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The Recovery Audit Contractors are rolling out: Are you prepared?

Get your utilization review committee, peer review process ready to go

If there's anything to be learned from the Recovery Audit Contractors (RAC) demonstration project, it's that your hospital could take a significant financial hit. With the economy lagging, budgets tightening, and staff dwindling, the impact of a RAC audit could be devastating to your hospital's financial foundation.

The RACs now are finally rolling out across the country. And despite continued confusion about the rules and the continual updates, you need to know what you can do to be ready for the "RAC attack." Having a utilization review committee that fits Medicare's Conditions of Participation (CoPs), educating physicians on what auditors will be looking for, and implementing an effective protocol for peer review of medical records are three ways you can move in the right direction.

Of the first, **Deborah Hale**, CCS, president of Administrative Consultant Services LLC, a health care consulting firm based in Shawnee, OK, says many hospitals aren't in compliance. Though the CoPs require it, Hale says, "Many hospitals don't have an effective utilization review committee. . . They're trying to run this program with case managers who are inappropriately making final decisions about medical necessity of admission." The UR committee and the peer review component therein are quite significant in dealing with RAC audits.

The importance of the UR committee and peer review

"Typically, peer review — physician-to-physician review — is directed more toward quality; but one of the most significant recoveries that were made during the demonstration project for the RACs had to do with medical necessity of admission. And, of course, the final decision that an admission is medically unnecessary, according to the CoPs and the Medicare Benefit Policy Manual, can only be made by another physician. So peer review is critical to hospitals being able to demonstrate their ongoing compliance," she says.

The utilization review committee must include at least two physicians (either doctors of medicine or osteopathy); yet they don't have to be practicing. Hale says you can have other representatives at the table, such as

IN THIS ISSUE

Financial Disclosure:
Managing Editor and Writer Jill Robbins, Associate Publisher Russ Underwood and nurse planner Paula Swain report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Patrice Spath discloses she is principal of Brown-Spath & Associates.

SEPTEMBER 2009
VOL. 34, NO. 9 • (pages 101-112)

quality improvement directors, case managers, and financial officers, but only the physicians can vote in determining whether a record supports medical necessity of inpatient admission.

In fact, recent updates that went into effect July 1 in the Medicare Benefit Policy Manual and the Medicare Claims Processing Manual reminded hospitals that nurses cannot make final decisions on the appropriateness of medical necessity determinations — only physicians. Medical records that don't meet screening criteria should always be evaluated by another physician, Hale says. Review of admissions may be performed before, at, or after hospital admission. However, moving to a real-time review of records is what you want to work toward.

When this peer review process for an inpatient not meeting the inpatient screening criteria is completed while the patient is still hospitalized and that review confirms the inpatient admission to be medically unnecessary, the hospital protects its right to bill for the procedures and testing provided during the stay. By completing this peer review process prior to the patient's discharge, the patient's status can be changed from inpatient to outpatient. This process allows the hospital to file an outpatient claim (Bill type 13X or 85X) with Condition Code 44 that includes all medically necessary services ordered by the physician(s) and provided by the hospital, according to Hale.

If this same peer review process is performed retrospectively (after discharge), the hospital must file a Provider Liable claim and may only bill for medically necessary diagnostic services such as lab and X-ray and certain surgical supplies and prosthetics, she says. Whether the peer review is concurrent or retrospective, the attending (or admitting) physician has the right to provide his or her view before a final determination is made.

"I think what I see being most common is the hospital's real intent and desire to identify those cases that are not appropriate inpatient admissions based upon screening criteria like InterQual or Milliman. But many are not following the requirement that a physician be the one to make the final decision," says Hale, who attributes this to a lack of knowledge of the rules.

Education on Medicare's requirements

It's the responsibility of the hospital to provide medical staff education and awareness regarding appropriate level-of-care determinations, she says. "Many hospitals will read the guidelines and not completely understand the requirements, especially for Condition Code 44. They think that as long as the attending physician agrees to make the change, that's all they need. And that's not the case."

Hale says peer review is required for medical necessity of admission determinations, even with the agreement of the attending physician to change the level of care from inpatient to outpatient.

Hale says hospitals are falling short, both in

Hospital Peer Review® (ISSN# 0149-2632) is published monthly, and **Discharge Planning Advisor**™ and **Patient Satisfaction Planner**™ are published quarterly, by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to *Hospital Peer Review*®, P.O. Box 740059, Atlanta, GA 30374.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

The target audience for **Hospital Peer Review**® is hospital-based quality professionals.

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Subscription rates: U.S.A., one year (12 issues), $499. 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 1 month of the missing issue date. **Back issues**, when available, are $78 each. (GST registration number R128870672.)

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having a UR committee and in having a sound peer review process in evaluating records. Getting up to speed "involves infrastructure that has the support from the CEO on down. It's got to be a philosophy of management that we are going to address this issue and that we're going to give it the resources — the human resources and the time resources — that are necessary to do the process according to regulatory guidelines," she says.

Many hospitals build the UR committee into the quality improvement one, but Hale believes the heady agenda of both necessitates two separate teams.

The UR committee has to have the staffing, but it also has to have the knowledge, Hale says. "We can't just have physicians who rubber stamp things. They've got to be trained appropriately to understand the issues, without being influenced by politics or some of the other dynamics within a hospital. They've got to be able to make sound clinical judgments that are evidence-based as to what's appropriate and what is not. It's really the hospital putting their compliance, their success in the hands of these physicians, and they've got to know they've been properly trained and they have the integrity to carry out that role appropriately."

Hale laughs when asked about just who is responsible for educating the medical staff on all the CMS requirements. She says many commenters have asked CMS if the agency will be offering any education for physicians and its response is, "It's the hospital's responsibility."

Because of the complexity of the rules and the frequent modifications and updates, Hale says many hospitals are working in concert with consultants to provide education. Because now, lack of education can cost your hospital big.

If you're looking at consulting companies, Hale says "you really want to look for a firm that has real experience in the field, that has a track record. And another thing hospitals should always look for is that recommendations made by the consulting firm are supported by published regulatory guidelines. If they can't give you chapter and verse as to where that rule is published, then you should really think twice about implementing a recommendation."

Identifying opportunities for improvement

Identifying problematic areas and physician patterns is the next step in preparing for the RACs. "If you just try to deal with correct level of care determinations on a chart-by-chart basis, you will forever be spending time, probably full-time for a large staff, to get through every record," Hale says.

She suggests analyzing data to identify entry points where admissions are most often likely to be unnecessary and then drilling down from there to see which physicians and specialties are most often noncompliant to direct education or process redesign. In doing this, you can also reassign or add case management staff to cover your vulnerable areas.

Data measures to collect

Hale also suggests collecting data about short stays — one- and two-day stays and other procedures or DRGs most often found to represent unnecessary admissions in the RAC demonstration project.

Find out how many one- and two-day stays you have assigned to the specific problematic DRGs found in the RAC demonstration project. She also suggests looking at the following to see if anything can be improved (i.e., more staffing, etc.):

- what day of the week these patients typically are admitted;
- who the attending and admitting physicians are;
- time of day the admissions occurred.

RACs can review any records back to Oct. 1, 2007. "So there's not much hospitals can do other than self-disclose or get additional documentation for those records. It may be possible that the physician actually does have additional information that would help support why they did what they did. The hospital should certainly consider asking the attending [physician] to provide addendums to the record when that is the case. [And they must be] properly dated and authenticated," she says.

Use physician advisors if you can

If your hospital has the resources to employ physician advisors, Hale recommends that you do it. If you find a case of a patient who should have been admitted as an inpatient but was instead referred for outpatient observation services and you address it in a timely manner, the physician advisor can recommend to the provider of record that the status be changed to inpatient, she says. Physician orders for the appropriate sta-

tus benefit the hospital and the patient. "Because we can't have a meeting of the utilization review committee every day to address those kinds of issues, then the role of the physician advisor allows us to get peer review quickly and protects our right to bill for all services provided."

The physician advisor can always speak with the attending physician about what he or she was thinking. And the physician advisor can get additional information from the provider that allows him/her to say, "Hey, I think the physician's inpatient order is correct. The fact that it doesn't meet criteria isn't the problem. It's OK. I can approve it based on clinical judgment and will document the rationale for this decision in the medical record."

She says there's been a rash of "rent-a-doc" or physician advisor companies because the RAC audits have such a big impact on hospitals' financial solvency. Sometimes, she says "it's just too hard to get around the politics in the hospital [to get unbiased internal peer review], especially in the smaller hospitals. They can't really afford to have a physician advisor full-time, and if it's a practicing physician in a small hospital, he's almost always going to have a financial interest in the case or a professional interest in the case, which would make that physician ineligible to render a decision. So renting or contracting out this physician advisor for this peer review process has become very attractive."

Bottom line, she says, is make sure you're compliant with Medicare's requirement for peer review. "I think that's the No. 1 liability [hospitals] face right now as they anticipate RAC audits. And make sure that the physicians they are using for peer review are appropriately trained so that they can make judgments that are consistent with Medicare regulatory guidelines because the hospital's compliance, the hospital's ability to avoid denials lands squarely in their lap."

(Editor's note: To see findings from the RAC demonstration project and the expansion schedule visit: www.cms.hhs.gov/RAC/02_ExpansionStrategy.asp#TopOfPage and select "CMS RAC Demonstration Evaluation Report." See Appendix G for top services with overpayments and Appendix P for service-specific examples of overpayments.) ■

Questions surround OPPS on physician supervision

Clarification still ambiguous

In the 2010 OPPS proposed rule, the Centers for Medicare & Medicaid Services (CMS) raises a number of issues, offers clarification, and makes some proposals regarding physician supervision issues. One such issue discussed in the proposed rule has to do with what "immediately available" means.

Providers have raised many questions about what constitutes a physician being immediately available, and as a result of the questions raised over the past 18 months, CMS appears to have responded. **Jugna Shah**, MPH, president and founder of Nimitt Consulting in Washington, DC, says we may have to be more careful about what we ask for, because in the proposed rule CMS describes "immediately available" as "without interval of time." Yet this seems contradictory with statements related to the physician not having to be present in the department or the room. This attempt at clarification seems to be causing even more confusion and perhaps immediately available should be left defined as it has been to date, she says.

The "immediately available" precedent relates to the provisions of what constitutes appropriate physician supervision in an outpatient setting, an element that has had a fair share of controversy beginning about two years ago when CMS updated its manuals. At that time, providers began questioning what CMS was updating vs. what it had laid out back in April 2000.

"The OPPS 2010 proposed rule goes farther than the 2009 OPPS final rule in recognizing and addressing open items of concern to hospitals, and CMS should be commended for addressing this issue in a more robust manner than it has historically," says Shah.

In essence, the physician supervision rules have laid out who can act in a supervisory role should problems arise during outpatient therapeutic procedures and where the supervisor should be in relation to the site where the procedure is taking place.

NPP supervision proposed for expansion

Shah, says "one thing that's definitely new [in the 2010 proposed OPPS rule] is the recognition of non-physician practitioners [NPPs]" — a change she knows hospitals will unanimously ask CMS to finalize for 2010, and one that will have them applauding.

In the proposed rule, she says, Medicare opens the supervisory role beyond physicians to mid-level practitioners. The rule reads "for CY 2010 we are proposing that nonphysician practitioners, specifically physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives, may directly supervise all hospital outpatient therapeutic services that they may perform themselves in accordance with their State law and scope of practice and hospital-granted privileges, provided that they continue to meet all additional requirements, including any collaboration or supervision requirements as specified in the regulations at §§410.74 through 410.77."

"The concern from a compliance perspective," Shah says, "is that many hospitals may have assumed that that was in fact the case before." And those hospitals may have already had NPPs providing supervision, as CMS' previous guidance on this issue had been seen as ambiguous. The good news, she says, is that in the proposed rule, Medicare makes it clear that, if made final, this is a change going forward (and does not impact historical practices) and it appears to be, in large part, in response to comments and concerns raised by the provider community.

What does that mean for RAC audits, which can review records dating back to Oct. 1, 2007, or even OIG reviews? That could be an area for take-backs or fraud claims if reviews uncover that appropriate levels of supervision were not being provided.

"That's where compliance officers and lawyers, along with hospital associations, have concern and are discussing this among other ambiguous language from the April 2000 proposed rule with Medicare. Everyone would breathe a collective sigh of relief if Medicare would acknowledge that its own guidance was ambiguous in the past and may have led providers to different conclusions about non-physician practitioners providing guidance as well as the notion of 'immediately available,'" she says.

A letter to CMS, authored by the Association of American Medical Colleges, the American Hospital Association, the Federation of American Hospitals, and the National Association of Psychiatric Health Systems, takes issue with the policy prior to the "potential modifications" indicated in the 2010 OPPS proposed rule. At issue, they write, is the 2009 OPPS rulemaking's statement that a "restatement and clarification" of the physician supervision policy was necessary because there was "misunderstanding" about what level of supervision was required for incident-to outpatient therapeutic services. The letter goes on to state that "direct supervision" by a physician had been a requirement since 2001 only to those services furnished outside of the hospital's campus, but not to those furnished on campus as the rule is written.

"For CMS now to say otherwise about past time periods opens up the entire hospital community to misplaced enforcement scrutiny,

including by potential *qui tam* relators, for services furnished in a hospital or on a hospital's campus before Jan. 1, 2009," the letter states.

"Through our ongoing dialogue with CMS, we learned that an assumption made by CMS in 2001 may be the root cause for the concerns related to the policy. During the 2001 rulemaking, CMS assumed that when services are furnished 'on the premises' (a location description that CMS determined included both in a hospital and on a hospital's campus), 'physician supervision is always at hand.' (63 *Fed.Reg.* 47,593.) The stated assumption, however, does not specify any particular level of physician supervision that CMS expected to be available. As a result, most hospitals interpreted the policy to require only 'general supervision' by a physician for services furnished in a hospital or on a hospital's campus."

The letter then restates the risk that this could expose hospitals to take-backs: "Such claims are often attractive to whistleblowers because of the lucrative amounts of Medicare reimbursement at issue, which is determined based upon the nature of the direct physician supervision requirement, its impact on the payment status of all services furnished to Medicare beneficiaries in that department, and the construct of the penalty and damages provisions of the federal False Claims Act."

Where does quality stand?

There are no new quality measures in the proposed 2010 rule, though CMS requests comments for many others for future consideration. CMS "seems to be slowing down some of their onward march toward value-based purchasing and quality, quality, quality. Not that those things aren't important to CMS any longer; they are. But I think CMS seems to recognize that hospitals have been hit with a lot of changes under the OPPS over the past few years, and perhaps it's time to slow things down and monitor the impact of some of the new 'efficiency and quality' initiatives before introducing new ones," Shah says.

CMS had proposed doing voluntary validation of data in 2008 but didn't due to staffing resources on its end. It will continue to require hospitals to abstract and submit data on the seven quality measures introduced in 2008 and use its own claims data to examine the four imaging measures introduced for reporting this year. But what exactly CMS is looking at in terms of the imaging measures remains a bit of a mystery, and hopefully CMS will release information on this early in 2010, Shah says.

For hospitals to be in compliance now, she says, they simply have to report the data. At this point, she says, the agency appears to be measuring utilization more so than actual quality, but the outpatient measures are a start toward examining service delivery, utilization, and quality.

With the inpatient rule, CMS told *Hospital Peer Review* it was essentially holding off on adding quality measures until such time that it could be abstracted electronically from hospitals' electronic health records (EHRs).

Pulling information from medical records and/or claims data is ideal in that it minimizes and perhaps even eliminates administration burden for hospitals, Shah says. Yet granting open access to EHRs is of concern to many and would likely have parameters associated with it so that hospitals are providing a feed rather than CMS having open access, Shah adds.

"I think Medicare is trying to be mindful of hospital burden, which is why the agency seems to be looking for ways to obtain the data and information it needs from claims data, existing registries, EHRs, etc.," says Shah.

She also acknowledges that with health care reform looming, CMS may be waiting to see what happens there before adding more changes for hospitals to contend with in 2010. ■

Hospital drops readmission rate for HF patients by 10%

Patients not forgotten post-discharge

It's going to hurt at first. Financially, from both the cost side and the revenue side. The investment is huge. And it's a lot of work — a lot of starts and stops, says **Gray Ellrodt**, MD.

With the Centers for Medicare & Medicaid Services beginning to publicly report readmission rates, reducing them is becoming ever more important. But the problem and the improvement process aren't easy.

"This is as complicated as it gets because you're worrying about everything from hot dogs to telemedicine to as sophisticated care as you can imagine with resynchronization therapy, etc. all the way down to don't drink that Campbell's soup," says Ellrodt, chief and chair of medicine at

Berkshire Medical Center (BMC) in Pittsfield, MA, and professor of medicine at the University of Massachusetts Medical School.

Targeting your readmission rates, though it may not be financially rewarding up front, will likely save you money in the long run.

Ellrodt says Berkshire had always tracked its overall admission rate, but once it homed in on the rates associated with certain populations, especially heart failure, with a rate as high as 27% within 30 days in 2007, "the bells and whistles went off" and the hospital decided it had to do something.

Alicia Ferrarin, FNP-C, cardiology nurse practitioner, clinical manager, BMC heart failure program, joined the forces in 2007, when BMC initiated a comprehensive inpatient program. As part of this were multidisciplinary rounds and a more in-depth review of patients throughout their hospital stay, paired with a home-based program in which nurses from the health system's Visiting Nurse Association (VNA) were charged with patients' care post-discharge. In the fall, BMC brought in a heart failure specialist from Baystate Health and opened an outpatient clinic.

"So now we had a process in which we followed patients in the hospital, at home, and then they were hooked into the outpatient clinic," Ferrarin says. "So we were able to close the loop."

In 2008, the program began following up with discharged heart failure patients by phone 24 to 48 hours after discharge to check on their status, that they had all their necessary medications, and that they had received all the services they needed. "We also used that opportunity to use some of the teach-back methods for education to make sure that they understood what they were taught while they were here," she says.

Beginning in 2008, a pre-discharge time out was implemented before heart failure patients were sent home. For each patient, Ferrarin meets with all the physicians involved with the case, the primary nurse, and the patient's case manager to review the chart in depth to ascertain whether everything is ready for the patient to go home.

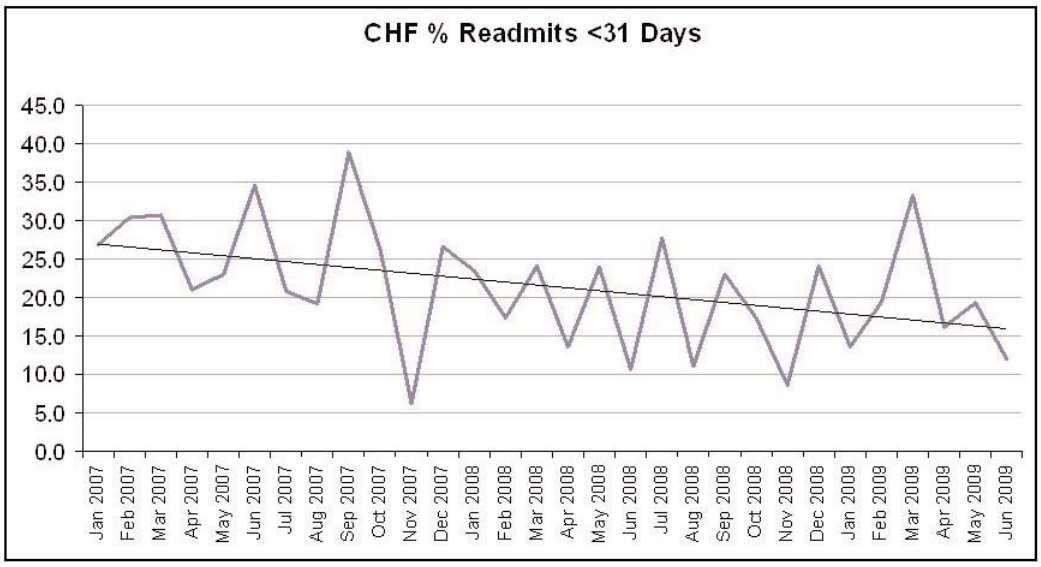
The team discusses any potential future barriers — "whether it be financial issues and having medications taken care of or safety issues at home," Ferrarin says.

Telemedicine and real-time monitoring

A nurse visits each patient usually within 24 hours of discharge. The in-home visit includes "a full evaluation including safety assessments. [The nurses] go through the cabinets. They do diet education, medication education, reconciliation, a physical assessment, and then usually they will certify the patient for a 60-day period," Ferrarin says.

Eligible patients also participate in the hospital's telemedicine program. The patient is given an electronic scale, blood pressure cuffs, and an SPO2 monitor to assess his or her oxygen saturation. All the data obtained from these are uploaded to a web site for daily monitoring of weight, blood pressure, and oxygen level.

The data are transferred to the VNA and reviewed by a triage nurse. If he or she sees a problem, the patient's physician is contacted.



Source: Berkshire Medical Center.

"Generally, the physician's office will get back to the VNA as to what the plan is, and then the VNA with either contact the patient for medication changes or make an extra visit," Ferrarin says.

Patients are given a number to reach either the visiting nurse or Ferrarin herself if complications or problems arise.

For those who are readmitted, each is "completely dissected to figure out what actually was the cause of their readmission so we can take it from there, whether it was a medication issue, a compliance issue, whether they needed more services at home, whether they didn't get in to see their physician," she says. "For all readmissions, we pull the charts and try to come up with a reason for the readmission so that we can fix it and do it better the next time."

About the same time the hospital began its heart failure readmission charge, it also began implementing a hospitalist program. Ellrodt points to that program as having given the hospital "a much tighter relationship between the hospital care and the outpatient care." Within that program, the hospital began to make follow-up appointments with patients' primary care physician or subspecialist.

"I think having a comprehensive inpatient hospitalist program with a mandate to communicate effectively with primary care physicians and the rest of the caregivers across the continuum was absolutely essential" to the program's success, he says.

Beginning in July, the hospital developed what it calls a geographic hospitalist program with one or two hospitalist teams per floor per unit based on the size of the unit. "We think this makes it a whole lot easier," he says. "Almost all of the heart failure patients — 95% — are basically on one unit, our telemetry unit."

He says this has made it easier for Ferrarin to locate patient-specific physicians. And as department chair, he says "having to manage 125 physicians vs. 16, guess which is easier? So you can very easily get protocols in place if we decide to look at BNP levels on discharge [which the hospital has been doing] and trying to predict high-risk patients."

The alignment between the hospitalist and the primary care physicians, he says, has been a big part of improving communication. Representatives from skilled nursing facilities are on BMC's transitions committee, and now it is mandated that discharge summaries be dictated on the day the patient is discharged. Physicians also have home access to the system's electronic medical record system if problems arise.

Downward trend

The hospital continues to see a downward trend in readmissions for heart failure patients **(see graph, page 107)** and has gone from a 27% 30-day rate in 2007 to a current rate of about 15-16%. Ellrodt says the team will see a few bumps in certain months. "What Alicia did with her team was go back in and look at every one of those readmissions. What she found basically was the difference was two patients were readmitted multiple times during that time frame. What we did was we then developed for those two patients a custom-tailored strategy that basically changed our approach to those patients."

What's made the biggest difference? Ellrodt thinks it's the outpatient clinic, which takes the highest-risk patients. The readmission rate there, among the sickest patients, is down to 3% now. "I think the large part of the impact is the heart failure clinic's ability to intensively monitor the highest-risk patients. I think this has had a huge impact, along with all of the other things we've done."

Ellrodt acknowledges the program has been an expensive one — one that is not currently in the financial interest of the hospital. Readmissions get reimbursed at a significant amount, but seeing the tide changing in the near term, even though you may "by preventing readmissions, decreasing your revenue" you're doing the right thing. ■

Transitional care model proves its worth

Mary Naylor's model put to the test

Recent literature highlighting the high number of hospital readmissions has brought the issue front and center. Coordinated care, an integral indicator of quality, means managing patients, especially those at high risk for rehospitalization, in the hospital and beyond. It means educating patients on their conditions, medication regimens, and self-care instructions; intervening when post-discharge symptoms come up; and ensuring that follow up visits with primary care physicians or other providers are scheduled.

Transitioning patients from hospital to home or any post-acute care in a successful way means a lot of things, which have a big impact on the continued health of the patient and of the hospital.

There are myriad discharge or transitional care models out there today. And one of the most discussed is that of Mary Naylor, PhD, RN, professor of gerontology and director of the NewCourtland Center for Transitions and Health at the University of Pennsylvania, school of nursing.

Joan Doyle, RN, MSN, MBA, executive director at Penn Home Care and Hospice Services, part of the University of Pennsylvania Health System, is part of a pilot using the model with the Hospital of the University of Pennsylvania. The pilot focused on patients with congestive heart failure, chronic obstructive pulmonary disease, and frail elders with several comorbidities at high risk for readmission.

Within the pilot, 112 patients completed the intervention. The readmission rate associate with the project, between September 2008 and July 2009 was 13.2%, or 76 of the 112 patients.

Patients are followed by an advanced practice nurse while in the hospital. Within 24 hours of discharge, the nurse follows up with the patient and continues to make regular home visits with ongoing telephone support.

If the patient has problems post-hospitalization, he or she can call the nurse to discuss it. "It's what we call 'red flag management' — to get the patients before they spiral down," Doyle says. "It's an emphasis on early identification and response to health care risk and symptoms and avoidance of those adverse events that lead to readmissions."

The nurses are charged with actively engaging patients and their families or informal caregivers in education, disease management, and support. They also facilitate communication to and among health care providers — physicians, nurses, social workers, discharge planners, or any other providers involved in the patient's care. They schedule post-discharge follow-up appointments for patients and often will accompany patients on those visits.

They ensure patients have their medications and that they're taking them, they educate about diet compliance, and they help patients manage any other symptoms that may crop up while at home.

All the nurses in the program undergo an orientation program and educational programs designed for the program by Naylor.

Penn's clinical strategies are under the auspices of what it has coined its Blueprint for Quality. "That framework is really an institution-wide event in that the chief medical officers and the chief nursing officers really spearheaded it," Doyle says.

Within that framework, they undertook the pilot using Naylor's transitional care model. Doyle says they've identified several layers that she says "make the biggest difference in transitions in care and the overarching goal of how we prevent unanticipated readmissions."

- Triaging and identifying patients "at greatest risk for readmission and identifying what their post-acute needs are" is one of the crucial steps. Doyle says one element found to be "really effective is real-time readmissions feedback."

For every readmitted patient, there is a focused review looking at what happened — what was the reason the patient was readmitted — and then assurance that the patient receives a post-acute follow up. "So we try to make sure that if they have come back in, when they go back out again, they have an assessment and whether there are other things we need to put into place."

- Interdisciplinary care planning played a big role in the pilot's success. In each of the hospitals in the system, there is a unit-based leadership team comprising a triad of a nurse, a physician, and a quality officer. "So each one of the inpatient units at our three hospitals can drill down on their individual metrics and start to look at their own patient populations, their own readmission rates," Doyle says. So discharge involves a whole team.
- Primary care follow up, medication management across the continuum, and education/red flag managements all have been crucial to Penn's success. ■

Tips, common mistakes in getting survey-ready

Hearing "The Joint Commission is here" doesn't have to send staff into shock. And it shouldn't mean last-minute scrambling to get ready. In upcoming months, *Hospital Peer Review* will provide perspectives from your peers, health care consultants, and other experts about being survey-ready at any point by looking at mistakes or lapses hospitals make in preparing for their surveys and tips on how to make the process most effective and efficient.

Paul L. Green, RN, MS, CPHQ, is chief quality officer at Memorial Hospital of Gardena (CA) and principal, founder of Greenlight Healthcare Consulting LLC. He says the starting point is a full organization assessment, either by internal staff with sound knowledge of compliance or by an outside consultant. Because he's in California, which has a consolidated survey (a joint survey by The Joint Commission, California's Department of Health, and the Institute for Medical Quality), he looks for an organizational picture along all regulatory body rules — Joint Commission, as well as federal and state governing bodies.

"Once you've got a good sort of organization-wide picture of where your strong points are and where your weak points are, then I think a very detailed action plan with time lines and responsibilities is absolutely critical," he says.

Assigning responsibilities, time lines

It's up to your facility to provide that, he says and therein he sees a lot of organizations falling short. "The most common mistake that they make is that they don't make the responsibility clear and they don't make the due dates clear and they don't hold people accountable to actually getting stuff done," he says, especially when you're in the mindset of thinking, "Oh, the survey is two years from now," and let things slide.

"The standpoint is anyone can come in at any point in time, and some of us who have lived through that experience of having the state descend or having the feds descend or even have Joint Commission descend, it's really critical to stay on top of that stuff and get it done and hold people accountable to getting it done," he adds.

The worst situation is when you've identified a problem and 18 months down the road, you still haven't rectified it. It is critical, he says, to stay on top of things on an ongoing basis, and to do that "you've got to have some kind of regulatory steering committee within the organization that includes senior leadership." It is the executive-level staff that can hold people accountable for getting their part done.

You can assign duties by chapters, by problem areas, or by function, but there's got to be a multidisciplinary team working together. Whoever on the team is responsible for one area must pull in other areas from the organization affected by that standard. For instance, Green says, if you assign your medical record director the information management chapter, he or she must pull from many other areas outside his or her scope. "Information management covers everything from your computer systems to HIPAA issues to unapproved abbreviations to documentation issues. And it crosses a lot of people. I think the common mistake people make is they turn that over to the health information director who then

CNE *questions*

9. According to the Centers for Medicare & Medicaid Services, a hospital's utilization committee must include two practicing physicians.
A. True
B. False

10. How many quality measures were added to the proposed 2010 OPPS rule?
A. zero
B. two
C. four
D. eight

11. As part of Berkshire Medical Center's telemedicine program, eligbile patients are equipped with a:
A. scale
B. blood pressure cuffs
C. SPO2 monitor
D. all of the above

12. Paul L. Green, RN, MS, CPHQ, suggests doing tracers once a year.
A. True
B. False

Answer Key: 9. B; 10. A; 11. D; 12. B

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

says, 'Well, I can't make sure the doctors get something signed before they do a procedure.' Well, sure you can, if you pull in the people who are involved with that." The assigned staff members must understand what they are responsible for and that they are responsible.

"So you've got this piece where you get the assessment, you get an action plan, you assign people to work on specific portions of the action plan, you've got to set up due dates in relationship to getting particular pieces done, and your steering committee has got to hold people accountable in relation to that," he says.

Another common mistake Green sees is when organizations go through the process, and the person responsible for a specific chapter says, "Yes, I have the policy written. It's done."

Green's response: "Prove it to me, prove it me. . . if you have something, you're going to show it to me." To ensure people were educated about the standard in question, he asks to see the content, the dates education was done, and the sign-in sheets of who was there. "Show me how you evaluated whether people learned anything or not. And I want to see all those documents, and I want to see them together."

And he asks to see where the policy meets the intent of the standard and answers the associated element of performance. When they answer those questions, Green creates a notebook with all the documentation. "If a surveyor should walk in tomorrow and say, 'We've got a question about restraint usage.' Well, right there at my fingertips, I can pull the restraint policy, I can pull the practice logs, I can pull the monitoring data."

Tracers keep you fresh

Once you get your organization up to compliance, Green asks, how do you maintain that? His answer is through ongoing tracer activity and monitoring.

He prefers to organize tracers functionally. "So, for example, you would operate it from the standpoint of the way a surveyor would look at it. A surveyor doesn't look to do a tracer by department; they do a tracer by patient."

So the tracer would take a look at a patient admitted to the emergency department the previous night and, as it follows the patient, look at the components of assessment, planning, and medication administration. Then he does departmental tracers as well to make sure departments

CNE objectives

To earn continuing education (CNE) credit for subscribing to *Hospital Peer Review*, CNE participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from The Joint Commission or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■

COMING IN FUTURE MONTHS

- ■ Details on Joint Commission's Medicare condition-level deficiency follow-up survey
- ■ Dealing with patient grievances
- ■ Joint commission and flu vaccination of children
- ■ RAC stories from people who went through it

are keeping up to speed.

He suggests holding monthly tracers. Mock surveys he does annually.

Where should you focus?

"National Patient Safety Goals is still the big hot button," Green says. And as part of those, what's huge now and will continue to be are:

- hospital-acquired infections;
- medication-related goals, especially anticoagulant management;
- new elements in relationship to leadership, the medical staff, and environment of care.

"The whole environment of care thing got rewritten in 2009, so that's a pretty big touch point," he says.

Focus on any goals that are to be phased in within the current year. He also suggests putting a radar on ongoing practice evaluation for medical staff (OPPE). The Joint Commission, he says, used to call for hospitals every couple of years to review quality data when someone got reappointed and use those data as part of that staff member's reappointment process.

This changed a couple of years ago, he says, with what's now referred to as OPPE and focused professional practice evaluation, or FPPE. With OPPE, you now have to look at the data in each practitioner's performance no less than every nine months "to evaluate the quality of care that is being provided and make a determination about whether this person needs to go into a focused review.

Organizational cooperation

Being survey-ready and compliant is not "a job that belongs to the quality department," Green says. "This is about running your business. And everybody who is a business leader, whether that be a department manager to vice president, runs portions of the business, and they have to run their business according to what legal requirements there are.

"And so the quality department can serve as a consultative resource to you in doing that, but you have to take accountability for running your own business. And that's I think the biggest mistake people make. They still sort of say, 'That's your job. We won't worry about. We'll talk to you in another year.' And it's not that way anymore. Not that it ever really was. But you could sort of fake it if you needed to. You can't fake it anymore." ■