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New Important Message requirements became opportunity to 'market' services

FTEs added specifically to distribute Medicare forms

The newly revised "Important Message From Medicare" is being treated as a public relations opportunity at Stevens Hospital in Edmonds, WA, where the case management department turned added requirements into a way to "sell" its discharge planning services to Medicare patients.

Concerned that the detailed instructions on patients' right to challenge their discharge from the hospital would trigger a dramatic increase in appeals, interim Director of Case Management **Mary Bea Gallagher** took a proactive approach.

"What we're doing is marketing our discharge planning by saying, 'Medicare wants you to know that you have the right to participate in your discharge plan,'" says Gallagher, a Seattle-based senior consultant with ACS Healthcare Solutions.

The new Important Message — which now must be signed by the patient and presented before discharge as well as upon admission — goes on to state that patients have the right to appeal if they believe they are being discharged too soon and gives the telephone number of the hospital's regional quality improvement organization (QIO), she adds.

First, however, the form used by Stevens Hospital points out that the patient's discharge plan will be instituted within 48 hours and provides a number to call regarding that plan, Gallagher notes. "We highlight both numbers, but the emphasis is that we want [the patient] to participate, and don't feel there will be a need to appeal."

Key to the hospital's approach was the decision not to assign the task of distributing the Important Message to social workers but to hire employees specifically for that job, she says.

"We took an FTE [full-time equivalent] and divided it between two people at a clerical skill level," Gallagher says. Those employees, known as case management assistants, work from about 9:30 a.m. to 2:30 or 3 p.m. seven days a week, distributing the Medicare forms to patients who will be discharged within the next 48 hours, she adds.

That includes locating the next of kin or the person with power of attorney if the patient is unable to act on his or her own behalf, and making the necessary arrangements if the patient doesn't speak English, Spanish, or Russian, Gallagher says. The Centers for Medicare & Medicaid Services (CMS) provides the forms in Spanish, she notes, and the hospital had the form translated into Russian, which is spoken by a significant segment of the area's population.

The process appears to be cost-effective, and so far there have been no appeals, Gallagher says. "Most of the hospitals in our area have opted to place this [responsibility] onto their registered nurses and social workers — and they are seeing appeals."

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Whose responsibility should it be?

Assigning the task to social workers would mean paying about $10 more an hour for someone to do a job that is not his or her primary duty. "We are certain that if we left [distribution of the Important Message] to our normal case management social workers and RNs, too many cases would fall through the cracks."

Patient access employees present the Important Message form at admission, says **Evita Armijo,** patient access manager, except for cases in which, for example, there is an admission through the emergency department in the middle of the night.

Key to the success of the Important Message initiative has been the close communication between patient access and case management and an emphasis on ongoing education regarding the process, Armijo adds. "It's important to give the registrar as much information as possible, so they have the reason why the signing [of the Important Message] and documenting in the medical record is being done." **(See related story, p. 115.)**

Focus on who needs it

Regarding the distribution of forms prior to discharge, notes Gallagher, there were two considerations: "No. 1, social workers don't see all the Medicare patients — just those who need assistance; they're responding to orders from physicians or nurses.

"My mom, who is age 69 and healthy, is likely to have only a three-day stay for whatever [inpatient treatment] she has," Gallagher says. "She's one of those patients who is likely to be missed if a social worker is left to [distribute the Important Message] because she wouldn't need discharge planning. Social workers need to focus on the patients who need them."

The other consideration was the follow-up that is required by the Medicare regulations, she adds. "If the patient is not present to sign, you have to contact them. Medicare says you can contact them by phone, but you have to follow up with a certified, return-receipt letter. That takes about 10 minutes."

This follow-up may be necessary, Gallagher explains, when a patient is sedated, in a coma or on a ventilator and no family is present, or when there is a language issue. "There are a lot of patients who have no local family but may be admitted from a

nursing home or an adult family home."

In one instance, she adds, a patient was in the hospital with a poor prognosis, "but both of his sons just dislike hospitals," so hospital staff had to send them necessary information by mail.

Another case in which follow-up could be required is when a patient is initially admitted as an outpatient, but something goes wrong during outpatient surgery, and the person's status is changed to inpatient, Gallagher says. "If they're only here 36 hours, they may [be discharged] before we get everything organized and out to them."

"Our concern was that if we didn't hire someone for customer service skills and detail organization, then we're relying on a social worker with other primary concerns to take care of all of these instances and all of the follow-up," she adds. **(See examples of Important Message communications, pps. 111, 112, 113.)**

Anticipated appeals haven't happened

Although there have been no discharge appeals at Stevens Hospital since the new Important Message requirements went into effect, there was a case of an "almost appeal," Gallagher noted. The 84-year-old patient met with the discharge planner and the patient's girlfriend, also 84, who suggested that the patient come home with her, and that home health services be arranged.

While the man initially agreed, he later told staff that he didn't want to put the burden of his

Script for Discharge Anticipation

Presentation: Medicare wants you to understand that you have the right to participate in your discharge planning. Also, even if you have participated in the plan, if you believe that you are being discharged too soon, Medicare has an appeal process you can use. This is a notice that Medicare requires we provide to you in planning your discharge from the hospital — you need to acknowledge that you understand these rights by signing the form at Admission, and again within 48 hours of discharge. You may have already started planning for your discharge with hospital staff or your doctor. If you feel that you are being discharged too early, you can contact our Case Management office to discuss it, or contact Qualis Health to appeal. These are the two phone numbers on your "Important Message" letter.

Why are you giving me this notice? Medicare requires that we provide this notice to all patients who have Medicare Part A or Medicare HMO as their primary or secondary insurance to make sure that you understand your rights as a hospital inpatient.

What is Qualis Health or a Quality Improvement Organization (QIO)? This is an outside review organization that Medicare has hired to help make sure that you receive quality health care. They can look at your case to make an independent decision on whether you are ready to be discharged.

If I don't think I'm ready to be discharged, what should I do? You can discuss this with your doctor or call the Case Management office to discuss the specific reasons. To appeal the decision, you call Qualis Health at 1-877-290-4346. If you get voice mail, you need to leave a message with your name and phone number and tell them that you are at Stevens Hospital. They will want to talk to you to ask you why you don't think you are ready to leave the hospital.

When do I have to call Qualis Health to appeal my discharge date? You may call them as soon as you know your discharge date. You must call them no later than the day of your planned discharge and before you go home.

How soon will Qualis make their decision? Qualis Health will ask the hospital to send copies of your medical record to them to review. Once they receive the information from the hospital, Qualis will make a decision within 1 day.

If I appeal, will I owe extra money to the hospital? During your appeal, you will not have to pay for services you receive except for normal charges like copays and deductibles. If Qualis Health agrees with the hospital that you are ready to be discharged, the hospital will charge you for your care beginning at noon of the day after Qualis makes their decision. If Qualis finds that you are not ready to be discharged, Medicare will continue to cover your hospital stay.

What will happen if I don't appeal, but decide to stay in the hospital? You may have to pay for services you receive after your planned discharge date.

Who do I contact if I have questions about this notice? Call the Case Management department at 425-640-4668. This department has nurse case managers and social workers to help with your care in the hospital. Leave a message with your contact information and someone will return your call during the business hours of 8 a.m. to 4:30 p.m., 7 days a week.

What if I miss the deadline to appeal? You can still ask for a review of your case. If you have Original Medicare, call Qualis Health at the number listed on the form. If you belong to a Medicare Advantage Plan (managed care), call your Plan. If you do not appeal before the deadline, the hospital may charge you for any services you receive after your planned discharge date. If Qualis (or the Medicare Managed Care plan) decides in your favor, the hospital will refund any payments you've made other than your copays and deductibles.

Script for Admission

All Medicare inpatients must receive and sign the Important Message from Medicare at admission. If Medicare is the direct payor (primary, secondary, or tertiary), or the patient is a member of a Medicare Managed Care plan, the "Important Message From Medicare" is a requirement.
This form must be explained to the patient or their representative, and is then signed by them.
To explain:
1. This is a letter from Medicare that explains your rights as a patient. You have the right to:
   - Receive Medicare covered services while you're here and after you are discharged if they are ordered by your doctor.
   - Be involved in decisions about your hospital stay, and know who will pay for it.
   - Report concerns you have about your hospital care to Qualis Health, a Quality Improvement Organization hired by Medicare.
2. If/when you are here as an inpatient, hospital staff will work with you to make sure that you have a plan for discharge that meets your medical needs, and assist in making arrangements for services you may need after you are discharged.
3. When you no longer need inpatient care we will discuss discharge planning with you, and let you know about your anticipated discharge date. At that time, you will be asked to again sign a copy of the "Important Notice From Medicare" to indicate your receipt and understanding of your rights to discuss and/or appeal the discharge decision.
4. If you think you are being discharged too soon, you can talk to the hospital staff, your doctor, or your managed care plan (Medicare HMO) about your concerns.
5. You also have the right to ask Qualis Health to review your case and decide if you are ready to leave the hospital.
6. If you want to appeal you must call Qualis Health no later than the planned discharge date and before you leave the hospital. There are step-by-step instructions for appealing on the back of the "Important Message from Medicare" form.

care on the girlfriend, but didn't want to tell her that he didn't want to go home with her, she adds. "The case manager told the girlfriend that we felt that a skilled nursing home was a better option, and that we could work out the details."

Gallagher says she had anticipated — and so far has been happily proved wrong — that there would be a significant number of discharge appeals when the new rule became effective, and that most would be prompted by family and caregiver issues.

It's easy for family members reading the language required by the revised Important Message, she notes, "to come to the conclusion that it's no pain for [them] to ask for another few days and let the patient stay in the hospital."

Even if the appeal is lost, Gallagher adds, they've still gained some time before their responsibility for post-acute care begins.

"We expected the bulk of our appeals to come from family members, [as in], 'Dad wants to come home and I'm not ready,'" she says. "We did have one person say [to a parent], 'You can't come home today — I have plans.'"

In anticipation of those discharge appeals being generated, Gallagher notes, she prepared a spreadsheet showing the estimated cost to the hospital of handling them. **(See chart, p. 114.)**

The hospital was a bit late springing into action regarding the revised Important Message rule, Gallagher says, because of an initial lack of clarity on the changes in procedure that would be needed.

Gallagher arrived in mid-June — about two weeks before the effective date of the new rule — for her tenure as director of case management, and on June 18, attended a session on the rule's implications, sponsored by the hospital's QIO.

At that point, she adds, they outlined exactly what would be required. Up until then, the hospital staff's understanding from a letter they had received from the QIO was that "we would just give [a notice] at admission and with the discharge packet," Gallagher notes. "We had to totally revise our vision, and we started with the admissions on July 1. It was a Sunday, so the discharge notices didn't have to start until Tuesday, which was followed by a holiday."

A memorandum to clinical staff from the hospital's case management, patient access, and medical records departments outlines the plan that was devised for implementing the new ruling:

1. Patient access staff will deliver the Important Message to all admissions, including ED after-hours, outpatients who become inpatients, and late insurance verifications. Medicare stickers will be placed on the charts to help identify patients who will require notice of anticipated discharge.

2. Morning multi-disciplinary "huddle" will be used to identify inpatients with known plans to be discharged within the next two days.

3. Case management administrative support will create the Important Message in anticipation of the discharge, present it to patients for signature and date, and file the forms in the medical record. When the patient is not competent to comprehend his or her rights, a family member will be located and pre-

sented with the notice per Medicare guidelines.

4. Questions from the patient or family members will be addressed (also noted on the Important Message papers) as follows:

• Clinical questions to case management at (phone number listed);

• Appeal process questions to QIO at (phone number listed).

5. After-hours discharge decisions where the patient was not notified within the past two days will be addressed by the charge nurse as part of the discharge process. Medicare stickers will be placed on the charts to help identify patients who will require notice of anticipated discharge.

6. Appeal processing will be done by:

• Case management for detailed clinical listing of medical discharge reasons;

• Inpatient unit designee for medical record copies due to the patient (upon request) and to the QIO.

The memorandum points out that if the patient's status changes, and an anticipated discharge is delayed, another Important Message must be given within two days of the new date of expected discharge. That means, it adds, that the patient could possibly receive multiple notices of anticipated discharge.

The memo begins by explaining that the new Important Message is more specific in its wording on appeals, and specifically addresses discharge planning, as well as noting that the Important Message cannot be given routinely to patients as part of the discharge packet.

The procedure to follow if a patient has concerns about being discharged too early is outlined in the memo, which explains that the patient should register an appeal with the hospital's regional QIO.

If the patient does appeal, the hospital will be notified by noon the following day, the memo goes on to explain, and must provide the QIO with a copy of both a Detailed Notice of Discharge and the medical records by noon of the next notification day. The QIO will respond with a decision on the appeal by noon of the day following receipt of the information.

The patient has the right to remain in the hospital during the appeal process, the memo states.

'Right people, right work'

The Important Message process developed at Stevens Hospital is in line with the philosophy she followed throughout her tenure as interim case management director, Gallagher notes. "My key phrase while I've been here is, 'Make sure the right people are doing the right work.' Nurses should not be doing family counseling and social workers should not be doing clerical work."

Late Notice Letter for ER Admit and Discharge

Date: _____
To: _____
In Care of: _____

Regarding: An Important Message From Medicare About Your Rights

Medicare has instituted a practice effective 7/2/07 of informing hospital inpatients of their rights to participate in discharge planning, and the right to appeal a discharge that they feel is not appropriate. The form, "An Important Message From Medicare About Your Rights," is an acknowledgement of your understanding of these rights.

Due to your emergency admission on _____, and your early discharge on _____, our office's efforts to anticipate your discharge were not successful — you left today before we were able to present this form for you to sign.

Please read and sign the enclosed form, "An Important Message From Medicare About Your Rights." Keep the bottom two copies and return the top copy to Steven's Hospital in the enclosed envelope for inclusion in your hospital chart.

If you have questions, you can call the Case Management office at 425-640-4668 during business hours. The "Important Message from Medicare" also has the Case Management phone number and a phone number at Qualis Health to appeal a discharge decision.

Thank you for your attention to this matter.

Case Management Office
Stevens Hospital
21601 76th Avenue West
Edmonds, WA 98026

Medicare Discharge Notice Projected Costs

Department	Description	FTE Hours per week	Cost per	Cost per Week	Cost per Year	Known Total
						$117,417.96
Case Management	Admin staffing for delivery, signing, copy and filing of discharge notice records. Seven days per week, 5-6 hours per day	40	$12.95	$518.00	$26,936.00	
	Pager for CM Admin			? Unknown	? Unknown	
	Cell Phone for CM Admin			? Unknown	? Unknown	
	Social Worker — additional FTE 8 hours Sunday	8	$28.86	$230.88	$12,005.76	
	RN On-Call hours for weekends	16	$3.75	$60.00	$3,120.00	
	RN on-site for weekend appeals at tiem and a half	6	$52.5	$315.00	$16,380.00	
	Long Distance charges to reach family members of incompetent or sedated patients			? Unknown	? Unknown	
	Expedited mailing with return receipt as required by Medicare	5	$5.50	$27.50	$1,430.00	
	Printing and Copying — Estimate 700 forms per month, plus copying records for Qualis	175	$0.18	$31.85	$1,656.20	
	Translation services via phone — per minute		$1.25	? Unknown	? Unknown	
	Translation services in person — per hour		$30.00	? Unknown	? Unknown	
	Translation services for written forms (expect needs for Russian, Korean, Viet Namese, Spanish). CMS may provide Spanish			? Unknown	? Unknown	
	Postage and printing on 450 letters mailed to medical staff with privileges	450	$1.00		$450.00	
	Case Management Total					**$61,977.96**
Nursing	Charge Nurse time for After Hours, unexpected discharges	10	$45.00	$450.00	$23,400.00	
	Unit Secretary time for After Hours, unexpected discharges	10	$20.00	$200.00	$10,400.00	
	Weekend Huddle — RN time	10	$40.00	$400.00	$20,800.00	
	Training for Charge Nurses and Supervisors	20	$42.00		$840.00	
	Nursing resources for expected extension of Length of Stay due to patient appeals			? Unknown	? Unknown	
	Nursing Total					**$55,440.00**
Patient Accounting	Tracking over-turned post-appeal stay days for billing to patients					? Unknown
	Tracking appeal days approved for write-off to DRG					? Unknown
	Tracking uncollectable debt due to over-turned post-appeal days billed to patients					? Unknown
General Consid-erations	Length of Stay resources for patients who choose to stay during the appeal process: Nursing, Floor staff, PT/OT/ ST/RT, medications, radiation or chemo that would otherwise have been delivered outpatient					? Unknown
	Diversions up due to fewer available beds — increased staffing to locate diversion beds because other hospitals will be in the same situation.					? Unknown
	Transportation costs (ambulance, guerney services, cabulance) due to increased number of diversions					? Unknown
	Low collection rate on post-appeal days billed to Medicare patients					? Unknown
	Increased LOS against the same DRG reimbursement — stays not long enough to qualify for outlier payments					? Unknown

Gallagher's advice to any provider that has not adjusted to the new rule is that it is worth the clerical wages to pay someone to pay attention to its implementation.

"If you pull a social worker with a caseload of 20 to 25 patients to do it, [he or she] would be spending about an hour a day," she notes. "That means not working on discharge planning for patients, which means length of stay will go up and not for a good reason, [but because] we didn't have time to look for a bed, or find home health services."

At Stevens Hospital, Gallagher says, about 50% of the patients are on Medicare — "that's 10 patients a day" — and account for about 41% of the hospital's revenue.

The investment in clerical help to distribute the Important Message is also "so worth it" because of the high penalties from CMS that can be incurred if it is not implemented correctly, she adds.

"They say they will audit and I believe them."

(Editor's note: Mary Bea Gallagher can be reached at MaryBea.Gallagher@acs-hcs.com. Evita Armijo can be reached at earmijo@stevenshealthcare.org.) ■

Employee education big part in initiative's success

Important Message part of all staff meetings

Putting the "know" before the "why" for patient access employees was the focus at Stevens Hospital in Edmonds, WA, during implementation of its procedure for distributing the revised "Important Message From Medicare," says **Evita Armijo,** patient access manager.

"It's not just the operational process, but the education process," she adds. "It's about being responsible to educate [employees] on what the ramifications are if we don't have [the Important Message].

"What we've done," Armijo says, "is give them reading materials, a written procedure, the actual pieces from the manual that the Centers for Medicare & Medicaid Services provides of the regulations and rules. We've built a little packet for registrars."

Patient access staff must sign a form, filed as part of their education records, stating that they have read the materials, she says.

Additionally, ongoing education related to the Important Message always will be on the agenda — "part of our 'Pillar for Quality'" — of departmental staff meetings, Armijo adds. "We talk about how well we're doing and what types of obstacles we're running into. We brainstorm together as a group on how we can improve the processes."

At present Important Message procedures are mostly manual, she says, built around the limitations of the hospital's existing computer system. A new system is scheduled to be installed in the summer of 2008, Armijo notes.

"We do get a report every day from information systems with the names of all Medicare patients that are in-house," she says. "One of the patient access coordinators goes through those names and makes sure that a signed copy of the Important Message form is scanned and in the record for those patients, and that we have a good communication process to follow up if some patients have been missed."

When patients are missed, Armijo notes, it is usually because they were admitted through the emergency department. **(See cover story.)**

With the installation of the new computer system, she says, there likely will be alerts or perhaps a screen process whereby registrars can't go to the next page of the registration process without taking care of the Important Message.

The new system might also print the forms on demand, Armijo adds, eliminating the need for NCR forms.

Sooner than that, she says, the hospital plans to add Korean to the languages — now English, Spanish, and Russian — in which the Important Message is distributed. ■

Right charges, resource key to charge capture success

Consultant: Push job back to clinicians

When it comes to the crucial arena of charge capture — making sure that providers are paid at the appropriate level for all services rendered — it's all about "the right charges and the right resource putting the charges in," says **Gala Prabhu,** a New York City-based senior manager for Accenture.

If your patient access department is tasked with entering those charges, you should be pushing that job back to the departments providing the service, Prabhu advises. "Charge capture

should be done by the people closest to delivery."

Tightly integrated charge capture and reconciliation processes are critical for hospitals, she says, pointing out that missing and/or lost charges have a significant impact on revenue for these reasons:

- Items that are never charged cannot be billed to the patient's insurance company.
- Missing charges adversely affect the level of reimbursement depending on payer (diagnosis-related group [DRG], fee for service, etc.).
- Poor reconciliation or lack of reconciliation can lead to billing errors due to inappropriate charges being entered on the front end because of submission of late charges or missing documentation.
- Missing charges impact census balancing and capacity management.

"There are different ways that charges get into the system," Prabhu explains. "One way is for the charge to drop as soon as an order comes in. Another way — as with pharmaceuticals — is for [the charge to drop] once a nurse indicates the drug has been given."

Radiology charges, she notes, in many cases don't drop unless the test has been read and the results dictated.

The goal is to make sure that if 10 patients came in for services, there are 10 sets of charges — that you're not missing revenue or documentation of charges, Prabhu says. "What we do is go in and say, 'How can you prevent lost or missing charges?'"

The solution, she adds, lies in developing internal controls and reconciliation mechanisms to verify that all eligible charges are accounted for and processed within 24 business hours.

"You make sure, by running exception reports, that you are tracking that you got the charges in, and that they actually hit the billing system — that they don't, for example, go to the wrong account," Prabhu explains.

In the operating room, charges typically are checked off as they are incurred, while the surgery is taking place, as with a super bill, she says. "The issue comes if you didn't pick the right patient or the right encounter. If someone is not doing reconciliation, the account just lies there. Sometimes a whole batch doesn't go through due to technical error, and sometimes staff on the back end don't know to ask, or who to ask."

While it is considered best practice for charges to be entered at the point of service by clinicians, she says, her experience has been that patient access staff continue to perform the job at many health care institutions.

"In the past, what's happened with some of the clinical departments is that they say they don't have time for administrative work, that they're too busy looking out for the patients, so it's pushed onto patient access," Prabhu says.

"A lot of the systems are not sophisticated enough or programmed appropriately to capture the charges [automatically], so a lot is done on paper," she adds. "Pages are missing and the department is always trying to follow up on missing charges. So they finally say, 'We'll get someone to come in and take over that responsibility.'"

That someone typically has been a clerical employee in patient access, Prabhu says. "They don't go to medical records staff — they're too expensive.

"What normally happens," she adds, "is clinicians fill out a super bill, and patient access has the responsibility of getting the charges in, doing data entry."

At the end of the day, Prabhu says, "the OR used to collect encounter bills and send them to the front end. Patient access staff could run back up and check with the nurse [if there was a question]. That was the thinking."

The problem with patient access staff performing the job, she contends, is that "they really don't own it. It's unfair for them to do it because they don't know what happened to the patient. It won't strike them to ask, 'How can a person have this knee surgery without an implant [listed on the bill]?'"

With the new technology and software now available, Prabhu says, "things are changing. [Technicians] are punching into a handheld device or directly into the legacy system that they gave the patient this drug, instead of filling out a super bill."

Data entry should be done at the point of service by clinical persons, she emphasizes. If patient access staff are doing this, they should be saying that it's best practice for it to be done by the clinician delivering the care."

(Editor's note: Gala Prabhu can be reached at sumangala.prabhu@accenture.com.) ■

New CMS 'error' rule has access implications

'We can affect patient outcomes'

A recent announcement by the Centers for Medicare & Medicaid Services (CMS) that it will no longer pay for care required because of

hospital error has implications for patient access.

The change is one of several initiatives being touted by the administration as ways to improve the accuracy of Medicare's payment for inpatient care and to encourage hospitals to improve the quality of their services.

The rule identifies eight conditions — including three serious types of preventable incidents sometimes called "never events" — for which Medicare will no longer cover the cost of treatment. CMS has said it would work to add three more conditions to the list next year.

Hospitals in the future will be expected to pick up the cost of additional treatment required by a preventable condition acquired in the hospital, according to the rule.

While at first glance it's easy to assume that patient access is not impacted by the clinically oriented rule, closer consideration suggests otherwise, notes **Keith Weatherman**, CAM, MHA, associate director for patient financial services at Wake Forest University Baptist Medical Center in Winston-Salem, NC.

"Certain things we do can affect treatment protocols and, yes, even patient outcomes," Weatherman points out.

"Patient access is responsible for getting the exact patient name while completing the medical record search and the registration," he says. "Mix-up of records because of a registration error can certainly affect the treatment plan for patients regarding the patient's history, allergies, etc."

Clinicians must be able to trust that the information given to them via registration is exact, Weatherman adds. "Also, it is vital that patient access departments with responsibility for bed management get patients to the correct bed, including transfer situations."

Transporters at his hospital, for example, are assigned to the patient access department. "It is vital, not just because of this ruling, that transporters — and actually, all staff — are well trained in safety precautions."

Weatherman cites an instance at another facility in which a friend of his was injured while being discharged from the emergency department (ED).

"As she was being put into the wheelchair, her hand slipped," he says. "Her finger got caught in the frame of the wheelchair and it actually pinched the end of her finger off. This terrible incident is proof that even non-clinical staff — including patient access — can affect patient outcomes.

"The other things that we do — preregistration, financial counseling, precertification, verification, point-of-service collections — must mix into the patient flow so that treatment that is urgent or emergent is not delayed," Weatherman adds.

In 2006, Congress gave CMS the power to prevent Medicare from giving hospitals higher payment for the extra costs of treating a patient when infections and other preventable conditions occur during a hospital stay.

Hospitals are to begin reporting secondary diagnoses present on the admission of patients starting with discharges on Oct. 1, 2007. One year later, cases with these conditions would not be paid at the higher rate unless they were present on admission.

'Some spin issues'

Stephen Frew, JD, a web site publisher (www.medlaw.com) and health care risk management specialist, has expressed skepticism about the motivation behind the rule, pointing out what he calls "some spin issues."

"Not all of these 'errors' are preventable in the best system, and patients often contribute to the events in ways that are beyond hospital control," he says. "Not paying for the 'errors' has a strong emotional appeal to the public, but what are the real costs and consequences going to be? I am not all that sure CMS has those even on the radar yet."

Frew raises the question of whether cutting payments to hospitals for these events will improve care so that after a while all providers are receiving full payment again, and says that he believes such an outcome to be unlikely.

"Once money is 'saved,'" he adds, "it has a way of disappearing into the great federal black hole, and it certainly does not occur to Congress to return it to the taxpayers — or to pay it to hospitals to cover the care of uninsured patients."

Frew predicts that private insurers will join in on the idea, and that balance billing will be one of the unintended consequences of the rule.

"Under Medicare, denied claims cannot be billed to the beneficiary, so the denied claim is just the hospital's loss," he says. "Similarly, most managed care plans and some states prohibit balance billing.

"What happens to patients who have private insurance that cannot enforce a 'no balance billing' rule because there is no state law?" Frew adds. "Odds are that the patient gets stuck with the bill."

That could lead, he suggests, to a second unintended consequence of the new CMS rule: "When

patients get a notice that their care was not paid for because the hospital committed an unpardonable 'error,' many of them are going to seek out a malpractice lawyer, and these issues will suddenly become prima facie proof of malpractice."

Another concern, Frew says, is the cost of testing every patient admitted to the hospital to determine whether the person already had an infection.

The health care system would be better served, he contends, if CMS were to set aside more money — not less — and reward hospitals that reach goals for reduction in errors that the agency is concerned about.

"Maybe there are hospitals out there that would like to have more revenue and would do something to reduce risk to get higher reimbursement," he notes.

"Most of the [hospitals] I visit are working their hearts out to get these risks under control for a lot of reasons," Frew adds. "If it were just a simple matter of trying, all of these issues would have disappeared a long time ago."

(Editor's note: Keith Weatherman can be reached at kweather@wfubmc.edu.) ■

AZ project targeted ED 'frequent flyers'

'Secondary gains' a factor

Education challenges faced by the organizers of a pilot project in Nogales, AZ, aimed at emergency department (ED) "frequent flyers" involved secondary gains experienced by patients who didn't participate and the cultural phenomenon known as "yes means no."

The project — which targeted diabetes patients who often received care in the ED — took place in what is primarily a Latino community, says **Donna Zazworsky,** RN, MS, CCM, FAAN, diabetes care center manager for the Tucson-based Carondelet Health Network.

"Carondelet Holy Cross Hospital in Nogales had started an inpatient case management program, where anyone hospitalized with diabetes would be seen by a nurse case manager/diabetes educator and referred to diabetes self-management classes held in the community," she notes.

This helped people who were hospitalized, but the process missed those ED frequent flyers with diabetes, Zazworsky says. "These individuals were not making their way to the classes.

"Many of these patients said that it was just too hard to get to the classes," she explains, "or there was a secondary gain they had. In one case, a gentleman wanted to get on disability and needed to get documentation, so he didn't want to get any better.

"Others wanted to [use their disease to] get attention from family," Zazworsky says. "They had the wherewithal to get to classes, but just didn't go."

Another barrier identified by the team was "the concept of 'yes means no,'" she points out. The phrase, used as the title of a book written in regard to Native Americans, also applies to Latinos, Zazworsky says. "It's not polite to tell you, 'No, I don't want to do that,' so they say yes."

Carondelet Holy Cross Hospital received a grant from the Arizona Department of Health Services to conduct the pilot project in March 2007, she says, and had to complete it by June 30. "We had to use [the funds] by the end of the fiscal year.

"We already knew the community nurse case management program would be funded beginning July 1, but we got the grant to fund the nurse to identify the tools, test them, and put them in place," Zazworsky adds.

"We had a tracking system in place for inpatients and were building a database for why we needed a program to extend beyond the walls of the hospital," she explains. "When the grant came along, it gave us the opportunity to put the structure in place for that program."

The program was promoted to the hospital's ED nursing supervisor, care manager, and social worker, each of whom was involved in shaping the pilot, Zazworsky says. "The program targeted only patients who came through the ED for a diabetes-related episode."

One of the objectives of the project was to reconvene the Nogales Diabetes Partnership Team, which had already been instrumental in establishing a number of programs and services related to diabetes for the Nogales community. The team met every other Thursday from noon to 1 p.m. over a period of seven weeks.

In addition to Zazworsky, that team includes a diabetes nurse practitioner with the Carondelet Diabetes Care Centers; the diabetes nurse case manager and several other clinicians and administrative staff with Holy Cross Hospital; and three representatives from the Mariposa Community Health Center in Nogales.

The behavioral health specialist from the Mari-

posa center was an active member of the partnership team, Zazworsky notes, attending the biweekly meetings and available to coordinate visits to his counseling program.

As part of the pilot project, the team used assessment tools from the Case Management Adherence Guidelines (www.CMSA.org), as well as a risk assessment tool that was already in place for Carondelet diabetes inpatients, she adds. "We were targeting everybody and trying to get a baseline on readiness, knowledge, and motivation."

The tools were translated into Spanish by a licensed translator from the area who works with the Carondelet system, Zazworsky says. "This is important to guarantee that we are using the appropriate terminology specific to our Latino region.

"The bottom line was that we were able to get patients into the program and agree to have a nurse case manager make a home visit," Zazworsky says. "The key was the ED nurse, who provided patient referrals to the community nurse case manager and explained the program to patients. There had to be some kind of handoff so that the patient was aware of the program."

To facilitate that process, she notes, the ED nurse made 3 x 5 note cards, explaining that the nurse case manager would be calling to set up a time for a home visit in order to see how she could help the patient.

The nurse case manager would call within 24 hours to set up the visit, and would then make the visit within 48 hours, Zazworsky says. During the visit, she adds, the nurse case manager would use the tools to gauge the patient's knowledge, readiness, motivation and literacy level in regard to the diabetes.

Of 36 patients contacted about participating in the pilot, 20 — ranging in age from the 40s to over 70 — became part of the project, she explains. Fifteen patients actually completed the project, Zazworsky says.

Short-term outcomes, she adds, showed that "the tools worked, and helped guide the case manager on how to do her work, and there was immediate improvement in patients' levels of confidence."

As a result of the pilot, she adds, the partnership team will continue to monitor numbers to determine appropriate cutoffs for risk level, adherence level, and intervention strategies.

"We still have those outliers that refused services from the nurse case manager and continued to use the ED," she says. "We know as case managers that we are not able to convince everybody that they could benefit from our help."

One of the team's observations in regard to the outliers, Zazworsky says, was that high knowledge/high motivation does not equal better self care, and that, in fact, modifiers — such as the desire for more attention from the family — have a greater effect on patient behavior.

"When we realized that, we really wanted those patients to have some behavorial health [intervention], but they weren't willing to get the appointment, and it wasn't the kind of scenario in which we could have [therapists] come into the home."

One possibility for addressing that issue, she adds, is to look at "telebehavioral health" — a video phone setup that allows the therapist to work with the patient remotely.

"That can open the door to other modalities," Zazworsky says. "What it's about is building the trusting relationship."

(Editor's note: Donna Zazworsky can be reached at donnazaz@aol.com.) ■

Cell phones to the rescue when weather woes hit

Emergency, on-call staff affected

Cell phones replaced land-based pagers at Richland Hospital in Richland Center, WI, when the area was hit by severe storms and flooding in late August.

"Like any technology, you can't always depend on ground-based communication, says **Chuck Aber,** MBA, senior assistant administrator and CFO. "The land-based medical pager antenna took an electrical hit and reduced the capacity to transmit the signal as far as it normally can.

"Cell phones are improving all the time, so we tried to evaluate whether cell phones or the land-based pagers should be used, and we decided that the cell phone signal was stronger," Aber adds. "So for a few days we converted to cell phones to contact staff in emergency situations."

Because of the flooding, the medical pager antenna could not be serviced for about five days, he notes.

"We communicated to certain physicians and staff who are on call on a daily basis for emergency situations and surgery that we would depend on cell phones," Aber says.

While the admission process at the hospital remained unchanged during the severe weather, he adds, the community was kept informed through radio and the efforts of a local government emergency group.

"We did an evaluation with the county emergency group to be aware of road closings so we could communicate to the community as far as providing information about road closures and alternate routes," Aber says. ▼

Majority of hospitals revised emergency plans

About 92% of hospitals surveyed in 2003 and 2004 had revised their emergency response plans since Sept. 11, 2001, according to a recent report from the Centers for Disease Control and Prevention.

Nearly two-thirds of hospitals had addressed natural disasters and four types of terrorism incidents (biological, chemical, nuclear-radiological, and explosive-incendiary) in their plans.

More than three-quarters engaged in cooperative planning with other local health care facilities, while 52% had written agreements to be able to transfer patients during a disaster. Facilities accredited by The Joint Commission provided for these elements more frequently than non-accredited hospitals.

Hospitals with 300 or more beds planned with other health facilities more frequently than those with fewer than 100 beds.

As to expansion of capacity during an emergency, 73% of hospitals had planned for cancellation of elective procedures and admissions, 65.5% had plans to establish an alternate care site, 60% had plans to make medical use of non-clinical space, 40% planned to convert their post-anesthesia care unit to accommodate intensive care needs, and 28% planned to activate decommissioned units. ■