Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

AHC Media LLC

IN THIS ISSUE

■ PSOs expected to boost patient safety: AHRQ releases list of first 15 PSOs. . . . . cover

■ Ambulatory surgery LOS reduced by Six Sigma 4

■ *C. Difficile:* A bigger problem than we thought 5

■ Endoscopy center recognized for improving reporting of test results 6

■ Constant analysis improves clinical documentation at DCH Health System 7

■ Home visits work for behavioral health patients 8

■ Pre-admission prediction tool improves process 9

■ New discharge form keeps satisfaction high 10

■ CMS shifts claim reviews from QIOs to MACs, FIs 11

JANUARY 2009
VOL. 16, NO. 1 • (pages 1-12)

Experts say PSOs will improve patient safety in U.S. hospitals

By assuring privacy, more data on errors likely to be collected

Experts in quality improvement say that the recent listing of the first 15 patient safety organizations (PSOs) under the Patient Safety and Quality Improvement Act of 2005 will help hospitals across the United States improve patient safety by enabling the establishment of a huge database on errors and what causes them.

Although several of the organizations have been in operation for a number of years, they tell *Healthcare Benchmarks and Quality Improvement* that the voluntary sharing of data by hospitals in their area has not been as widespread as they had hoped due to fears that the data would not be kept confidential. The Agency for Healthcare Research and Quality (AHRQ), which administers the Patient Safety and Quality Improvement Act, assures on its web site that the data collection activities under the act will provide "both privilege and confidentiality."

The new PSOs are:

- California Hospital Patient Safety Organization, part of the California Hospital Association and California Association of Hospitals and Health Systems;
- Clarity PSO;
- ECRI Institute PSO;
- Florida Patient Safety Corp.;
- Health Watch Inc.;
- Human Performance Technology Group;

Key Points

- Data collected by PSOs will not be discoverable by attorneys.
- Shared information about errors and causes expected to aid prevention.
- Many organizations will build upon proven patient safety strategies.

- Institute for Safe Medication Practices;
- Missouri Center for Patient Safety;
- ORQA LLC;
- Peminic Inc.;
- Quantros Patient Safety Center;
- Sprixx;
- Texas Patient Safety Organization Inc.;
- the Patient Safety Group LLC;
- the University Healthsystem Consortium (UHC).

What is a PSO?

William B Munier, MD, AHRQ's director, Center for Quality Improvement and Patient Safety, explains what a PSO is and what qualifies an organization to become a PSO. "The Patient Safety Act permits any entity — an entire organization or a component of an organization, a public or private entity, a for-profit or not-for-profit entity — to seek listing as a PSO," he says. "There is an exception, however, which is that a health insurer, or component of a health insurer, may not be a PSO."

While the organizations that seek listing as PSOs may "look" different, he continues, all PSOs will share a common goal of improving the safety and quality of health care delivery. "By providing both privilege and confidentiality, PSOs create a secure environment where clinicians and health care organizations can collect, aggregate, and analyze data that enable the identification and reduction of the risks and hazards associated with patient care," he says.

PSOs are designed to improve the quality and safety of U.S. health care by encouraging clinicians and health care organizations to report and voluntarily share data on patient safety events without fear of legal discovery, Munier explains. "PSOs are intended to help remove the barriers — the fear of legal liability or sanctions — that clinicians and health care organizations currently face related to patient safety event reporting and quality improvement," he says.

"PSOs will be a source of confidential and privileged external advice for health care providers seeking to understand and minimize the risks and hazards in delivering patient care. Furthermore, PSOs serve as a mechanism for aggregating sufficient numbers of patient safety events so that the underlying causes of patient harm and poor quality can more quickly be identified and addressed and lessons learned can be shared broadly."

Past may be prologue

Since many of these organizations have already been working with hospitals to improve patient safety, a closer look at a few of them can provide some insight into the benefits other hospitals could reap if they chose to participate in the program.

For example, the University Healthsystem Consortium, or UHC, in Oakbrook, IL, has created the UHC Patient Safety Net, a web-based, real-time patient safety event reporting tool, which is already in use in 68 academic medical centers and their affiliated community hospitals.

Healthcare Benchmarks and Quality Improvement (ISSN# 1541-1052) is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices. USPS# 0012-967.

POSTMASTER: Send address changes to ***Healthcare Benchmarks and Quality Improvement***, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421. Fax: (800) 284-3291. E-mail: customerservice@ahcmedia.com. Hours of operation: 8:30-6 Monday-Thursday, 8:30-4:30 Friday, EST.

Subscription rates: U.S.A., one year (12 issues), $549. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $92 each. (GST registration number R128870672.)

Editor: **Steve Lewis**, (770) 442-9805, (steve@wordmaninc.com).
Editorial Group Head: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcmedia.com).
Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@ahcmedia.com).

Editorial Questions

For questions or comments, call **Steve Lewis** at (770) 442-9805.

"It allows organizations to enter information on events," says **Wanda Clevenger**, RN, BSN, MBA, director of the UHC Patient Safety Net. "What makes it unique is that it has two levels of users. One is the 'anonymous' level, available to any employee of a hospital or health center using it; they do not need a login or a password. Then, there is the authenticated user."

Both can enter an event, she explains, but an authenticated user is a manager who also reviews and comments on the event, noting contributing factors and systems issues surrounding the situation.

Another unique aspect of the consortium, says Clevenger, is that all participating organizations have agreed to use common taxonomy. "This gives us the ability to compare data," she says. "This is something the PSO will be doing so we can compare 'apples to apples.'"

The tool can be used in a number of ways. For example, says Clevenger, she might get a call from a quality manager to look at issues involving radiology contrast problems. "We'd pull all the events in aggregate, look at contributing factors, best practices, and prepare a study," she explains. "This helps member organizations understand how these events happen, then look at their own policies and procedures and perhaps make changes.

"We found that with each study done we incorporated the information into the tool going forward," Clevenger continues. "Then, participants may ask additional questions. So, in the example of radiology extravasation (when dye is injected outside the vein), we could help them look for what impacts such errors — how long the IV had been in place, did they use a pump when injecting the dye, and so forth. When we have a larger database, we will be able to determine the most common reasons for those errors."

Which is not to say that UHC hasn't already gotten to the bottom of some vexing issues; for example, notes Clevenger, there is an event category the organization calls "delay in treatment."

"Participants had identified a high rate of delays in radiology," she notes. "When we looked at what happened, the staff thought the papers were all being faxed to the radiology department, but the organization did not have a preset phone number. They were being mis-faxed, and radiology never received them. So they have now preset all clinical areas to the radiology department — kind of like a speed dial — and things are no longer getting lost."

UHC currently is reviewing events involving epidural IV mix-ups, says Clevenger. "When we collected information, we ask the frontline reporter what happened and for recommendations around improvement," she notes. "We found in a number of events that it would be helpful if the epidural lines had different connectors." UHC, she adds, is currently investigating connector options.

In 2009, says Clevenger, UHC will be using its aggregate data to examine organization culture of safety, national safety initiatives, anti-coagulation, and fall prevention.

Clevenger believes the PSO designation will encourage even more facilities to participate. "One of the reasons why organizations were hesitant to join is *because* we always had this philosophy of sharing the data," she explains. "This PSO designation will give those organizations more of a comfort level because their information will be protected; it will not be discoverable by an attorney."

'Excited' about status

Becky Miller, MHA, CPHQ, FACHE, executive director of the Missouri Center for Patient Safety in Jefferson City, says she is "excited" to be a PSO because "we did not have any protection. Therefore, we've not been able to answer questions about what errors happened and why."

The organization has been active in patient safety in other areas, however. For example, says Miller, "We sponsored a project called 'Banding Together for Patient Safety' that helped hospitals in the state standardize the use of colored wristbands [to indicate certain patient conditions, such as DNR status]. We also got some grant funding for a statewide collaborative on a just culture. And we've been holding annual conferences that have been well attended, and serve as a resource on patient safety."

Going forward, however, she expects to be able to "really work with hospitals to identify what errors need to be reported, what is most meaningful to them, and to have the data and information about what errors happened, what caused them, and how we can work together to provide a prevention strategy. Until we got the ability to start collecting it, we have not had the data to support which direction we need to go in."

Looking ahead, Miller says, "I can envision us actually using some of the work groups we already have in place, which include representa-

tives from hospitals across the states, to focus on what we can learn about our most prevalent errors, then bring experts to the table, help us drill down to the cause then, and do a clinical collaborative on what we've learned, and develop educational programs around those issues."

A 'lifesaver' for organization

For the Florida Patient Safety Corp. in Tallahassee, its PSO designation may actually be the key to its survival. Founded in 2004 by the Florida legislature, it lost its state funding about two years ago. Now, with its new designation, it is seeking private support by asking participating facilities and physician practices to pay membership fees.

As of this writing, the organization was planning to launch its marketing campaign at the beginning of 2009, according to **Susan Moore**, CEO. "We will market not just to hospitals, but to surgicenters and large physician practices," she says. "They will pay for a product. We will be selling a product and will be putting out reports like we did before."

In the early years, she explains, the organization was able to collect data and created a near-miss recording system. "We put out several reports, but we had to stop doing it because we faced a huge budget crunch," she says.

[For more information, contact:
***Wanda Clevenger**, RN, BSN, MBA, Director, UHC Patient Safety Net, Oakbrook, IL. Phone: (630) 954-2808.*
***Becky Miller**, MHA, CPHQ, FACHE, Executive Director, Missouri Center for Patient Safety, 2422 Hyde Park Road, Suite B, Jefferson City, MO 65109. Phone: (573) 636-1014, ext. 225. Fax: (573) 636-8608. Toll-free: (888) 935-8272. Email: bmiller@mocps.org.*
***Susan Moore**, CEO, Florida Patient Safety Corp., 2722 Waterford Glen Court, Tallahassee, FL 32312. Phone: (850) 893-8936. Fax: (850) 893-4259.]* ■

Hospital cuts 30 minutes off ambulatory surgery LOS

Two different units participate in the initiative

The ambulatory surgery department in Glen Cove Hospital, part of the North Shore-Long Island Jewish Health System, has achieved its goal of reducing recovery length of stay from 190 minutes to 160 minutes with the implementation of a Six Sigma initiative and its attendant recommendations. The two-phase project targeted both the post-anesthesia care unit and the ambulatory surgery unit.

Key Points

- A number of factors examined to determine impact on length of stay.
- Six Sigma team conducts literature search, benchmarks best practices at other facilities.
- Scoring system created to see if patients are ready for discharge.

"We looked at a number of factors, including type of anesthesia, types of surgery, day of the week the surgery was performed, family availability, and transporter availability, as well as seeing if block booking [doctors tending to book most of their surgeries at a specific time of day] made a difference," says **Kathy Albert**, RN, MSN, a Six Sigma Black Belt. "We saw that most of the variation was coming from whether the family was available (to take the patient home) or not, whether or not patient needed to void prior to being discharged, and also the discharge criteria."

Preparing for the initiative

The first steps the Six Sigma team took, Albert recalls, involved looking at four other hospitals to benchmark what they were doing. "We wanted to see what their systems were — if they used beepers (to alert family members), had ride criteria, had criteria on fluids before discharge, and if they had a dedicated discharge nurse to get the patient prepared for discharge and evaluated," she explains.

They also conducted a literature search for evidence-based improvement plans, and discovered two important articles about post-op patients' ability to tolerate oral fluids and the necessity of voiding — or lack thereof. "We found it was *not* necessary to tolerate oral fluids, and also found that voiding was only necessary if the patient received a certain type of anesthesia and also if they had undergone certain types of surgery," Albert says.

Creating scoring system

The program was initiated on Aug. 21, 2006, with changes continuing to be implemented throughout 2007. "We implemented a post-anes-

thesia discharge scoring system that allowed us to determine if a patient was ready to be discharged," says Albert. "It scored a patient on their activity level, vital signs, nausea and vomiting, and pain and bleeding." The three-point system gives a patient a score of 0, 1, or 2, with 2 being the best score. The team also created the position of dedicated discharge nurse, which did not require an additional FTE. "We also assured that a ride would be available at the time of discharge," Albert says.

As with all new initiatives, there were doubts and questions from the staff. However, says Albert, "One ambulatory surgery nurse really stuck with them. She made sure the patients got moved when they should have been. In the past, patients would just hang out and nap after surgery, but she did not allow that to continue."

[For additional information contact:
***Kathy Albert**, RN, MSN, Six Sigma Black Belt, North Shore-Long Island Jewish Health System. Phone: (516) 396-6044.]* ■

Study: *C. Difficile* is very common in U.S. hospitals

Earlier research underestimated number of infections

A study initiated by the Association for Professionals in Infection Control and Epidemiology (APIC), has shown that 13 of every 1,000 inpatients surveyed were either infected or colonized with *Clostridium difficile (C. difficile),* an infection associated with severe diarrhea, colitis, toxic megacolon, sepsis, and death. According to APIC, this rate is 6.5-20 times higher than previous incidence estimates, which had looked at only one hospital or hospitals in one state, and it used different methodologies.

The APIC study was led by **William Jarvis**, MD, president of the epidemiology and infectious disease firm Jason and Jarvis Associates. Jarvis, formerly with the Centers for Disease Control and Prevention (CDC), oversaw a project that asked infection preventionists (primarily APIC's 12,000+ U.S. members) to collect data about all patients in their facilities who were identified with *C. difficile* on one day in May-August 2008. In all, 648 facilities of varying sizes were involved, located in 47 states.

"Most previous studies, including one I did at the CDC, did not even have hospital-wide data available," notes Jarvis. "It showed the infection rate increasing, but it was very slanted. Since that time, there have been two other analyses, but usually with very shallow data. With those little slices of all U.S. hospitals, they extrapolated to national numbers."

The advantage of this survey, he says, is that it represents "a slice of bread, not the whole loaf," which allowed for the collection of much more detailed information, including what kind of hospital was involved; how big it was; surveillance practices; antibiotic protocols; and so forth. "There was a lot of information generated including patient age, outcomes, what they were exposed to, if they required surgery, and so on," Jarvis adds.

"This gave us a snapshot in time, and indicates the prevalence was much higher than the other studies showed," he adds.

Key Points

- Most high-risk patients are over 60 years of age, with multiple admissions and recent antibiotic use.
- Pre-emptive isolation of all patients with diarrhea is recommended.
- Alcohol gel is ineffective against spore form of *C. difficile;* soap and water help, but only bleach will kill it.

A wake-up call

Jarvis says he hopes these findings will be a wake-up call to QI personnel that we need to put the necessary resources in place to help reduce the rate of infection. "The way to control it is to identify who the high-risk patients are," he says. For example, the study found that people at highest risk were the elderly (over 60 years age). In fact, he says, "69.2% were over 60, and the rate of infection increased as they went up in age." The high-risk patients also had a history of repeat hospital admissions, and more than 80% had received antibiotics within eight days.

"That population is increasing, so we think the prevalence we detected is a *minimum*," Jarvis adds. (Since the immunoassay test used is 73% reliable, he points out, 25% of the cases could have been missed.)

Jarvis recommends that hospitals put in place a

surveillance program that detects any patient who comes in with or develops diarrhea, and puts them in isolation preemptively. "If they are not in isolation, others are at risk," he explains. He further recommends that all health care workers wear gowns and gloves when they treat these patients, and that they use good hand hygiene.

There are two different forms of *C. difficile,* Jarvis says: vegetative and spore. "The spore form is very hard to kill," he warns. "The alcohol gel doesn't kill it. Neither will soap and water, but it will get it off your hands." Only bleach actually kills the spores, he adds, so rooms, equipment, and so forth must be cleaned with bleach.

A major driver of *C. difficile,* he adds, is antibiotic resistance. In particular, drugs like cephalosporin, fluoquinolone, clindamycin, and macromycins have been connected to the disease, and all are used widely in hospitals.

All of these factors must be taken into account, Jarvis advises. "Make sure your people understand how important their role is as part of the infection control team," he says. "Your next patient may be at risk."

[For more information, contact:
***Association for Professionals in Infection Control and Epidemiology**, 1275 K St., NW, Suite 1000, Washington, DC 20005-4006. Phone: (202) 789-1890. Fax: (202) 789-1899. E-mail: apicinfo@apic.org.*
***William Jarvis**, MD, President, Jason Jarvis and Associates. Phone: (404) 512-4777. E-mail: WRJMJ@aol.com.]* ■

Endoscopy center improves reporting of test results

The Endoscopy Center of Colorado Springs (CO) has won a national award for its improved system of reporting and explaining pathology results to patients.

The program is a winner of a 2008 Innovations in Quality Improvement Award presented by the Institute for Quality Improvement at the Accreditation Association for Ambulatory Health Care (AAAHC).

The goals of the program are to reduce the number of patients who don't receive their test results or don't follow up for needed tests or procedures, as well as to make pathology reports understandable and meaningful for patients. "Our old reporting system relied on phone calls to patients," said **Monica Clayton**, CGRN, director of the center. "Often, when a message was left, the patient did not return the call, and there was no system to guarantee that all patients received their results and recommendations for follow-up."

Key Points

- Endoscopy Center of Colorado Springs wins 2008 Innovations in Quality Improvement Award for its pathology reporting project.
- One year from implementing new system, 100% of patients surveyed received their pathology reports, were well informed of the results, and knew recommended follow-up dates.
- Five steps for better handling of test results.

Survey shows improvement

Before they implemented the new system, 23% of their patients did not receive their pathology results. Of these, only 40% understood the results, and only 25% remembered when they were due for a follow-up visit. "One year following implementation of our new reporting system, the last survey of 30 patients included in our study found that 100% of them received their pathology reports, were well informed of the results, and knew their recommended follow-up dates," Clayton said.

Mismanaging patient test results "is a subtle but common error in medical care," she said. "When the results of diagnostic tests are allowed to fall through the cracks, harmful delays in treatment or diagnosis can occur."

5 steps to better handling of test results

The new system developed by the endoscopy center includes these steps:

• Cross-referencing a daily pathology list and the specimen log book to ensure that both lists are 100% accurate. The daily pathology list then is used by the office to confirm that all pathology reports have been received.

• Development of a letter that reports pathology results and recommends appropriate follow-up for physicians to fill out and mail to their patients.

• Development of consumer-friendly language for physicians to use when filling out letters to patients.

• Coordination with office staff to ensure that letters are sent to all patients on the pathology list and that a copy of the letter is sent to each patient's referring physician.

• Referencing the specimen log to confirm that the endoscopy center has received the pathology results and patient letter and that all results are placed on the patient's chart. ■

Constant analysis helps improvement team succeed

Nurses, coders work together to assure accuracy

At DCH Health System, the clinical documentation improvement team takes a proactive approach to changes in the Centers for Medicare & Medicaid Services (CMS) documentation requirements.

For instance, as soon as the current MS-DRG system was proposed, the team began educating the physicians on complete and accurate documentation for congestive heart failure months before CMS began requiring specific documentation for the condition to be documented as a complication/comorbidity (CC) or major complication/comorbidity (MCC).

"It takes a good three to four months for physicians to routinely start following the new documentation requirements," says **Robin Holmes,** RN, MSN, manager of clinical documentation improvement at DCH Regional Medical Center and DCH Northport Medical Center in Tuscaloosa, AL.

The team started learning the APR-DRG system in 2006 when CMS proposed switching the DRG reimbursement system to the APR-DRG system developed by 3M.

Now, in addition to using the MS-DRG system for coding, the hospital's clinical documentation improvement department tracks the hospital data using the APR-DRG system to get an idea of how the physicians and the hospital system will stand up to national benchmarks, Holmes says.

The all-patient refined DRG (APR-DRG) system is more severity adjusted than the MS-DRG system, she adds.

"We know the APR-DRG severity level is close to the severity level used with public reporting. We can look at how we come out on the APR-DRGs and look for opportunities for improvement," she says.

The APR-DRG system ties severity of illness and risk of mortality to every DRG, she says.

Holmes works closely with the coding manager who prints out the hospital's case mix index every month and distributes it to everyone on the clinical documentation improvement team.

The clinical documentation specialists are all aware of the case mix index and, if it changes, they drill down to find out why.

"If it's up, it's usually because we had a high number of surgeries. If it's down, we look at whether the CC capture rate was down or it was due to another factor, such as fewer surgical procedures than usual," Holmes explains.

"We are always looking for opportunities to improve the quality of documentation and coding," she adds.

The team also tracks the hospital's symptom rate, or how many charts were coded with a symptom as the principal diagnosis.

"We don't want a chart to be documented with just a symptom and not a diagnosis. A lot of times, the physician knows what was wrong with the patient and just didn't document it," Holmes says.

The hospital system began its clinical documentation improvement program in 2002 when the performance improvement department targeted key DRGs for a pilot project to improve documentation.

The project was so successful that the hospital system decided to launch it in its two largest hospitals with dedicated staff who reviewed the charts of all Medicare patients for documentation integrity, Holmes says.

The clinical documentation specialists are nurses who go through a six-week training period developed by the hospital system and continuing education provided by the state quality improvement organization (QIO).

The clinical documentation specialists rotate weekly through the service lines in the hospital

Key Points

- "It takes a good three to four months for physicians to start following the new documenation requirements," says manager.
- Clinical documentation specialists are aware of the case mix index, and if it changes, they drill down to understand why.
- Clinical documentation specialists go through six-week training period.

and prefer the rotation because they can keep up their skills in all areas, Holmes says.

"We tried having them unit-based, but it works best if they can rotate. Because we offer weekend service, it's good for all the clinical documentation specialists to be familiar with documentation for all of the MS-DRGs. If someone is assigned to the cardiac unit and they have to review a neurological case on the weekend, it would be difficult," she says.

When the program started, the team began a post-discharge review initiative at the end of the month, after the bills had dropped. Each team member was assigned a particular DRG to review. He or she pulled all of the records and looked for opportunities to improve the documentation.

"Many coded charts have an educational opportunity for the clinical documentation improvement team, coders, and physicians," Holmes reports.

For instance, the team has targeted charts of patients with the diagnosis of chest pain. Here's one scenario: The physician does a cardiac workup that is negative and writes discharge instructions for lansoprazole and to follow up with a gastroenterologist. The patient has a history of gastroesophageal reflux disease.

"This is an opportunity to follow up with that physician and discuss with him that, if after study, he suspects or has determined the etiology of the chest pain, to please document this in the medical record. We can explain to the physicians how this might affect their physician profile and they are usually attentive," Holmes says.

By studying the charts, the team found items that were documented that the coder had missed and details that the clinical documentation specialists didn't get a chance to clarify while the patient still was in the hospital.

"We quickly recognized the need for a clinical review of coded charts prior to billing. As part of a team effort, the clinical documentation improvement specialists, corporate compliance, and medical records developed a system that would combine the clinical knowledge of the clinical documentation improvement team with the coders' knowledge of coding guidelines to assure that the charts are coded in a complete and compliant manner," Holmes says.

Currently, the team reviews the charts of all Medicare patients prior to billing.

"The clinical documentation specialists and coders work as a team to make sure we have an appropriate principal diagnosis and that every opportunity for accurate documentation has been satisfied," Holmes adds. ■

Home visits work for behavioral health patients

Care coordinators offer psychotherapy

When behavioral health patients who have been hospitalized receive interventions in their home, their compliance with treatment recommendations increases and hospital readmission drops, a study by PsycHealth Ltd.'s Home Intervention Program has found.

An analysis of 52 Medicaid managed care patients in the home intervention pilot project showed 100% participation and compliance with the treatment recommendations and an 86% drop in overall hospital readmission rates within six months compared to their hospital admissions six months before the program was instituted.

Participants in the study had a history of two or more hospitalizations within the six months prior to enrollment and were noncompliant with the traditional outpatient aftercare.

The study was so successful that PsycHealth offers the program to appropriate patients including those who have had multiple hospitalizations without follow-up outpatient therapy, those who dropped in and out of therapy, and patients with barriers to compliance, such as lack of transportation or child care issues, says **Madeleine Y. Gomez**, PhD, president of the Evanston, IL, managed behavioral health care organization.

PsycHealth coordinates mental health care for group and private insurance companies, providing everything from 24-hour clinical services and crisis management to case management, utilization management, and quality improvement.

PsycHealth typically begins managing the care of its patients while they are still in the hospital.

"All of our patients leave the hospital with a therapy referral and/or a medical referral. We use our data system to create a comprehensive picture of the patient's status and incorporate that information to coordinate the appropriate follow-up care," she says.

The home intervention program received a Gold Award for Healthcare Management from URAC.

Key Points

- When behavioral health patients who have been hospitalized are cared for in their home, hospital readmissions drop.
- PyscHealth's Home Intervention Project won a gold award from URAC.
- Program's goal is to increase compliance with post-hospital outpatient follow-up therapy and reduce rehospitalizations.

The Home Intervention Program provides services to patients who might not otherwise have received mental health treatment and follow-up, Gomez says.

The goal of the program is to increase compliance with post-hospital outpatient follow-up therapy and reduce rehospitalizations.

"Patients achieve better results and less recidivism if they have follow-up after leaving the hospital, but today it is reported that many people are basically being discharged with solely medication management referrals. Medication is one piece of the picture, but it doesn't change some of the habits or choices that have complicated the person's mental status. Psychotherapy can address those issues," she adds.

Faced with the challenge of overcoming patients' barriers to receiving follow-up therapy, Gomez decided to try an approach that was frequently used when she began her practice.

"It was once very common to do home visits. It was part of the arsenal of intervention. Some patients never go for their follow-up therapy visits. We have tried phone calls, letters, and all types of interventions. When that didn't work, we decided to pilot the home intervention program," she says.

People who have severe mental disorders often have problems dealing with day-to-day life and need a lot of support, Gomez points out.

"If they don't have a family or the family is unable to help, a therapist can help them comply with their treatment plan as well as reporting back to the psychiatrist if there are areas of concern or the patients are experiencing side effects," she says.

All patients whose care is being managed by PsycHealth receive a transition care visit from a care coordinator who is a social worker, a psychologist, or a licensed therapist.

When the firm's clinical care coordinator receives notification of a member's inpatient behavioral health admission, the case is referred to a therapist, who contacts the hospital case manager or patient before discharge whenever possible to set up the in-home appointment. The goal is for the therapist to see the patient for an in-home session within seven days of discharge from the inpatient level of care.

"The transitional care visit is the entry point into the home intervention program for many patients. If patients have a history of continuing their regular outpatient care or have a past relationship that has been effective, we would recommend that they continue, but there are other patients who would be appropriate for home interventions," Gomez says.

The therapist works to get informed consent releases signed in order to coordinate care with the patients' primary care physicians, she adds.

Ideally, the same therapist makes the assessment and conducts the home interventions.

In some cases, the transitional care therapist makes an assessment and recommends assignment of the case to a home intervention therapist.

The therapists are assigned by geographic area and by specialty. They come into their patient's home and work with the patient and whatever part of the family may need adjunctive treatment.

"During the home interventions, we focus on everything the patients need, including basic needs such as food, helping them fill out paperwork for assistance programs, or helping them get connected with a payment plan for utilities or gas, as well as individual and family therapy," Gomez says. ■

Pre-admission prediction tool improves process

Idea is to gain patient buy-in

Sometimes the best response to regulatory and payer changes in health care is to improve the discharge planning process.

And sometimes the best way to improve the discharge planning process is to start discharge planning before the patient is admitted to the health care facility.

This essentially is what happened when a team of leaders looked at the industry changes occurring in orthopedic surgery discharges and post-surgery rehabilitation and realized that

something major would need to be done.

A clinical performance management team at Massachusetts General Hospital in Boston, closely examined orthopedic surgery costs, length of stay (LOS), process improvement, and Medicare regulatory changes, says **Pamela J. Tobichuk**, RN, ONC, a nurse case manager with the pre-admission orthopaedic total joint program at Massachusetts General Hospital in Boston. Tobichuk spoke about using a pre-admission prediction tool to improve the discharge process at the 18th annual conference of the Case Management Society of America (CMSA).

"Most of our population wouldn't be able to go to an inpatient rehabilitation facility," Tobichuk says. "The majority would need to go home or to skilled nursing facilities, which was a huge difference in what they were used to."

The regulatory and payer changes meant too many issues would need to be resolved: First, patients might have expectations that could not be met, and secondly, the hospital's LOS for these patients might increase as a result of fewer viable discharge options.

"We wanted to be proactive and see how we could maintain our good LOS, if not decrease it, and yet manage patients' expectations around what they'd be doing after surgery," Tobichuk says.

One member of the clinical performance management team came across a risk assessment tool that looked useful. It was described in a 2003 issue of the *Journal of Arthroplasty*, in an article, titled, "Predicting risk of extended inpatient rehabilitation after hip or knee arthroplasty."[1]

"We took this tool back to the team and said, 'How can we use this as a starting point for our program?'" Tobichuk says. "And that's where the development and implementation began."

After receiving permission to use the tool, the team adapted it for their own use, primarily by changing words to work better for an American population. The tool had been used in Australia, she notes.

The resulting six questions are scored with two-or-three point answers, meaning the patient is at the lowest risk, and one-or-zero point answers, meaning the patient is at the highest risk, Tobichuk says.

Tobichuk calls patients prior to their surgery to ask them the tool's questions. As the patient gives answers, Tobichuk assesses their risk and discusses their post-discharge options, asking them, "Do you have a plan or preference for your discharge?"

Here are the tool's questions:

- What is your age?
- What is your gender?
- How far on average can you walk?
- What do you currently use to help you walk?
- Do you currently have any help from the community?
- Will someone be living with you who can care for you after your operation?

There is a maximum of 12 points. Anyone who scores greater than nine points is at the lowest risk for needing to be transitioned to a skilled nursing facility, Tobichuk says.

"If someone scores 10-12 points, then let's have that person go home," she adds.

At the other end of the spectrum, if a patient's score is less than six points, then that patient is at a high risk, she says.

"We would predict that patient would have to go to a skilled nursing facility for nursing rehabilitation," Tobichuk says.

Patients whose scores fall in the middle category of six to nine have moderate risk, and their discharge outcome is unpredictable, she adds.

"They either could go home with a visiting nurse or be transferred to a skilled nursing facility," Tobichuk explains. "If someone scores in the middle range and their preference is to go home, then that might be someone who could benefit from more physical therapy in the hospital to help them get over the hump, and we might send them home with more support."

When using the tool to assist with discharge planning, it's important to consider the patient's general motivation to work at rehabilitation in whichever setting the patient might prefer.

A patient who scores at low risk and who is highly motivated might not need home care services, but could go directly to outpatient physical therapy after being discharged from the hospital, Tobichuk says. ■

New discharge form keeps satisfaction high

Helps with instructions, resources at home

For the past two years, the ED at Avera Weskota Medical Center, a small, rural critical-access hospital in Wessington Springs, SD, has been using a new "Emergency Services Aftercare"

instruction form to help patients remember vital information about the care they received and instructions to follow once they get home. It might be no coincidence that in 2007, the hospital received The Press Ganey Summit Award, which is based on a department ranking in the 95th percentile or above for at least three years.

In fact, the ED received a ranking of the 99th percentile for the period between Jan. 1, 2007, and June 30, 2007. The new form addresses one of the most pressing issues in emergency medicine today: poor communications upon discharge. In fact, a recent study by the American College of Emergency Physicians found that about 75% of discharged ED patients failed to understand their discharge instructions.

"At the end of a visit the patient is bombarded with all kinds of information, and once they get home they forget it," notes **Julie Schultz**, LPN, quality improvement coordinator at Weskota. "We developed the form and instructions we want the patient to follow, which they and their spouse can refer to once they get home." The instructions include what patients should and should not do, including when to return to work or school. The form also documents the education that has been given to the patient, the medications they must continue to take, and if they need to have a follow-up visit, she says. "If one of our clinics happens to be open at the time, we will set the appointment up for them," Schultz adds.

The benefit of the form is the fact the patients get information they can refer to that they may have forgotten, says **JoAnn Hettinger**, RN, director of patient care services. "You can give them verbal instructions, but the visual form is a lot better," Hettinger says.

Previously, patients simply received oral instructions or staff might have written the instructions on a piece of paper, but it was not consistent, says Schultz. Now, the patients and nurses sign the form to indicate it has been reviewed. "Many times the provider will personally review it with the patient [rather than the discharge nurse], adds Schultz. ■

CMS shifts claim reviews from QIOs to FIs, MACs

Change will mean efficiency, consistency, it says

Citing improved efficiency and consistency, the Centers for Medicare & Medicaid Services (CMS) has begun transitioning the handling of hospital claim reviews from quality improvement organizations (QIOs) to fiscal intermediaries (FIs) and Medicare administrative contractors (MACs).

FIs and MACs are tasked with preventing improper payments, while improper payments will be measured by CMS' Comprehensive Error Rate Testing program (CERT).

According to CMS, the transition will also free up QIOs to focus on quality of care improvement issues and provider assistance efforts.

CERT began reviewing acute care hospital claims for improper payment measurement in April 2008, and will review claims submitted from April 1, 2008, and beyond. FIs and MACs began shortly afterward reviewing acute care inpatient hospital claims for improper payment prevention and reduction, and will review claims submitted from January 1, 2008, and beyond.

"This is significant in that hospitals will now need to call their FI rather than their QIO for some specific topics," according to **Jackie Birmingham**, RN, MS, CMAC, VP Professional Services for eDischarge™, Curaspan Health Group, Inc., in Newton, MA.

FIs and MACs began education efforts along with the reviews that commenced in the summer. Experts warn that the shift will mean that statistics generated after the transition won't be accurately comparable to previous sets of statistics.

Until recently, QIOs were responsible for Hospital Payment Monitoring Program (HPMP) reviews, including utilization reviews for payment purposes and accuracy measures of Medicare payments for short- and long-term acute care hospitals; quality of care reviews for

COMING IN FUTURE MONTHS

- What impact will the new administration have on quality improvement?
- A 'Top Ten' list for a safe and effective sign-out
- Hospitals that excel at patient safety share their secrets

Medicare beneficiaries; provider-requested, higher-weighted diagnosis-related group (DRG) reviews; and EMTALA reviews.

Prior to the transition, FIs and MACs had no acute care hospital claim review duties, and the CERT program wasn't responsible for measuring improper payments involving acute care inpatient claims.

Under the new system, QIO focus shifts to quality improvement. QIOs will continue to conduct quality reviews, some utilization reviews, and expedited determinations. FIs and MACs will perform most utilization reviews in the new process.

CMS cites three main benefits to the change in review-handling:

• Consistency in having all Medicare fee-for-service (FFS) settings reviewed by FIs and MACs (Acute long- and short-term hospitals were the only FFS sites not reviewed by FIs and MACs.)

• Efficiency in having the same entities that process claims responsible for preventing improper payment. CMS believes the new designation of responsibility will also be a cost-saving measure.

• Lessened perception of conflict of interest raised when QIOs measured the payment error rate for claims on which they themselves made payment determinations. ■

Cleveland Clinic docs name innovation 'Top Ten'

Medical researchers are coming up with new discoveries at such a rapid pace it's difficult to keep up with them all, but physicians and consultants at The Cleveland Clinic try to sharpen our focus by shining a light on those that hold the most promise. They have just released their list of Top Ten innovations in medicine, which they disclosed at the conclusion of their Innovation Summit in Cleveland. The Top Ten list is:

- use of circulating tumor cell technology;
- warm organ perfusion device;
- diaphragm pacing system;
- multi-spectral imaging systems;
- percutaneous mitral valve regurgitation repair;
- new strategies for creating vaccines for Avian flu.
- LESS (laproendoscopic single-site surgery) and NOTES (natural orifice transluminal endoscopic surgery) applications;
- integration of diffusion tensor imaging;
- doppler-guided uterine artery occlusion;
- National Health Information Exchange. ■