

HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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Inpatient vs. observation: Get it right the first time

Decision affects reimbursement, patients' out-of-pocket expenses

Helping your hospital optimize reimbursement and avoid losing money in today's healthcare audit environment starts with ensuring that the patient is in the right level of care from the beginning — and this means making sure that observation services are ordered only when they are appropriate.

It's often a balancing act to determine if a patient should be admitted to the hospital or receive observation services as an outpatient, but it's more important than ever for hospitals to get it right the first time. The decision can have implications for hospital reimbursement as well as patients' out-of-pocket expenses.

“Hospitals are being hit from all sides in terms of audits and second-guessing. The Recovery Audit Contractors (RACs), Medicare Administrative

EXECUTIVE SUMMARY

It's often a balancing act to determine if patients should be admitted to the hospital or receive observation services as an outpatient, but it's critical to get it right the first time so the hospital will get appropriate reimbursement and avoid having money taken away following audits.

- Reimbursement is much lower for observation services, but if a patient is admitted inappropriately, Medicare or other payers can take back the reimbursement.
- Patients receiving observation services as outpatients are subject to Medicare Part B co-pays. If the patient is later admitted, the time in observation doesn't count toward the three-midnight inpatient stay requirement for Medicare to pay for a skilled nursing home admission.
- One-, two-, and three-day stays are often targets of auditors.
- Case managers must work closely with physicians to help them determine the appropriate level of care.
- In certain circumstances, Condition Code 44 can be used to change a patient's level of care from inpatient to observation.

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Contractors (MACs) and the Comprehensive Error Rate Testing (CERT) contractors all are scrutinizing records to determine if patients meet inpatient criteria,” says **Deborah Hale**, CCS, CCDS, president and chief executive officer of Administrative Consultant Service, a healthcare consulting firm based in Shawnee, OK.

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Editorial Questions

For questions or comments, call Russ Underwood at (404) 262-5521.

If the admitting physician orders observation services when the patient should be admitted as an inpatient, the hospital will receive much less reimbursement for the case than it would for an inpatient admission, Hale points out.

For instance, if the physician orders observation services for a patient experiencing syncope and the patient receives tests and treatment on an outpatient basis, the best-case scenario for reimbursement is about \$700, with ancillary services bringing the total to about \$1,000, Hale says. If the case warrants an inpatient admission, the geometric mean length of stay is 2.3 days and the hospital stands to receive around \$4,300, Hale says.

On the other hand, if patients are admitted when they should receive observation services, Medicare auditors can deny the claim, in which case the hospital not only loses the reimbursement but has the added cost of appealing the denial, says **Linda Sallee**, MS, RN, CMAC, ACM, IQCI, director for Huron Healthcare with headquarters in Chicago.

Patients who receive observation services are outpatients and have to pay their co-insurance for outpatient services, which can total more than the inpatient deductible. In addition, patients in observation have to pay for all self-administered drugs. “This can be very expensive for some patients, such as those who need anticoagulation or inhalers. Even if the nurse administers it, it’s considered a self-administered drug,” she says.

If a patient receives observation services, then is admitted as an inpatient, the time spent in observation does not count toward the requirement that patients be in the inpatient setting for three midnights to qualify for a nursing home stay that is paid for by Medicare. If these patients don’t have three midnights as an inpatient and need to go to a lower level of care, they’ll have to pay for it out of pocket.

Be aware that rules for assigning observation services vary among payers, Hale says. Medicare has one set of rules for patients covered under Medicare fee-for-service, which is the traditional Medicare program. Medicare Advantage payers have a separate contract with hospitals and are not bound by Medicare fee-for-service rules, and commercial payers may have their own set of rules, she says. In addition, Medicaid and Medicaid HMOs all have different rules, which may vary depending on which state is providing the Medicaid coverage.

“Hospitals frequently are accused of misusing observation,” Hale says.

She cites a 2010 letter in which Marilyn Tavenner, acting administrator of the Centers for Medicare & Medicaid Services (CMS) wrote to the American

Hospital Association and other trade organizations, expressing concern that the number of observation hours being billed by hospitals has been steadily increasing to well over 48 to 60 hours.

“Level of care determinations are a balancing act, and it’s hard for physicians to get a clear understanding of the rules. It’s not the intent of CMS for physicians to order observation services for all patients coming into the hospital. CMS wants the determination to be made and the patient informed and the hospital to get it right the first time,” adds **Kathleen Miodonski, RN, BSN, CMAC**, manager for The Camden Group, a national healthcare consulting firm based in Los Angeles.

Case managers should work with physicians to help them in the decision-making process as they determine the appropriate level of care. The admitting physician must make the final decision on the patient’s level of care and write the orders, but case managers can work with them to help in the decision-making process, Miodonski says. *(For tips on working with physicians, see related article on this page.)*

Auditors are paid based on reimbursement, which incentivizes them to focus on cases that are most likely to be unnecessary. They are focusing on one-day, two-day, and three-day stays, Hale says. DRG 312 is assigned to patients admitted with syncope/collapse, presyncope, and orthostatic hypotension. Cases assigned to this DRG are often denied by the RACs, Hale says. Chest pain and transient ischemic attack with neurological deficit ruled out are also high on the list of denied DRGs, she adds.

Cases that are least likely to be targeted for medical necessity and denied are those in which patients have major complications and comorbidities (MCCs). That’s why it’s important for documentation to fully capture the severity of illness, Hale says.

Keep in mind that a one-day stay can be appropriate based on what the physician knows at the time the decision is made.

Make sure the physician is considering the risk for the patient and don’t be afraid to admit patients in inpatient status if they meet criteria, advises **Elizabeth Lamkin, MHA**, chief executive officer and partner in PACE Healthcare Consulting, LLC, based in Hilton Head Island, SC.

Observation is appropriate for patients who can be treated within 24 hours and sent home or those who need diagnostic tests to determine if they can go home or need inpatient care, Sallee says.

Observation is not a status; it’s a service ordered by a physician who has privileges to order outpatient services, Hale says. “It’s up to the physician to order observation services, but just because the services are

ordered, it doesn’t mean they are covered,” she adds.

Observation should not be used as a way to reduce throughput time in the emergency department just because tests have not been completed. In those cases, patients should stay in the emergency department and not go to the unit with observation services, Hale says.

Observation services are not appropriate for outpatient surgical patients unless unexpected clinical issues arise, such as the need for additional treatment to manage a complication such as uncontrolled blood pressure, Hale says. “Observation has to be medically necessary, and it’s seldom appropriate for post-surgery. Payment for the standard recovery period following surgery and routine preparation for surgery is built into the outpatient APC payment structure,” she adds. Physicians cannot order observation services before outpatient surgery in any situation.

Observation should not be billed concurrently with another Medicare Part B service when active monitoring is part of the procedure, such as during a colonoscopy, blood transfusion or chemotherapy, she says.

Observation hours start after the physician has written the order and the nursing notes indicate that the patient is receiving observation care. In most cases, observation ends when the physician writes the order to discharge the patient or admit as an inpatient. In some cases, observation ends when care is finished after the physician writes the discharge order. For example, if the patient received the final IV antibiotic two hours after the discharge order is written, observation ends after the antibiotic is delivered. However, the time a patient waits for a ride home and other delays in discharge don’t count, Hale says.

Recovery Auditors and Medicare Administrative Contractors can deny a case even it meets screening criteria, since the auditors do not typically subscribe to any one criteria, Lamkin says.

“This points out the necessity for case managers to complete a good assessment and have a second-level review if there are any questions. What we see is that hospitals that use good clinical judgment and thoroughly document the record are in a good defensive position if they have to appeal,” Lamkin says. ■

Educate physicians on level of care, documentation

Staff access points during peak hours

Physicians don’t want patients to be burdened inappropriately and want the hospital to do well

financially, but they may not understand the difference between an inpatient admission and outpatient services, says **Kathleen Miodonski**, RN, BSN, CMAC, manager for The Camden Group, a national health-care consulting firm based in Los Angeles.

As they work with physicians, case managers should make sure physicians understand the implications of getting the patient level of care incorrect and to document fully and appropriately, Miodonski suggests.

Case managers can apply criteria, but they can't make the final decision. If there are any questions about whether the patient should be admitted or receive observation services, case managers should ask their physician advisor to review the case, adds **Elizabeth Lamkin**, MHA, chief executive officer and partner in PACE Healthcare Consulting, LLC, based in Hilton Head Island, SC.

A second level of review before an order for observation is issued is always a good idea for patients who are older or who have multiple comorbidities, Lamkin says. "If there is a question in the care manager's mind about a patient's medical necessity for a level of care setting, the physician advisor can use his or her clinical judgment to determine if there are risks for the patient," she says.

Since it may not be practical for all hospitals to have the case management staff work 24-7, there has to be a mechanism for staffing up to a certain point, then catch up the next morning, Lamkin says. "If you don't get it right in the first 24 hours, it's difficult to get it right," she adds.

The areas to target may be unique to each hospital depending on the practice patterns of physicians, she says.

Hospitals should look at their own patterns of denials and determine the best places to have a case manager reviewing admissions. For instance, if there are a lot of issues with surgical admissions, a case manager in surgery scheduling may be indicated.

Analyze your peak hours for admission and have a case manager on staff to support physician decision-making during that time, Miodonski suggests.

It takes someone with expertise and training to review the cases and make sure they meet medical necessity, adds **Linda Sallee**, MS, RN, CMAC, ACM, IQCI, director for Huron Healthcare with headquarters in Chicago.

Medical necessity criteria are updated every year, and physicians don't have the time or inclination to keep up with it, she says. Physicians are going to do the same for their patients regardless of the level of care.

"This year InterQual has made a lot of changes,

and some of the criteria are very different from what it was in the past. Case managers need to stay up to date and review the cases, if not at the point of admission, within a short time later," Sallee says.

Regardless of the level of care, case managers should make sure physicians document completely so the medical record accurately shows the patient's condition and services received. "Healthcare seems to have trended toward minimal documentation, but auditors have to go by what documentation is in the medical record, and if severity of illness is not documented, they are likely to deny the payment," Miodonski says.

Physicians have to learn how to describe their decision-making, what they are concerned about, what are the implications for the patient's condition, and why the acute care setting is appropriate, she says. "Help them learn how to paint the complete picture," she adds.

A good education tool is to analyze denials by physician service and share the information with the physicians. At one hospital, Miodonski gave physicians the audit detail form from the Recovery Auditor Contractors to show them how the RACs scrutinize the chart. "It was an eye-opener for the physicians and a great educational tool. They wanted to go back and review the charts to see what could have been improved," she says.

Case management directors also need to make sure that the case management staff understand the difference between observation services and an inpatient admission, Miodonski says. "I find that different case managers often have different ideas," she says.

Miodonski suggests that case management directors give case managers patient scenarios and ask if inpatient admissions or observation services are appropriate. Use the information to determine gaps in knowledge among staff members and to tailor your educational efforts.

Every care management department should regularly conduct inter-rater reliability testing, Lamkin adds. This is normally part of the Milliman or InterQual software for determining medical necessity, she adds. ■

Inappropriate admissions mean more paperwork

Use Condition Code 44 to change level of care

If patients are admitted to the hospital when outpatient services were appropriate, the level of

care can be changed, but there's a lot of paperwork involved to correct the error.

Hospitals can file Condition Code 44 to change a patient's inpatient status to outpatient and bill all medically necessary outpatient status but only if the change in patient status is made before discharge, the hospital has not submitted a Medicare claim for the admission, and the admitting physician and a member of the utilization review committee concur in the decision.

"Case managers need to review admissions at the point of entry or as soon as possible to make sure that the patient is an appropriate inpatient admission. If it's determined that the admission was inappropriate and the patient has already been discharged, the hospital can't bill for therapeutic outpatient services provided during the encounter. It's best to get the level of care right at the onset," says **Deborah Hale**, CCS, CCDS, president and chief executive officer of Administrative Consultant Service, a healthcare consulting firm based in Shawnee, OK.

The hospital may not change a patient's status from inpatient to outpatient without utilization review committee involvement and the physician responsible for the care of the patient has to concur and change the level of care order to outpatient.

Hospitals are required to submit a claim for any Medicare inpatient admission, even if it is determined that the admission is not covered. If the hospital's utilization review committee determines after discharge that an entire admission did not meet inpatient criteria, the hospital must submit a provider-liable claim, admitting, in effect, that it made a mistake.

When patients are placed in observation status after being admitted as inpatients, the hospital must give them a written notice of their change in status and that they might be responsible for their Medicare Part B deductible and co-pay for outpatient services. If patients insist on continuing as an inpatient, the hospital must give them a hospital-issued notice of non-coverage (HINN), notifying them that Medicare does not cover their care.

"The most confusing part of the Condition Code 44 process is the timing of the order and the decision on whether to bill for observation time," Hale says.

CMS intends for hospitals to bill only for the services that have been ordered, which means that the clock for observation services doesn't start until the attending physician gives a subsequent order for observation services. Medicare does not permit retroactive physician orders or interference of

physician orders. Hospitals may not receive reimbursement for observation services for the time the patient was in the hospital before the order was changed to observation services. Instructions for proper billing are found in the Medicare Claims Processing Manual, Chapter 1, Section 50.3.2.

The patient must have received at least eight hours of medically necessary observation services following the physician's order for observation services and nursing documentation of the services for the hospital to be paid.

"If the change from the inpatient level of care is made quickly enough after admission, the physician can order observation services and the hospital is likely to have enough time to bill for observation," Hale says.

The webinar by Deborah Hale, "Strategies for Appropriate Level-of-Care Determination: Avoiding Overutilization of Observation Services," is available at: www.ahcmedia.com/public/products/Strategies-for-Appropriate-Level-of-Care-Determination-%252d-Avoiding-Overutilization-of-Observation-Services-.html

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Hospital initiative reduces heart failure readmissions

Transitions in care are the target

By revamping the discharge process and working with post-acute providers, UConn Health Center/John Dempsey Hospital, Farmington, CT, reduced 30-day heart failure readmissions from 25.1% in August 2010 to 17% in March 2012.

Key initiatives included making follow-up appointments before patients leave the hospital, adding automatic dietician, social worker, and pharmacy consults to the heart failure order set, revising the educational

materials the patients receive at discharge, and collaborating with community providers on ways to smooth transitions.

“Readmissions are a hospital problem, but they go well beyond the walls of the hospital. We recognize that once patients leave the hospital, we have to work with the next level of care to facilitate the discharge plan and continue treatment,” says **Wendy Martinson**, RN, BSN, QA specialist in the clinical effectiveness and patient safety department.

The hospital assembled a committee of hospital staff and representatives from post-acute providers who meet monthly to collaborate on ways to improve transitions from one level of care to another.

The committee has revised the discharge forms, agreed on using the same educational materials, and works together to improve communication between the hospital and post-acute providers. (*For more details on the meetings with community providers, see “Meetings help improve patient transitions”*: Hospital Case Management, September 2012, pages 132-133.)

The 184-bed hospital, an integrated academic medical center connected with the UConn Schools of Medicine and Dental Medicine, participated in a state-wide collaborative on reducing readmissions for heart failure patients sponsored by the Connecticut Hospital Association.

To spearhead the readmission reduction project, the hospital assembled a multidisciplinary team that included the physician leader, Jason Ryan, MD, the heart failure nurse practitioner, dietitians, social workers, case managers, representatives from nursing, pharmacy, and the hospital’s outpatient clinics. The team analyzed readmissions and looked for ways to improve the discharge process. One of the

first initiatives was to look at ways to make sure that every patient with heart failure left the hospital with a scheduled follow-up appointment within seven days of discharge. The hospital trained the unit secretaries to make the appointments and enter them into the computerized discharge instructions. “We also educated the heart failure clinic staff that patients needed to be scheduled for an appointment within seven days. Four physicians at the clinic agreed to over-bookings to ensure that patients were seen in a timely manner,” she says.

While a major portion of heart failure patients discharged from the hospital go to the hospital’s heart failure clinic, some are being treated by cardiologists or primary care providers who are not part of the health system.

When the staff can’t schedule a timely appointment with these providers, they contact them and ask if they will agree for the patient to be seen in the heart failure clinic just once to make sure they are managing their condition at home and understand their treatment plan. “We have not encountered any problems with this arrangement because we make clear to the providers that we aren’t taking their patients. We just want to make sure they are seen by a physician within seven days of discharge,” Martinson says.

The team tackled the patient education process to ensure that everyone who cared for the patients was telling them the same thing and that educational materials were written at a level patients could understand.

Working with students from the University of Connecticut School of Pharmacy, the team created a health-literate medication booklet that explains the different medications typically prescribed for heart failure and lists all the brand names and generic names in each category.

“We found that often patients are taking one beta-blocker or ACE inhibitor when they come in and are prescribed a different one in the hospital. Sometimes they don’t understand and take both of them when they go home,” she says. The booklet includes questions to ask their doctor, questions to ask their pharmacists, and information on how to safely dispose of unused medications.

The team obtained copies of three different heart failure educational booklets and asked the patients to indicate the one they preferred. “The patients all chose the booklet written on the third-grade level. This helped us understand how we needed to structure our education program,” she says.

The hospital created its own Heart Failure Zone sheet, which describes warning signs and symptoms and what to do when each occurs. Patients are

EXECUTIVE SUMMARY

UConn Health Center/John Dempsey Hospital, Farmington, CT, reduced 30-day heart failure readmissions from 25.1% in August 2010 by analyzing readmissions and looking for ways to improve the discharge process.

- When patients can’t schedule a timely appointment with providers who are not part of the healthcare system, the case manager schedules one appointment with the hospital’s heart failure clinic.
- The team created an easy-to-understand medication booklet, got patient input about which heart failure educational booklet to use, and created a heart failure video for patients, families, and staff.
- Hospital representatives meet monthly with representatives from post-acute providers to collaborate on improving transitions.

instructed to put the zone sheet on the refrigerator using a magnet that shows “red flag” symptoms to watch for and a place for their physician’s phone number. They receive a weight chart and are asked to keep it by their scale.

Working with Qualidigm, the Connecticut Quality Improvement Organization (QIO), the hospital obtained special funding through Medicare to create an educational video for licensed and unlicensed staff as well as patients and families. “We also showed this video to our nurses and nursing assistants to make sure they all teach the same thing,” she says. (*The video is available through Qualidigm’s website: www.hearttalk.org.*)

Whenever possible, the nurse practitioner from the heart failure clinic visits patients in the hospital to start the education on the heart failure zones and to begin to develop a relationship that will continue in the clinic.

The team developed a process to notify the hospital staff of all patients with heart failure. Each morning, the hospital pharmacy sends Martinson a list of all patients who are receiving diuretics. She compares the diuretic list with the patient list and reviews the patient charts to determine which patients have heart failure, then sends a list of the patients and their hospital floor to about 150 staff including unit secretaries, pharmacists, the cardiology and hospital medicine service, the chief resident, social workers, case managers, dietitians, nurse managers, assistant nurse managers, and nurses in the heart failure and primary care outpatient clinics. “I also list patients who are not admitted for heart failure but have a history of it. The staff knows that these patients don’t need follow-up but they do need education,” she says.

When the list comes out, the unit secretaries put a blue heart next to the patient names on the unit’s census board so everyone on the team will be aware. When they receive the email, the social workers know to schedule a complete assessment of discharge needs and nursing knows to start the education process.

When a patient on the heart failure list is ready for discharge, the case manager notifies everyone who receives the daily emails about the discharge date and discharge destination. This alerts everyone on the team to finish what they need to do. The unit secretary knows to make the follow-up appointment. Pharmacy is cued to address the medication regimen.

SOURCE

• **Wendy Martinson**, RN, BSN, QA, Specialist in the Clinical Effectiveness and Patient Safety Department, UConn Health Center/John Dempsey Hospital, Farmington, CT. email: wmartinson@uchc.edu. ■

‘Strategic triad’ initiatives help health system cut LOS

Interdisciplinary meetings focus on discharges

UCLA Health System in Los Angeles reduced length of stay and improved patient throughput by using a “strategic triad” of initiatives that includes interdisciplinary rounds, clinical high-risk meetings, and use of escalation to overcome barriers to discharge.

“Capacity issues, unfunded patients, and health care reform provisions have created significant challenges for our health system as well as other healthcare providers today. Our care coordination department undertook this initiative to address these challenges and to train the staff to effectively implement the strategies,” says **Marcia Colone**, PhD, LCSW, system director for care coordination, UCLA Health System. The health system includes Ronald Reagan UCLA Medical Center, UCLA Santa Monica Medical Center, Mattel Children’s Hospital UCLA, and Resnick Neuropsychiatric Hospital UCLA.

Since UCLA began the initiative, the average length of stay at Ronald Reagan Medical Center has dropped by 0.8 day and by 0.5 day at Santa Monica Medical Center. Since the weekly clinical high-risk meetings, which focus on patients with longer-than-average stays, were begun on May 1, 2010, the average long lengths of stay have dropped from 17.2 days to 16.1 days at UCLA Ronald Reagan Medical Center and from 11.3 days to 10.4 days at UCLA Santa Monica Medical Center.

“We usually are over 95% occupancy. We have to get patients moved through the continuum quickly and safely, and we are always looking for ways to do so,” Colone says.

The interdisciplinary team on each medical unit holds rounds on every patient every morning and lightning rounds in the afternoon to discuss patients whose discharge is pending.

Participants in the morning rounds include physicians, nurses, case managers, representatives from ancillary services, and the hospitalist team. They discuss the care plan, the patient’s progress in meeting his or her goals, what is to happen that day to meet the goals of the care plan and get the patient ready for the next level of care and any barriers to discharge.

The case manager presents basic information about each patient, including the prior living situation, functional status, payer source, and other pertinent information, then asks each discipline to provide updates, expected length of stay, and

expected discharge destination.

For instance, the house staff identify the goals of care, how the patient is responding to treatment, results of tests, clinical care planned for the day, rationale for level of care, and anticipated discharge date. The bedside nurse reports on intensity of service, what is being provided for the patient, and gives a brief rundown on family engagement, patient teaching, the patient's capacity to learn, and activity level. The social worker discusses family engagement and family resources, and sets up a family meeting with the team, or requests financial assistance if needed.

"The interdisciplinary rounds are pivotal in enhancing communication and hand off. We make sure the discussion points are very clear and that everyone understands what we are focusing on. We have developed scripting that helps people stay on track and doesn't allow anyone to deviate into other discussion points," Colone says.

Each of the six medicine services holds lightning rounds with the case manager as the facilitator and focuses on patients who are expected to be discharged the next day. Other participants include physical therapists, social workers, discharge planners, and pharmacists.

The team discusses medical necessity, progress on goals for the day, barriers to meeting the goals, next steps, anticipated discharge, and discharge destination.

During weekly clinical high-risk meetings, the team looks at patients with a length of stay that is greater than one standard deviation above the average length of stay. The one-hour meetings are led by the care coordination manager and attended by case managers and social workers. The team reviews problematic cases and focuses on what the barriers are and develops strategies to address the barriers. When appropriate, the team uses the High Intensity Escalation process to identify real or emerging barriers, interventions attempted and failed, and escalate through the chain of command.

"We take a laser focus on what has to happen and what are the issues. We use escalation when routine strategies have failed, when the patient has been medically ready for discharge for at least a day and the discharge plan is sketchy or seems illogical, and when the case manager or social workers feels that a real barrier is emerging," Colone says.

For instance, if there are avoidable delays because of the physician action or inaction, the case manager or social worker first communicates with the physician, then escalates to the physician advisor for a physician-to-physician discussion, then informs the care coordination manager about what is going on. If the delays are because the patient is reluctant to discharge

or doesn't have an adequate support system, the case manager or social worker first talks to the patient and family, then asks the physician to talk to the patient and family, and strategizes with the care coordination manager about the next step.

"High Intensity Escalation isn't second nature. With high caseloads, often interventions are started and paused and focus is lost when the escalation process isn't formalized and integrated into the daily workflow. The escalation process is designed to get the staff focused and helps them understand that the goal is to advance the care plan and discharge the patient safely and that everything in the middle has to be managed," Colone says.

SOURCE

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Hospital reduces med errors to 0.1 per 1,000

Operating a small hospital doesn't mean you can't think big. Ellenville Regional Hospital (ERH), a 25-bed rural hospital in Wawarsing, NY, is enjoying success with a medication reconciliation and patient safety project that would be the envy of any large teaching institution by reducing medication-related events to a very low 0.1 occurrences per 1,000 doses dispensed.

As a result, Physicians' Reciprocal Insurers (PRI), the second largest medical malpractice insurer in New York state, presented Ellenville Regional Hospital with its 2012 Best Practices in Risk Management and Patient Safety Award.

The program was born in 2008, says **Michael Stearns**, RPh, director of pharmacy. Stearns and others at the hospital had been eager to address medication safety issues, particularly the number of admissions due to unsafe medication practices, after the 2001 "To Err is Human" report.

"There were therapeutic duplications of medicine, overdoses of therapeutic medicines, underdoses, and things like that. They were all preventable," Stearns says. "So we thought if we implemented some education protocols and sat down to really spend time with people, this could really be beneficial to our patients."

Along with Stearns, **Ashima Butler**, CPMSM, CPCS, vice president of quality, compliance, and medical staff management, was worried about

patient safety being compromised by medication errors. Those errors included those brought on by patients not fully complying with or understanding their medication use. “Being a small hospital, we weren’t having a significant amount of medication errors but enough that we really started to worry about where the gap was, why our staff were missing some key information and not getting the right medication to the patients,” Butler says.

The resulting program involves having Stearns, the hospital’s only pharmacist, see patients by appointment to discuss their medications. He also visits inpatients in the hospital. In addition, the program was taken outside the hospital to the hospital’s senior living center and family physician practice. “I’ve seen over 1,500 patients, and they all walked away with more knowledge than they came with,” Stearns says.

The number of medications was a first concern, but Stearns also considers issues such as how many doses per day the person was supposed to take of all the medications. “We found that some people were supposed to take 30, 40, 50 doses of their medications a day, and that was not feasible,” Stearns says. “We redesigned their programs to make them more achievable. Patients became more aware of their healthcare and were able to interact more effectively with their doctors and nurses.”

Patients often were counseled multiple times, but Stearns found that even meeting with a patient just once could produce significant improvement in medication compliance and safety. In what he refers to as “getting the pharmacist out of the pharmacy,” Stearns began interacting more directly with the physicians and staff during patient care, visiting to perform medication reconciliation at the bedside. “The doctor prescribed the medication, but instead of just having it delivered, he would sit with the patient and discuss what it was, how it worked, what kind of reaction they might have, how and when to take it,” Butler explains. “Mike also started reviewing the MARS [medication administration records] on a daily basis to make sure nursing wasn’t leaving any gaps, like a missed dose.”

The effort has changed the role of the hospital’s pharmacist from dispensing to consulting, says **Steven L. Kelley**, FACHE, president and CEO.

“In the future,” Kelley says, “I see the pharmacist becoming more the decision-maker, much more so than now, in recommending which medications to use. The provider will be focused on diagnosing and recommending treatment, and the pharmacist will be much more active rather than just dispensing on someone else’s order.” ■

Got culture change? CUSP tools can transform safety

Challenges include engaging senior leadership

The Agency for Healthcare Research and Quality (AHRQ) has created a website with a wealth of tools to help hospitals set up the Comprehensive Unit-based Safety Program (CUSP). (www.ahrq.gov/cusp-toolkit) Frontline users that have implemented CUSP say they not only reduced infections, but dramatically transformed their overall patient safety culture.

While a proven method to reduce central line-associated bloodstream infections (CLABSIs), CUSP is adaptable to various projects and can also be used to prevent non-infectious adverse events. It combines clinical best practices with an understanding of the science of safety, improved safety culture, and an increased focus on teamwork. Because different users will need different resources, the toolkit is designed to be modular and flexible to local needs.

“It is essentially a multi-pronged quality improvement program, and very importantly it is customizable and self-paced,” said **Carolyn M. Clancy**, MD, director of AHRQ. “It includes instructive guides, presentation materials, and implementation tools such as checklists and videos that demonstrate desired behaviors. As a physician myself, I need to point out that the toolkit was developed by clinicians for clinicians.”

The CUSP evolved out of an effort to prevent central line associated bloodstream infections by **Peter Pronovost**, MD, PhD, senior vice president for patient safety and quality at Johns Hopkins Medicine. The current model in the toolkit can be used to address a variety of infections, harms and hazards.

“[CUSP] is an iterative process because we are always learning,” Pronovost said. “The first [step] is to make sure all of the staff know the science of safety — there is a science that underlies it. Too few of us clinicians were trained in that. There is a great program in the tool kit for this.”

With high staff turnover a common problem at some facilities, the CUSP science safety module can also be used as a primer for new employees.

Involvement of executive leadership is stressed heavily in CUSP, suggesting that interventions undertaken without clear administrative support are less likely to be successful. “The senior leadership at our hospital is involved in this [CUSP] process,” said **Theresa Hickman**, RN, nurse educator at Peterson Regional Medical Center in Kerrville, TX. “Every month I make a report on how we are doing, and it goes straight to

the board.”

The CUSP tool kit suggests recruiting executives who can authorize the use of the resources needed to help unit-based teams resolve patient safety issues. Senior leaders should be familiar and comfortable with the goals of the project. Executives who have a vested interest in the quality of care make great CUSP team members, the program emphasizes.

“Leadership is so key — leadership becomes part of that unit team trying to fix problems,” Pronovost said.

However, the CUSP program concedes that senior executive buy-in might be the most significant obstacle a team faces, particularly if the administrator does not have a clinical background.

“In these situations the use of a tool like an Opportunity Estimator, which calculates estimated lives lost and dollars spent as the result of CLABSIs, can engage hospital executives with the prospective cost savings that can result from CUSP implementation,” the CUSP tool kit states. “Encouraging senior executives, particularly those without a clinical background, to ‘shadow’ a nurse or physician champion can [also] help them to better understand unit challenges firsthand.”

Team building is a critical part of the program, as health care workers are empowered to work for positive change in ways that may break down some of the traditional roles in medicine. The key CUSP team members — nurses, physicians, and senior executives — are needed to ensure that the initiative is implemented on the frontlines and adequately resourced. However, input and participation is then needed from other unit or hospital specialists. These team members include infection preventionists, medical directors, pharmacists, respiratory therapists, patient safety officers, chief quality officers and ancillary or support staff.

“The team is a concept really — it is not necessarily a list of people,” said Michael Tooke, MD, chief medical officer at Memorial Hospital in Easton, MD. “When you put in a central line, at any given point in time the team is an entirely different set of people because it depends on who is on duty. So it will not work without [complete] unit-based participation. These lines are put in in the middle of the night by different nurses and doctors. It has to be engrained in the way the entire unit takes care of patients.”

On the other hand, Tooke’s ventilator-associated pneumonia [VAP] prevention team is a multi-specialty group that makes rounds in the ICU twice a day. “So that team is pretty much the same people,” he said. “They make rounds to make sure that the ventilator care is appropriate.”

In addition, urinary catheters are placed all through

the hospital, thus prevention of catheter associated urinary tract infections [CAUTIs] must involve teams throughout the facility to determine if and when catheters can be removed.

“So you have a [CAUTI] team at one level — say the overall nursing and medical staff — but then each unit has a team because there is a nurse manager that is making sure the protocol for getting out Foley catheters is the same,” he said. “The team is set up depending on where it is, the breadth of the intervention, and who is there the day that the device or the intervention is put into place.”

The CUSP toolkit suggests keeping the “4 E’s” model in mind in starting and sustaining initiatives:

Engage: Engaging a staff member is an example of adaptive work in which CUSP teams help unit staff understand the effects of a preventable harm caused by a clinical problem. One method of engagement is sharing stories about patients affected by this problem and estimating the number of patients who could be harmed as a result of this problem.

Educate: CUSP team members transmit information to staff and senior leaders regarding actions to take to prevent clinical problems.

Execute: An example of adaptive work, execution is based on the principles of safe system design: Simplify the system, create redundancy, and learn from mistakes.

Evaluate: Evaluation is an example of technical work in which unit teams collect and submit data related to any clinical problem to analyze the progress of an intervention.

“We also added another E — enthusiasm,” Tooke says. “We acknowledged every victory. One month without infections, 100 days, a whole year. We had a unit-based celebration every time we had a victory. This helped reinforce the role of ownership of this project to those at the bedside. We have gone from keeping track of days since the last infection to days until the next celebration.”

If an infection or another adverse event occurs, the CUSP model recommends a “learning from defects” approach that often reveals that systems contribute to the underlying causes of problems. The CUSP mantra in this regard is: “Every system is perfectly designed to achieve the results it obtains.” Learning from defects is termed “second-order” problem solving, which examines the underlying causes and processes that contributed to the event. Clinicians are generally adept at “first-order” problem solving, which is “recovery” problem solving to correct errors after they occur.

“But we want them to learn — not just recover — from those mistakes,” Pronovost said. “In other words, make sure another patient won’t be harmed.”

Tooke cited this defect-evaluation aspect as an example of ongoing use of the tools to improve medical care. “We experienced two bloodstream infections in patients that were undergoing an innovative therapy on one of the medical floors,” he said. “We used the [defects] tool to work through the process and determine the root cause of those infections. We haven’t had a similar infection on that floor in over a year.”

The majority of the CUSP Toolkit modules focus on quality improvement projects at the unit level, where culture is necessarily local. However, the program also includes a “spread” module that helps an organization move the components of a successful intervention from the unit level to the larger organization. ■

CNE INSTRUCTIONS

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

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

CNE OBJECTIVES

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

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

COMING IN FUTURE MONTHS

- Why it’s important to partner with hospitalists.
- Tips for surviving RAC audits.
- Helping physicians have difficult conversations with patients.
- Discharge planning for the uninsured.

CNE QUESTIONS

1. What are the implications for patients if they are outpatients receiving observation care?
 - A. They have to pay co-pays for outpatient services.
 - B. They are responsible for the cost of “self-administered drugs” even if the nurse administers them.
 - C. If their stay is converted to inpatient status, the time in observation doesn’t count toward the Medicare requirement that patients spend three midnights as inpatients to qualify for a Medicare-funded nursing home stay.
 - D. All of the above
2. According to Deborah Hale, CCS, CCDS, president and chief executive officer of Administrative Consultant Service, cases least likely to be targeted for medical necessity and denied are those where there are major complications and comorbidities.
 - A. True
 - B. False.
3. What conditions must be present for hospitals to change a patient’s level of care from inpatient to outpatient with observation services using Condition Code 44?
 - A. Upon review, the case manager finds the case doesn’t meet inpatient criteria and the admitting physician agrees and changes the order.
 - B. The change in patient status is made before discharge, the hospital has not submitted a Medicare claim for the admission, and the admitting physician and a member of the utilization review committee concur in the decision.
 - C. The patient has been in observation for 48 hours and still needs care that can be provided only in the hospital.
 - D. The patient is still in the hospital, the utilization review committee votes to change the status, and the case manager delivers a notice to the patient and family.
4. When heart failure patients at UConn Health Center/John Dempsey Hospital, Farmington, CT, are being treated by a community physician not in the health system and the staff can’t get them a timely follow-up appointment, what do they do?
 - A. Double up on the education and check back with the patients frequently after discharge.
 - B. Refer them to a different physician who can see them within seven days.
 - C. Get an order for a home health nurse to follow up with the patient.
 - D. Contact the provider and ask if the patient can be seen in the hospital’s heart failure clinic just one to ensure a timely follow up.

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