment rate was first measured in 1996. After the Office of Inspector General estimated the improper payment rate from 1996 through 2002, Congress passed the Improper Payments Information Act in 2002. The primary objective of the Act was to enhance the accuracy and integrity of federal programs by requiring executive branch agency heads to review their programs annually to identify those that may be susceptible to significant improper payments. The Secretary of Health and Human Services, through the Centers for Medicare and Medicaid Services, identified the Medicare FFS program as at risk for significant improper payments.

In 2010, Congress amended the Act when it passed the Improper Payments Elimination and Recovery Act, which shifted its focus from simply obtaining information about overpayments to recovering those overpayments and eliminating them if possible. To address improper payment issues, CMS developed the Comprehensive Error Rate Testing program to define the improper payment rate.