HOSPITAL CASE MANAGEMENT™

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

AHC Media LLC

IN THIS ISSUE

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Get ready for a totally new DRG system focused on hospital costs, not charges

CMS proposes major changes in the IPPS, with more to come

The Centers for Medicare & Medicaid Services (CMS) has proposed sweeping changes to the hospital inpatient prospective payment system for fiscal year 2008, which begins Oct. 1, 2007.

In a surprising move, CMS announced its intention to use the Medicare-Severity DRG (MS-DRG) system for 2008 instead of any of the five other severity-adjusted DRG systems it has contracted with the Rand Corp. to evaluate.

However, in its proposed rule, the agency did not rule out implementing another DRG system in FY 2009, according to **Deborah Hale**, CSS, president of Administrative Consultant Services Inc., a health care consulting firm based in Shawnee, OK.

CMS is continuing with its evaluation of the five alternative DRG systems for long-term use and has asked Rand to evaluate the proposed MS-DRG system, using the same criteria it is applying to the other DRG systems. CMS will not make a decision as to which DRG system to permanently adopt until Rand's analysis is complete.

"The new severity-based DRGs represent one of the most significant improvements to the hospital inpatient payment system since the institution of the prospective payment system in 1983. When combined with the reforms that were established last year, these refinements of the hospital payment system should significantly improve the predictability, reliability, and fairness of Medicare payments," said **Leslie Norwalk**, Esq., CMS acting administrator.

The proposed rule will implement a provision of the Deficit Reduction Act of 2005 that takes the first steps toward eliminating higher payments for the additional cost of treating a patient who acquires a condition, including an infection, during a hospital stay. Hospitals will be required to begin reporting secondary diagnoses that are present on admission, beginning in October. **(For details, see related article, p. 83.)**

Other provisions of the proposed rule include continuing the three-year transition to using hospital costs instead of hospital charges as a basis for reimbursement and expanding the number of quality measures that hospitals must report in order to qualify for the full market basket payment update.

CMS is soliciting comments on the proposed rule until June 12. The final rule, which will be effective for discharge on or after Oct. 1, will be issued later in the summer.

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CMS updated an analysis of the MS-DRG system, which it considered adopting in the mid-1990s, and proposes to create 745 new DRGs to replace the current 538. The new DRGs will be numbered 1 through 999, leaving room for new DRGs in the future.

"The proposed rule represents a significant improvement to the Medicare program's ability to recognize severity of illness in its inpatient hospital payments," CMS documents assert.

The new DRG system makes it more important than ever for case managers and coders to make sure that the documentation and coding is accurate, Hale says.

Hospitals could lose more than expected

"CMS is assuming that the new DRGs will result in better documentation and better coding, so they are planning a -2.4% adjustment to the standard payment rate. Therefore, if a hospital does not effectively improve documentation and coding, it may lose more than anticipated," she adds.

The emphasis of the changes is on re-evaluation of the complications and comorbidities list, Hale says. The way the base DRG is assigned remains essentially the same as in the current system, she adds.

"Under the current system, 80% of patients have a complication or comorbidity [CC] so the CC no longer gives the hospital adequate credit for severely ill patients," she says.

The MS-DRG system splits DRGs into three categories: MCC — major complication/comorbidity; CC — complication/comorbidity; and non-CC — neither of those.

"Many more DRGs will now be split based on the presence of MCC/CC/non-CC, including chronic obstructive pulmonary disease and congestive heart failure. However, there are more than 50 DRGs that are not split," Hale says.

Many conditions that are common CCs under the present system, no longer will affect the DRG assignment, she adds. These include blood loss anemia codes, arterial fibrillation, dehydration, urinary tract infections, and uncontrolled diabetes.

"The MS-DRGs better recognize the severity of illness than the current CMS DRGs," CMS said in a published statement.

The new system will both increase and decrease payments to hospitals, depending on the kind of cases they treat, CMS said.

"The MS-DRGs, like all of the severity DRG systems being evaluated by Rand, can be expected to increase payments to urban hospitals and decrease payments to rural hospitals. This impact occurs because patients treated in urban hospitals are generally more severely ill than patients in rural hospitals," CMS said.

Under the new system, hospitals treating more severely ill and more costly patients will receive higher payments, while payments for hospitals treating less severely ill patients will decline.

"The new DRG system presents opportunities to improve documentation and coding to receive higher payments without a real increase in patient severity of illness. By more accurately recognizing the cost of caring for a patient, the new MS-DRGs will further reduce incentives for hospitals to 'cherry-pick,' the practice of treating only the healthiest and most profitable patients," CMS said.

CMS: Specialty hospitals likeliest to get hit

One of the aims of the changes in the proposed rule, according to CMS documents, is to eliminate biases in the current system that have provided incentives for physician-owned specialty hospitals to treat the healthiest and most profitable cases, leaving the sickest and least profitable patients to general acute care hospitals.

Hardest hit are likely to be the cardiac specialty hospitals, according to a statement issued by CMS.

"Cardiac specialty hospitals generally treat the healthiest and least costly patients and their payments are projected to decline by 4% from the MS-DRG. This reduction is in addition to reductions of over 5% that we estimated last year," CMS stated.

The proposed rule for FY 2008 continues changes begun last year to improve the accuracy of Medicare's inpatient hospital payments by using hospital costs rather than charges to set rates. For FY 2007, one-third of hospital payments were determined using estimated hospital costs. Beginning in October, the figure increases to two-thirds of hospital payments.

More quality measures to come

The proposed rule adds five new quality measures, bringing to 32 the number of performance measures hospitals would need to report in FY 2008 in order to qualify for the full market basket payment update in FY 2009. The new performance measures that go into effect in October 2007 include measures in the Surgical Care Improvement Project (SCIP), 30-day mortality measures for some conditions, and the 27-item Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).

The HCAHPS measures patient perception of care in seven categories that include: nurse communication, physician communication, responsiveness of hospital staff, communication about medicine, cleanliness and quiet of hospital environment, pain management, and discharge information, along with two questions about overall quality of care and whether patients would recommend the hospital to others.

CMS also announced its intention to add five additional measures in FY 2009 and is soliciting comments on whether and how to add other measures in future years.

"These reforms represent CMS' continued push to become a more active purchaser of high-quality care for Medicare beneficiaries," Norwalk said.

As part of its quest to implement a value-based purchasing program for Medicare payments, beginning in FY 2009, CMS has developed an internal hospital pay-for-performance workgroup that is expected to issue a final report in June 2007.

(Editor's note: Look for more details on the MS-DRGs and how they will affect the activities of case managers in the July issue of Hospital Case Management.*)* ■

Prepare to track conditions not present on admission

CMS will stop paying for some in FY 2009

In a little more than a year, if a patient develops an additional condition or infection after admission, your hospital may not get paid for treating the condition.

As part of its move toward a value-based purchasing system, the Centers for Medicare & Medicaid Services (CMS) will stop paying for the treatment of select conditions that were not present on admission as of October 2008.

In its proposed rule for fiscal year 2008, CMS requires hospitals to report whether secondary diagnoses coded on the claim were present on admission starting in October 2007, according to **Deborah Hale**, CSS, president of Administrative

Consultant Services Inc., a health care consulting firm based in Shawnee, OK.

Hospitals filing claims on the UB-04 already have to include a "present on admission" code" on their inpatient claims, Hale says. CMS will issue instructions for how hospitals can include the code on electronic claims forms at a later date.

The pay-for-performance provision of the Deficit Reduction Act of 2005 requires CMS to identify two or more DRGs to focus on for payment reductions when the presence of a hospital-acquired infection increases the DRG payment.

The act stipulates that the conditions selected are high cost, high volume, or both; that they are assigned to a higher-paying DRG when they are present as a secondary diagnosis; and that they are reasonably preventable through the application of evidence-based guidelines.

"CMS wants to make sure they are not paying to treat complications that are the result of poor quality. They are identifying diagnoses that could occur while the patient is hospitalized that could have been prevented by evidence-based medicine," Hale says.

CMS to select preventable conditions

CMS has formed a workgroup of physicians and staff from CMS and the Centers for Disease Control and Prevention (CDC) to review a list of potential conditions and set priorities. In the proposed rule, CMS is proposing to select the first six conditions on the list, which include catheter-associated urinary tract infections, pressure ulcers, and *Staphylococcus aureus* septicemia, as well three serious preventable events ("never events") — objects left in surgery, air embolisms, and blood incompatibility.

CMS is soliciting comments from the public on these and seven other conditions to determine if they are reasonably preventable, currently have unique codes, and would be good candidates for future inclusion on the list.

In fact, the agency already has taken the first steps toward lowering payments for hospital-acquired infections.

In its final rule for fiscal 2007, issued in August 2006, CMS created two new DRGs for infectious or parasitic diseases resulting in an operating room procedure. DRG 579, infectious diseases for which the principal diagnosis is postoperative or post-traumatic infection, will result in approximately $10,000 less reimbursement than DRG 578 (infectious or parasitic diseases), Hale says.

Hale described a possible scenario that could occur in other DRG pairs if CMS singles them out for attention under the "present on admission" rule: An elderly patient comes in with a hip fracture (DRG 211) and develops pneumonia while in the hospital. Under the present CMS regulations, the DRG would change to DRG 210, indicating the presence of a comorbidity or complication.

"This DRG has a higher relative weight, which substantially increases the amount of the payment. If hospital-acquired pneumonia is one of the complications that CMS includes in the rule, the net effect would be that CMS will not reimburse the hospital for treating the pneumonia, which could have been prevented," Hale points out.

The same would be true for a decubitus ulcer or a urinary tract infection caused by a catheter, if those are diagnoses CMS chooses to include, she adds.

It's highly unlikely that a patient would come in for repair for a hip fracture and have pneumonia as well, but it's not impossible, Hale says.

Track when CCs occur

That's why it's important for hospitals to pay attention to complications and comorbidities and track when they occurred, Hale adds.

The "present on admission" reporting will include five options that must be included on all diagnoses:

- **Y** for yes;
- **N** for no;
- **U** for "no information in the record";
- **W** if it can't be determined clinically;
- **Blank** if the condition is exempt from "present on admission" reporting.

While recording the "present on admissions" diagnosis is the primary responsibility of the coding staff, case managers who are involved in clinical documentation improvement must make sure that all conditions that are present when the patient is admitted are included in the documentation.

This will enable coders to identify the appropriate sequence of diagnoses as they review the charts and note which conditions were present on admission.

"The only way to determine if a condition is not hospital-acquired is if it was noted in the documentation that it was present on admission," Hale says.

For instance, suppose a patient is admitted with a principal diagnosis of pneumonia. Two days later, the clinical documentation specialist

or case manager looks at the chart and points out that the patient also met the criteria for sepsis at the time of admission but it was not documented on the chart. The physician is queried and on the third day, adds the diagnosis of sepsis to the chart. "In this instance, it may be harder for the coder to determine whether the sepsis was present on admission or developed three days later," she points out.

Case managers and/or clinical documentation specialists should get in the habit of asking the physician to clarify whether an additional diagnosis was present on admission, Hale recommends.

Hospitals will need to educate and train their medical records and clinical staff on the new reporting requirements and compliance issues, she adds.

"Ultimately, it will be a good thing for hospitals because it will help provide a better picture of the severity of illness of their patients and the quality of the care they provide," Hale says.

Under the current system, many tertiary care hospitals appear to be providing substandard care because there is no opportunity to include the comorbidities and complications that patients had when they were admitted, Hale points out.

In preparation for the time when they may not be paid for conditions that are not present on admission, hospitals should begin tracking their admission data to determine what additional diagnoses are present on admission and which ones occur most frequently during the hospital stay, Hale suggests.

Identify QI initiatives

Use the information to identify opportunities for quality improvement initiatives, she recommends. Look at ways to avoid complications, such as infections and deep vein thrombosis, that occur during the hospital stay.

Start looking ahead and making sure that the documentation supports all of the conditions a patient had at admission, Hale says.

"When something is being documented as a late determination, the documentation should support that it was present when the patient was admitted," she says.

Pay for performance is an emerging trend in health care and the "present on admission" requirement is only a first step in the total overhaul of the Medicare inpatient prospective payment system, Hale points out. ■

Proactive approach improves documentation

CMs assess patients before they are moved to a bed

A proactive approach to documentation improvement has paid off for Northwest Hospital and Medical Center in Seattle.

"Documentation and other proactive initiatives have had a positive impact on the hospital financially, but more importantly, they also have resulted in better patient care," says **Becky Budke**, MSN, director of care management, performance improvement, and medical staff services for the nonprofit community hospital.

The hospital is 30% ahead of the state average for risk of mortality variance. The hospital has also received the 2007 Distinguished Hospital Award for Patient Safety from HealthGrades, indicating the hospital's placement in the top 5% of the nation's hospitals for patient safety.

"Paying diligent attention to physician documentation projects has impacted our case mix index, risk-adjusted mortality, severity of illness, and patient status. We have experienced significant improvements in each of the four areas," Budke adds.

At Northwest Hospital and Medical Center, case managers partner with social workers to manage the care of patients on the unit to which they are assigned.

Together, the two disciplines are responsible for a maximum census of 18 patients. The social workers oversee the discharge planning and typical social work functions. They see about 70% of patients. The nurse case managers are responsible for 100% of the patients, handling utilization management, DRG assignment, appropriateness for admission and continued stay, and communicating with payers.

The disciplines work together when patients have complex discharge needs, such as wound care or IV antibiotics.

The hospital's documentation improvement initiative is twofold — patient status and DRG assurance — and both parts are spearheaded by case managers.

Every patient who is admitted through the emergency department is assessed for admission status, using InterQual criteria, either by a case manager or a nursing supervisor.

The case managers rotate being on call to the

emergency department and have a commitment to answer their page within 15 minutes.

The admitting representative pages the case manager or supervisor when a patient has the potential for being moved to a bed. The patient is assessed using InterQual criteria before he or she can be moved.

Working in real-time

"We are determining whether a patient meets inpatient or observation status in real-time and are not reacting to it. It's far more efficient for case managers to conduct the review on the front end than to react to it after the patient has already been admitted," Budke says.

The nursing supervisors have been trained to review the patients when the case managers are not in the hospital.

"When we first tackled patient status, there was no documentation in the medical record to support patient status, and the physicians were very inconsistent with their orders," says **Susan Truscott**, BS, CCM, clinical documentation coordinator at the hospital.

The case management team educated the emergency department staff and physicians throughout the organization on what clinical criteria are required for patients to meet inpatient or observation status. Now every chart has a place for the physician order indicating patient status as well as a copy of the InterQual review.

For the DRG assurance program, the case managers work in partnership with the coders and physicians to ensure that documentation is in place to support the correct DRG before the patient is discharged.

When the hospital embarked on the DRG documentation improvement project, it called in an outside vendor who conducted a chart audit and identified opportunities of improvement, including DRG assignment and accurate reflection of severity of illness and risk of mortality for the hospital's patient population.

The case managers, coding staff, and physicians went through intensive training on documentation before the initiative began.

Now, the case managers work with physicians for documentation in real-time rather than the coders working with the physicians on documentation retrospectively.

Assigning the correct DRG concurrently, rather than retrospectively, has helped the hospital improve compliance with The Joint Commission and Centers for Medicare & Medicaid Services' hospital quality measures, Budke says.

When a patient is admitted into the hospital, the case manager reviews the charts and assigns a working DRG, consulting the coding staff with any questions. The coders and case managers have regular meetings and talk daily on a case-by-case-basis.

"Coders keep us up to date on changes in coding so we can adjust our queries and educate the physicians. We make sure the documentation is solid before they touch the chart so they don't have to do as much retrospectively," Truscott says.

The case management department has developed a bright-green lime sheet on which case managers write queries to physicians about documentation and record questions about potential complications and comorbidities to ensure that the physician's document is in a language that can be coded.

The sheets stick out of the charts about ¼-inch so the physicians notice them immediately. Physicians can check off, "Yes, I agree and I'll document it," or, "No, I disagree."

Speaking in codeable language

"We spell out what we see and what they are treating and ask if it's possible that the patient has a particular condition. We work with the doctors on putting their documentation into codeable language," Truscott says.

Because of their training, physicians tend to write down symptoms and lab results, rather than using words that can be coded, she adds.

For instance, the doctor may write "low hematocrit count, give transfusion" when the codeable phrase is "blood loss anemia, will transfuse."

"We educate and collaborate with the physicians, because, ultimately, it's the physician documentation that drives the severity of illness and the risk of mortality," Truscott says.

Budke watches for trends in the number of queries and query responses to determine if the queries were appropriate and whether they were answered.

"We can drill down to how many queries each doctor been asked, how many he or she answered, and how many were not answered," Budke says.

If some of the queries seem questionable or unclear, she educates the case manager responsible.

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CRITICAL PATH NETWORK™

Multi-thronged approach moves patients through continuum

Sticker alerts team to targeted LOS

A series of initiatives that includes on-site screeners for rehabilitation and long-term care, as well as a lounge for patients being discharged has helped Bay Regional Medical Center in Bay City, MI, move patients safely through the continuum of care in a timely manner.

"We take a proactive approach to discharge planning, making sure that the patient's care follows the clinical pathway, and working with ancillary staff to ensure that all of the tests and procedures are performed in a timely manner," says **Patricia Valley**, RN, case manager on the neuro unit.

For instance, when the hospital's length of stay crept up from an average of 4.24 days during the winter months, the hospital targeted the length of stay for its top four DRGs — pneumonia, chest pain, congestive heart failure, and acute myocardial infarction.

Now, when a patient comes into the emergency department with one of the four diagnoses, the unit or floor case manager puts a sticker on the front of the chart, alerting the treatment team to the targeted length of stay for the patient.

For instance, when a patient with pneumonia is transferred to Valley's unit, she knows by looking at the sticker that the patient is likely to be ready for discharge in four days and works to make sure that whatever tests and procedures he or she needs are conducted in a timely manner.

Another initiative ensures that patients who are admitted in observation status quickly receive the diagnostic studies needed for the physician to make a decision on whether to admit or discharge the patient.

"It alerts the nursing staff that the patient needs to move along. We have only so many hours to decide if this patient should be admitted or discharged," Valley explains.

When a physician puts a patient in observation status, the case manager puts a yellow sticker on the chart, alerting the staff that if anything is ordered, it has to be immediately completed so the patient can be admitted or released in the 24-hour time frame allowed for observation status.

"The physician might order a chest X-ray for a patient in observation. If it's a newly admitted patient, the X-ray can wait, but if the patient is in observation status, it needs to be done immediately," Valley says.

At Bay Regional Medical Center, case managers are assigned by unit. Each unit has an anchor case manager and one who rotates between units.

For instance, Valley is the anchor for the neuro unit, which treats patients with strokes, traumatic brain injuries, cerebral injuries, debilitation, and those who undergo elective neurosurgery or orthopedic surgery, such as lumbar and cervical surgery. The other case manager works in the neuro unit and the orthopedic unit to handle overflow cases.

The unit includes a neuro step-down unit with eight telemetry beds for patients who are transferred out of critical care but still need monitoring and specialized care.

The beds also are for cerebrovascular accident (CVA) or transient ischemic attack (ITA) patients who bypass critical care and are admitted directly to the neuro unit.

Case managers are on-site in the emergency department 10 hours a day from 10 a.m. to 10 p.m. One case manager or social worker is on duty in the hospital every Saturday, doing discharge planning

and ensuring that observation cases are either discharged or admitted in a timely manner.

The case management staff rotate on call for evening, Sundays, and holidays.

Case managers handle both the utilization review and discharge planning for their patients, Valley says.

"It works well for us because the physician talks to just one person and we have an opportunity to establish a good working relationship with them," she says.

On the neuro unit, a multidisciplinary team that includes case managers; occupational, physical, and speech therapists; and the rehabilitation screener works together to facilitate discharges and look for opportunities to improve patient care and throughput.

The entire treatment team, including the nursing staff and the case managers, meet every day to review the treatment plan and discharge potential for their patients.

"We meet to brainstorm on the patients. If the plan is for the patient to go home, I know that I need to talk with the family," Valley says.

The nursing staff use the meeting as an opportunity to bring the rest of the team up to speed on any new orders.

When a patient is admitted to her unit, Valley reviews the records to determine that the patient meets inpatient admission criteria.

If the patient is admitted with a diagnosis that has a clinical pathway, such as a stroke patient, she makes sure the clinical pathway is being used and standing orders for each day of the stay are in place. The orders list possible tests, procedures, and consultations with a place for the physician to check off.

"When a patient is admitted to a unit, we immediately start looking at discharge options. For instance, we evaluate the potential for a patient to need ongoing antibiotics after discharge. If the patient's insurance won't pay for IV antibiotics at home, we start looking for other options," Valley reports.

For instance, the case managers work closely with the pharmacy department to keep up with companies that may provide medications for free to indigent patients.

On-site screeners key

On-site screeners from the hospital system's rehabilitation center and long-term acute care hospital (LTAC) are another key to a speedy and safe discharge. Based on the patient's admitting diagnoses, such as stroke, closed-head injury or craniotomy, they frequently evaluate patients on the day of admission, instead of being called in after the physician writes an order for an evaluation.

The screeners work with the case managers, the physical therapists, and occupational therapists to determine which patients are likely candidates for post-acute care and make the arrangements in advance for appropriate patients.

For instance, the rehabilitation screener reviews all stroke admissions for a potential rehabilitation stay and sets up a physiatrist evaluation if it appears that the patient is likely to need inpatient rehabilitation services. She also coordinates transfers to other rehabilitation centers throughout the state if patients from other parts of Michigan want to go to a facility that is near their homes.

Valley alerts the patients and family as far in advance as possible so they can arrange transportation when a patient is being discharged to home.

"It's hard for patients who live outside Bay City to get a ride home when it may be an hour or longer away. We notify them ahead of time so they can make arrangements for their transportation," she says.

She reminds the patients that they can go home later in the day and up until midnight if the person who is taking them home works during the day. The hospital operates a courtesy van, staffed by volunteers who take patients home within the city limits.

Lounge for waiting discharge patients

As part of its initiative to improve patient throughput, the hospital created a hospitality lounge for patients who are waiting for discharge to home. The lounge, created from two patient rooms, is equipped with recliners, a television, movies, food, and beverages. Patients who are able to wait comfortably and independently are moved to the hospitality lounge while they wait for their ride home.

The lounge is operated from 8 a.m. to 8 p.m. Monday through Thursday and from noon to 8 p.m. on Fridays. It is staffed by an admission nurse.

Valley serves on the CVA work group, a multidisciplinary team that was formed eight years ago to develop a clinical pathway and standing orders for stroke.

In recent years, the workgroup has concentrated on meeting the criteria to achieve The Joint Commission's stroke certification.

In addition to Valley, the team includes the neuro floor nurse manager who also serves as the group's chair; the neuroscience nurse clinician; the rehabilitation screener; the nursing director for the neuro and orthopedic floor services; the hospital's stroke champion who is an emergency department physician; and representatives from physical therapy, critical care, the emergency department, and diagnostic imaging. Other ad hoc committee members who come occasionally include representatives from pharmacy and the quality staff.

The hospital's quality and resource management department, of which case management is a part, tracks "opportunity days" — days when discharges were held up pending glitches in the system.

Working the data

The department reviews InterQual data to identify variances and when there is reports to a committee of select medical staff and nursing management. The physician advisor to case management presents the data to the department or physician group responsible for the variances. In addition, each physician receives a confidential report of his or her own length of stay.

The case management team works to come up with solutions. For instance, when data showed that there was a long delay in getting results of MRIs, CT scans, and cardiac stress tests from the hospital's radiology department, the team looked at ways to get a quicker turnaround.

One solution was a contract with Night Hawks, a group of radiologists in Australia who read the tests on-line, giving the clinical staff access to a report 24 hours a day. The hospital radiologists reread the films the next day.

"It's helped us with patient flow. If the results are negative, the patient can go home. It's also helped us provide timely treatment for patients who present with strokes," she says.

For instance, if a patient comes in with symptoms of an ischemic stroke, the hospital has three hours to determine from a CAT scan that the patient did have an ischemic stroke and administer Tissue Plasminogen Activator (TPA), a clot-busting drug.

The team established a neon-green form that includes the date, the time, and what test was performed. "The physicians can look at the form during rounds and let us know when they need the results. If discharge is pending the results, I call the film room and ask them to expedite the results," Valley says.

Before starting the process to gain certification, the CVA workgroup reviewed patient charts to make sure that the hospital is meeting all of the quality indicators for stroke care.

The workgroup created stroke assessment orders, revised the acute ischemic stroke order sets, and updated the clinical pathways for stroke. The team has developed stroke discharge and home care instructions and developed community education projects.

For instance, members of the team conduct education programs at Bay Regional Medical Center's volunteer clinic for people without health insurance.

"Many of the people who come to the clinic are overweight, smoke, and are hypertensive. Health care speakers come on-site monthly and talk to them about healthy lifestyles while they wait for treatment," Valley says.

Members of the workgroup set up booths at health fairs and community events and conduct stroke screenings at an off-site location every year during May, Stroke Awareness Month. ■

'Discharge by appointment' taking 'hardwiring'

'Patients really like it,' director says

A "discharge by appointment" initiative at St. Joseph's Medical Center in Towson, MD, has had some success, but is being challenged by physician delays and families who aren't arriving on time.

"We're finding that some weeks are better than others," says **Jackie Connor**, RN, MS, CCS, director of case management. "We're working now to push up the number of patients scheduled. Our goal is 80% of the patients [in the project] will get a scheduled discharge date and time, but the most we've been able to achieve is about 50%."

Of those with scheduled dates and times of discharge, close to 80% were sent home on time, Connor notes. "We have to keep working with

the physicians. The nursing staff is doing a great job, but many times, we are waiting for the physicians to arrive."

In addition, "the nursing staff is trying to be more proactive with patients and families," she says. "Another reason [for delays] is the family not getting here in a timely manner."

Roots of the plan

The idea was piloted in 2006 on the hospital's surgical unit and with interventional cardiology patients, and was expanded earlier this year to include the patients of a large cardiology group and St. Joseph's hospitalists, Connor reports. Initially, the project was to have expanded to all patients at that time, she adds.

"We decided just to expand on the cardiology unit, because to do it on seven units — with the follow-up and action planning — would have been very resource-intensive," Connor says.

It also was part of the original plan to identify a date and time of discharge within 24 hours of admission, she says, and there was a concern that the process would get confusing when the cardiology patients were transferred off that unit.

The project parameters were changed, Connor adds, when "we found that we were not successful in identifying candidates for successful discharge within 24 hours because the patient population was too complex."

"Patients came in and were here for a day or two or three being worked up," she explains. "We couldn't make a discharge plan when we didn't even have a primary diagnosis." Until that primary diagnosis and the treatment for it were determined, Connor says, "it was too difficult to determine the discharge date."

In view of that, the decision was made to schedule discharge the day before it occurs, she says. "Every day, the nursing staff and case managers do rounds and identify patients we believe are most likely to be discharged the next day."

Discharge upon physician agreement

The discharge is not actually scheduled until an agreement is reached with the physician, Connor says.

"Some of the processes are automated," she explains. "In order for the scheduled discharge appointment to be recognized by the physician and the ancillary departments, we have to communicate that time. Before the date and time can be put in to the system to alert the physicians and the ancillaries, there has to be agreement between the case manager or nurse and the physician."

Because the information is not entered until that agreement is made, Connor says, "if we see a date and time on the census reports that nurses use, the case management reports, or the physician roster, everybody can be assured" that the plan is set.

A small project team — made up of Connor, the nurse manager and case managers from the unit involved, a physician advisor, and one of the ancillary department managers — meets weekly to review data and decide what action steps to take, she says.

Ten weeks into the project, Connor adds, "we are happy with the results achieved. We believe we've accomplished what a lot of hospitals have not."

Follow-up telephone calls to those whose discharges were scheduled indicate that "patients really like it," she says. "They can plan, and look forward to [the discharge date]. It's all about the planning."

While the process "requires a lot of oversight and hardwiring," the payoff is worth it, Connor says. "We've decided to continue our focus."

Effort began in 2005

The project has its roots in a discharge task force established in June 2005 as part of a three-year effort aimed at capacity maximization, explains Connor, who was hired in April 2005.

"We had an issue with 'boarders' in the emergency department, and as we started collecting data, what came to the surface was that if we could just fix transportation and discharge, 80% of the problem should be fixed."

One of the main goals set by the discharge task force was to increase the percentage of patients discharged by noon, she says, but even with that specific intent, several months of data collecting revealed little change.

"The concentrated effort toward getting everyone discharged by noon caused 'bolus' discharges," Connor adds, and then later in the day there would be "bolus" admissions. "There was not an even workload throughout the day."

That's when the decision was made to move to discharge by appointment, she notes.

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If it's a physician problem, the medical director reviews the chart and calls that physician.

"If the omission affected severity of illness or risk of mortality, or the presence or absence of a complication or comorbidity, the physician may be notified regarding his or her documentation," Budke says.

Any time a physician fails to answer a case management query, the coders may send a retrospective query.

"This has resulted in fewer queries that go unanswered. It's difficult for the physicians to remember everything about a case after the patient is discharged and they have to review multiple pages from the chart in order to answer the query retrospectively. It's much easier for them to answer queries while they are managing the care of the patient," Truscott says.

Some documentation problems come up frequently, Truscott says.

Among those are: documenting "anemia" instead of "blood loss anemia;" distinguishing between controlled or uncontrolled diabetes; improper documentation of sepsis; and using incorrect documentation for community-acquired pneumonia and aspiration pneumonia.

The other area in which the case managers are constantly educating the doctors is the use of up and down arrows to document, instead of codeable language.

For instance, doctors may use a K with an arrow pointing up to designate hyperkalemia or elevated levels of potassium in the blood.

"This is a hard habit to break because they've been doing it for so long but we need words written out to be able to document it," Truscott says.

At Northwest Hospital and Medical Center, case management reports to the chief medical officer.

"This works well because many of the things we're trying to accomplish are physician-related, such as issues with documentation and patient criteria. Having support from the physician leader adds credibility and facilitates collaboration with physicians," Budke says. ■

Advocate for patients but be sure it's on firm ground

CMs should brush up on HIPAA regulations

A case in which a Lafayette, LA, case manager was arrested and charged with obstruction of justice should serve as a reminder to case managers that they must be familiar with the Health Insurance Portability and Accessibility Act (HIPAA) as well as their local and state patient privacy laws, says **Elizabeth Hogue**, Esq., a Burtonsville, MD, attorney in private practice specializing in health care issues.

"There are still a lot of misunderstandings about HIPAA and what hospitals must do to protect patient privacy. For their own protection and the protection of the people for whom they advocate, case managers should be familiar with HIPAA provisions," she says.

Hogue was referring to a case in which a federal judge recently threw out a false arrest lawsuit filed by **Elizabeth Maier**, RN, a case manager at Lafayette General Medical Center, who was charged with obstruction of justice when she refused to allow police officers to interview a woman who was being treated for domestic abuse injuries.

U.S. District Court Judge **Tucker Melancon** issued a summary judgment for the defendants, ruling that HIPAA does not block officers from obtaining information about a crime from a victim and doesn't prohibit hospital personnel from giving police access to a victim of a crime.

The incident, which took place April 9, 2005, occurred while a 66-year-old woman was being treated in the emergency department for injuries on the head, face, and forearm, and told a nurse that her husband pushed her down. The patient later told Maier that she did not want to report the abuse but a nurse already had called 911.

According to papers filed in the false arrest lawsuit, when the police arrived, Maier stood in the door of the treatment room and refused to let them talk to the patient, telling them they were called by mistake. The woman later left the hospital with her husband.

The police obtained a warrant from a judge and arrested Maier in May 2005. The Lafayette Parish district attorney's office declined to prosecute.

"The case manager said that she did not give police access to the woman to protect her confidentiality but HIPAA doesn't say that. It says that health care professionals should share information when someone may be in imminent danger," Hogue says.

"No doubt, this case manager thought she was doing the right things and had the best intentions,

but her actions were based on a lack of understanding of the law," Hogue says.

In this case, rather than interposing herself between the patient and the police, Maier could have stepped aside and let the woman tell police she didn't want to pursue the matter, Hogue points out.

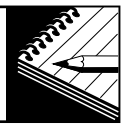
"In her lawsuit, Maier claims that she did not block the entry of the police in a way that amounted to obstruction. She says she stood at the door of the exam room and told the police that if they forced access, she would sue them under HIPAA," she says.

Louisiana domestic abuse statutes require police to notify victims that they can get a protective order against their abuser and to escort them to a shelter if they request it, Hogue says.

"The court's point of view was that even if the patient didn't want to talk to the police, they had an obligation under Louisiana law to make her aware of her rights and to give her an opportunity to exercise those rights. Because Maier did not give the police access, they were unable to inform the victim of her options and choices," Hogue says.

The judge issued a summary judgment in the case, pointing out that Maier's suit is not supported by the law, Hogue adds. ■

GUEST COLUMN



Involve patients in mistake prevention

How to overcome communication barriers

By **Patrice Spath**, RHIT
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Patients and their families play an important role in reducing adverse events. A growing number of news reports and federal and local initiatives are calling for more consumer involvement in the prevention of medical errors.

However, we cannot expect that patients and families will assume greater responsibility for the safety of health care services by merely telling them how to become more involved. Several factors inhibit the ability of consumers to serve as effective "safety watchdogs" during the delivery of health care services.

One inhibiting factor is our own professional attitude. The thought that case managers or any practitioners would perform in any way less than perfect does not mesh with our professional concept of infallibility. Yet, mistakes do occur. Our perception of what causes errors can actually prevent us from getting help from patients. We may believe that errors occur because the practitioner was not careful enough or because he or she didn't try hard enough.

If a patient asks the case manager to wash his or her hands, the subtle inference is that patient is challenging our professionalism. Such challenges can be uncomfortable and, thus, we may be reluctant to encourage patients to speak up. However, it's important that we admit human errors will occur despite everyone's best efforts. Overconfidence of our professional abilities can actually cause harmful mistakes.

Although patients can play an important role in preventing untoward events, there are challenges to getting them more involved. The patient may not understand the value of their role in the prevention of errors or be reluctant to participate. They may be hesitant to speak up, indifferent to the need for involvement, or disinclined to help out practitioners.

To engage the public in health care efforts to prevent errors, case managers and other caregivers need to understand what prevents patients and their families from becoming involved. The most common barrier is patient-practitioner communications. Ineffective communication can interfere with the patient's ability or willingness to help in reducing medical errors. If caregivers can help patients move past these barriers, their ability to act as system safeguards will be enhanced. Below are suggestions for addressing common communication barriers.

Bridging language barriers

If a patient does not speak English well, a bilingual staff member or an interpreter should be used so the patient can provide information about their history, their current condition and ask questions about their treatment. It is important to use someone other than the patient's family or friend as an interpreter, since the patient may not feel comfortable sharing personal information or expressing concerns about their care in front of a family

member or friend. Interpreters should be instructed to not omit information related to sensitive issues about the quality of care or other concerns raised by the patient. An objective interpreter can help reduce the patient's reluctance to share their personal medical history, current symptoms, and concerns while maintaining their right to confidentiality.

Translate materials designed to educate patients about safety into the patient's language. This may seem an obvious suggestion for the non-English-speaking patient. But it is important to remember that many immigrants may not read English and, even if they do, they often are more comfortable reading in their own language. Bilingual materials should be made available for patients to use if they wish.

Patients who have low levels of literacy often feel ashamed and will go to great lengths to conceal their difficulties reading or comprehending information. Therefore, a literacy barrier is not always obvious and caregivers need to carefully screen for literacy problems. Case managers can do this by eliciting feedback from the patient and evaluating if the patient understands by asking questions and reiterating key points.

If it is discovered that the patient has difficulties in grasping or retaining information, case managers must be sure to simplify the information and verify the patient's comprehension in a respectful manner. Written materials about patient safety and the patient's role in reducing errors may need to be supplemented or replaced by verbal discussions and visual aids that illustrate key points. Eliciting questions and feedback from the patient will help practitioners assess their comprehension and engage them as willing participants in their care.

Know whom you're talking to

To ensure patient safety and reduce errors, case managers must understand the cultural beliefs and practices of different ethic populations. Knowing what to say is as important as how to say it. Case managers need a general understanding of how each culture defines health, views illness, and responds to death. The role of family, whether medications and pain treatments are acceptable in their culture, and how their religion or philosophy supports them in times of extreme stress also are valuable factors for practitioners to understand.

In some cultures, patients have preferred methods for how they wish to communicate and receive information. For example, 75% of cultures around the world are group-oriented. One of the many

CE *questions*

21. The new MS-DRG system that CMS has indicated it will use beginning Oct. 1, has ___ new DRGs.
A. 539
B. 999
C. 745
D. 850

22. According to Deborah Hale, many of the new DRGs will be split to account for severity of the patient's condition. How many will not be split?
A. more than 50
B. more than 30
C. more than 60
D. more than 100

23. CMS will stop paying hospitals to treat select hospital-acquired conditions beginning ____.
A. on or after Oct. 1, 2008.
B. on or after Oct. 1, 2007.
C. on or after Jan. 1, 2008
D. on or after Jan 1, 2009.

24. In a ruling on a false arrest lawsuit filed by a case manager, U.S. District Judge Tucker Melancon ruled that HIPAA does not prohibit hospital personnel from giving police access to a victim of a crime.
A. True
B. False

Answer Key: 21. C; 22. A; 23. A; 24. A.

CE 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. **The semester ends with this issue.** You must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

manifestations of this cultural value is that the extended family is extremely important. Family members want to be involved in the patient's care and, if educated along with the patient, can greatly increase the likelihood that information will be retained and recommendations practiced. The patient's cultural beliefs and practices become barriers when case managers fail to acknowledge and adapt practices accordingly.

Many health care organizations have developed resources for staff members to use when providing care to patients from different cultures. These guides help remind all caregivers of the patient's cultural perspectives and values and how nonverbal behavior should be interpreted. While not all members of one cultural group behave in exactly the same manner, it is helpful to have a basic understanding of the culture in order to engage patients in their care and effectively communicate.

Patients can gain a sense of control when case managers take the time to discuss the plan for their care, help them choose options, and educate them about their illness. Providing individualized attention to patients can have a dramatic effect on their willingness to disclose concerns about their care. When patients and their families trust their caregivers, they are better able to communicate effectively, cooperate in treatment, and cope with uncertainties. The trust of patients and family members depends upon the degree to which they see caregivers as competent, caring, and responsible. When case managers approach patients in an open manner, they are more likely to reveal personal thoughts and feelings.

Being proactive in providing information and anticipating questions is the first step in involving patients in error reduction activities. Case managers can actively seek patient participation by making a habit of asking them if they have questions, if there is anything that has been overlooked, and if there is anything else that needs to be done for them. Patients should be told what will be done before it happens. And most important, this conversation should be done without using medical terms and acronyms that will be unfamiliar to the patient. By offering explanations about post-discharge plans or other care coordination interventions, patients are given an opportunity to serve as "checks" in the system. The patient's request for clarification could easily help prevent a mistake from occurring.

Involving patients and families to a greater degree in the health care experience will only benefit the patient safety movement. When a patient asks questions about his or her plan of care, the patient is serving as a safeguard in the system. Such questions can help remind case managers to recheck or validate that the right thing is being done. We must welcome questioning patients and family members as vital partners in our efforts to prevent unintended mistakes. ■

AMBULATORY CARE

QUARTERLY

Interventions improve care, not necessarily outcomes

Health Disparities Collaborative helps care centers

A study published in the March 1 issue of the *New England Journal of Medicine*[1] found that interventions for chronic conditions in the Health Disparities Collaboratives led to improvements in processes of care, but the authors could not document improvement in clinical outcomes.

The Health Disparities Collaborative was designed to improve care in community health centers in which many minority and uninsured patients receive care.

The process improvements achieved included:

- A 21% increase in foot examinations for patients with diabetes.
- A 14% increase in the use of anti-inflammatory medication for patients with asthma.
- A 16% increase in the level of Hb_{A1C} screening for those with diabetes.

However, the researchers found no improvement in intermediate outcomes, including:

- Control of blood sugar for people with diabetes.
- Control of blood pressure to normal levels for patients with hypertension.
- No reduction in urgent care, emergency department visits, or hospitalization for people with asthma.

There are logical explanations for some of the results, notes **David M. Stevens**, MD, senior medical officer for quality improvement at the

Center for Patient Safety & Quality Improvement, Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD, who initiated the Health Disparities Collaboratives while working with the Health Resources and Services Administration (HRSA), which administers the program.

So, for example, in terms of lack of process improvement in hypertension, he notes, "There is limited access to meds, as many of those patients are not insured. This translates as well in the ambulatory care facilities that hospitals run; 30%-40% of patients who are not insured may not have access to the treatments you prescribed."

Nevertheless, it is evident from the results that the collaboratives are doing something right. "We wanted to break new ground; our main message was that *this* would be different. Our measures were very patient-centered, and we decided to start building from the beginning," Stevens says.

"We had a common language and framework — the 'Care Model' of what care should look like," he says. That model can apply to hospitals as well as to health centers, he adds. "You know what all the key elements are, what you are trying to give the patients, and what outcomes you want," he explains. "The model talks about teams, decision support, and other things that help you get there; it's a common language around improvement, a standard way of doing things, which was very important."

HRSA, Stevens notes, concluded an interagency agreement with AHRQ to study the work of the collaboratives. "When we started this, we only had two measures; we wanted to err on the side on parsimony," he recalls. Steven adds that while the subjects of the study were health centers and not hospitals, "many principles are the same."

One other important factor for successful improvement in health centers that is certainly applicable to hospitals, Stevens continues, is a strong quality improvement team that is fully integrated into the organization — not, he emphasizes, "viewed as a marginal 'science fair project.'" **(An important tool aimed at hospitals that Stevens says is helpful is available at www.ahrq.gov/qual/teamstepps.)**

Looking at outcomes

One of the reasons outcomes were not seen to improve, Stevens suggests, "is that it takes longer than a year." If a quality manager is looking to measure outcomes, he says, "maybe what you want to do is set up some process measures of your own, so you track not only what is tested and done, but also the structural changes you want.

For example, if you put together a team, you may want to measure whether the team has gone from identifying its aims to small tests, and to implementation. Also, you may want to see if you get some immediate successes, while not expecting to see normal blood pressures right away, and so forth.

One of the key elements in the Care Model, he continues, is patient self-management, but he cautions quality managers against thinking in terms of the word "compliance."

"That word may not be that helpful," he offers. "If you have two different patients, you will have two different sets of goals. You should work with the patient and their family to get a mutually

CE objectives

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

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

COMING IN FUTURE MONTHS

- ■ Ways other hospitals have improved patient throughput
- ■ Details on the latest new regulations from CMS
- ■ Proving the worth of your case management activities
- ■ How case managers can be involved in nursing magnet activities

agreed-upon goal and look for ways to support them."

The patient, he continues, also must think about what things will help achieve his goals, and what some of the potential barriers are. "Then, you can help them overcome those barriers, and problem solve. This is *very* powerful," says Stevens.

This type of approach could be very helpful in the hospital setting, says Stevens, "both on discharge, and also in helping to limit unnecessary ED visits or primary care visits — and of course, by following mutually agreed-upon treatment plans. If we can figure out ways to use our resources to help patients do that and take advantage of new technology like e-mails and the web, I think in the future this model will be very helpful."

Reference

1. Lando BE, Hicks LS, O'Malley AJ, et al. Improving the management of chronic disease at community health centers. *N Eng J Med* 2007; 356:921-934.

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