HOSPITAL CASE MANAGEMENT™

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

AHC Media LLC

IN THIS ISSUE

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MS-DRG system offers opportunities, potential changes in the bottom line

Accurately documenting severity of illness is the key to success

The adoption of the new MS-DRG system, coupled with the Centers for Medicare & Medicaid Services' (CMS) move to cost-based relative weights is likely to have a significant financial impact on hospitals, says **Deborah Hale**, CSS, president of Administrative Consultant Services Inc., a health care consulting firm based in Shawnee, OK.

But the changes are not all bad. By better recognizing severity of illness, MS-DRGs shift payments from the less expensive to the more expensive cases. Much of the negative financial impact can be offset if hospitals pay attention to detail and document accurately to reflect the severity of illness of the patients they care for, she adds.

"Hospitals that want to do well financially have no choice about improving documentation and coding accuracy. Coders, case managers, and physicians must work collaboratively on documentation improvement. Documentation and coding must be accurate and complete for the hospital to get the reimbursement it is entitled to," Hale says.

Before you embark on your documentation improvement project

Before embarking on any kind of documentation improvement project, hospitals should determine the potential impact the new system will have on its bottom line, says **Bert Amison**, managing director of health care advisory services for KPMG.

One way is to conduct an analysis of the changes the new system will make on reimbursement by service line, either internally or by hiring an outside consultant.

"An analysis, by service line, of where reimbursement may improve and where it may go down, will allow the organization to make strategic decisions about where future investments go," Amison says.

The new system replaces 538 DRGs with 745 new MS-DRGs with a

new number system designed to more accurately reflect the severity of each patient's condition by creating a distinction between severity levels.

MS-DRGs 'a coding improvement adjustment'?

"CMS has referred to the new MS-DRG system as a coding and documentation improvement adjustment. They believe that the new system will improve coding accuracy by forcing hospitals and physicians to document more thoroughly," says **Carol H. Eyer**, RHIA, senior manager of clinical compliance and reimbursement at Pershing Yoakley & Associates' Atlanta office.

The biggest change with the new system is the way secondary diagnoses are treated, Hale says. The MS-DRG system refines the list of secondary diagnoses and splits the DRGs, sometimes into three different categories — with a major complication/comorbidity (MCC), with a complication/comorbidity (CC), and with no CC or MCC.

"CMS projects that 41% of cases will have no CC. When you compare that with 20% of cases in the past with no CC, you can see that the impact will be significant," she says.

Only 40 medical MS-DRGs do not change with the presence of a CC or MCC, Hale adds.

"There are so many examples of DRGs where we haven't worried about CC conditions in the past because it didn't make any difference in reimbursement, but it can have a tremendous difference in reimbursement now," Hale says.

For instance, hospitals could receive a considerable reduction in payment for chronic obstructive pulmonary disorder (COPD), one of the most frequently assigned DRGs, if the documentation does not indicate the presence of a CC or an MCC, Hale points out.

For a hypothetical hospital with a hospital-specific rate of $5,500, reimbursement for COPD without a CC/MCC (MS-DRG 192) will be $4,480 in fiscal year 2008, compared to $5,173 for MS-DRG 191 (COPD with CC) or $6,127 for MS-DRG 190 (COPD with MCC). The reimbursement for COPD without a CC/MCC is projected to drop even further to $4,061 in 2009, when the relative weights are 100% cost-based, she says.

"Case managers will play a most important role in implementing the new system by learning the most common CCs and MCCs that occur among their patient population under the MS-DRG system and ensuring that they are documented correctly," Eyer says.

Identify your top CC, MCC diagnoses

Instead of trying to memorize the entire CC and MCC list, Eyer suggests that case managers work with their health information management departments to determine their facility's top CC and MCC diagnoses.

Identify those that you need to work on now vs. those that either occur less frequently or will have less impact and focus your efforts accordingly, she says.

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How it all plays out: See how coding affects reimbursement

Case studies illustrate the importance of accuracy

Accurate documentation always has been important but it can have an even bigger impact on reimbursement with the new MS-DRG system, according to **Deborah Hale**, CSS, president of Administrative Consultant Services Inc., a health care consulting firm based in Shawnee, OK.

"With MS-DRGs, proper coding of a secondary diagnosis can affect the DRG assignment and have a tremendous impact on reimbursement in ways that it did not in the past. Coders must base their coding only on what the physician documented. They cannot look at diagnostic tests or other information in the record to determine more specific terminology," Hale says.

Here are three case studies on how proper coding can affect reimbursement. The data were calculated using a hypothetical hospital with a hospital-specific reimbursement rate of $5,500.

• Chronic kidney disease as a secondary diagnosis

In the past, stages 1-5 of chronic kidney disease were treated as CCs. Under the MS-DRG system, only stages 4 and 5 count as CCs.

If the physician documents with the terms "end-stage chronic kidney disease" or "end-stage renal disease," it is considered an MCC.

The stage of chronic kidney disease now is determined by the glomerular filtration rate (GFR) and a CC is present only in patients who are progressing toward a transplant or dialysis and have a GFR of 29 or below, Hale says.

"If the physicians are not quickly calculating the GFR, it could be a great documentation improvement initiative to make sure the physician is using the right terms," she says.

If a physician says "chronic renal insufficiency" or "chronic renal failure," it doesn't count as a CC, she adds.

She cites a case in which a patient's principal diagnosis was a cerebrovascular accident with a secondary diagnosis of chronic kidney disease. If the physician documents "renal insufficiency," the diagnosis falls under MS-DRG 66, intracranial hemorrhage or cerebral infarction without a CC or MCC, which for the hypothetical hospital has a relative weight of 1.0303.

If the physician documents "chronic kidney disease, stage 4," it bumps the case up to MS-DRG 65, intracranial hemorrhage or cerebral infarction with a CC, which increases the relative weight to 1.1901 and increases reimbursement by $878.52.

• Congestive heart failure as a secondary diagnosis

In order for congestive heart failure to count as a CC or MCC, the physician must document whether heart failure is acute and if it is systolic or diastolic. If the record says "heart failure" or "congestive heart failure," the condition cannot be coded as a CC.

Here's how it can make a difference:

Simple pneumonia with congestive heart failure falls into MS-DRG 195 with a reimbursement for the hypothetical hospital of $4,619. Simple pneumonia with chronic diastolic congestive heart failure is MS-DRG 194 with a reimbursement of $5,629 but if the secondary diagnosis is acute diastolic congestive heart failure, the case falls into MS-DRG 193, with a reimbursement of $6,878.

Under the old system, all three scenarios were DRG 89 with a reimbursement of $5,707.

• Secondary diagnoses for major small/large bowel procedures

Reimbursement for MS-DRG 331, major small/large bowel procedures without a CC or MCC (DRG 331), is $10,129 for the hospital. If a CC is documented (MS-DRG 330), the reimbursement is $15,916. On the other hand, DRG 329, major small/large bowel procedure with an MCC, carries a reimbursement of $24,784. ■

With the new system, conditions that doctors are not accustomed to documenting can make a difference in the DRG that is assigned and, ultimately, the reimbursement, Amison says. For instance, surgeons tend to document what is relevant to the procedure they performed but not necessarily any other conditions that can affect the level of care needed, he says.

"There are new conditions altogether that in certain clinical examples do make a difference now. The MCCs take us to a greater level of acuity than we've ever been able to reach before," he says.

Many chronic conditions have been removed from the CC list because they don't necessarily cause an increase in the cost of care, Hale says.

For instance, emphysema, chronic bronchitis, and chronic obstructive pulmonary disease have been eliminated as CCs. However, if the COPD is acutely exacerbated and the physician documents "acute exacerbation," it is a CC.

At the same time, there are conditions that did not affect reimbursement in the past but do affect it now, Hale points out.

Among those are acute ulcer, Alzheimer's with behavioral disturbance, aphasia, a body mass index of less than 19 or more than 39, CAD of

bypass graft, chronic pancreatic, hemiplegia, jaundice, diabetic osteomyelitis, pancytopenia, transient ischemic attack, and ulcerative colitis. Viral pneumonia and encephalopathy were not CCs in the previous system but now are major CCs, she adds.

Under the MS-DRGs, nutritional status can impact reimbursement. Protein-calorie malnutrition, malnutrition, cachexia, or a body mass index of less than 19 or more than 39 count as a CC. Severe malnutrition and protein malnutrition can be coded as MCCs.

If anyone on the staff sees evidence of behavioral disturbance, such as a patient wandering off, he or she can document it in the chart and the physician can include that in his or her documentation. Nurses or dietitians can document the body mass index values.

Body mass index values are the only conditions that do not have to be documented by a physician, Hale points out.

Gastrointestinal disorders such as diverticulitis, gastric ulcer, blood in stool, and GI hemorrhage are CCs. Diverticulitis or diverticulosis with hemorrhage or gastritis with hemorrhage are MCCs. The physician must link the bleed to the source.

When decubitus ulcers are a secondary diagnosis, physicians must be very specific, Hale points out, adding that decubitus ulcers can be an MCC, depending on the location. For instance, decubitus ulcers of the back, hip, buttock, ankle, or heel are MCCs but ulcers of the elbow and head or those with unspecified sites are CCs.

Documentation education program

The key to developing a documentation improvement education program is to know where your efforts will have the most effect, Amison says.

Look at MS-DRGs that are high volume in your hospital as well as conditions that you don't treat as frequently but that have a heavy weight, he suggests.

"It's up to physicians to document what they feel is appropriate and it's up to the coders to code following guidelines. The case managers can be a bridge between these two groups, creating a powerful compliance step for a hospital," Amison says.

As time goes by, track any changes in your case mix and revisit the MS-DRG educational process periodically to make sure the changes are covered, he suggests. For instance, if a new heart hospital opens in your area, you may be handling fewer cardiac cases and more of something else.

Build regularly scheduled meetings between coders and case management into your program, Amison suggests. It's effective for both disciplines to take 15 minutes or so each week to discuss trends and documentation gaps, he says. Either designate one coder and one case manager to meet and take the information back to their peers or rotate staff, he says.

"There needs to be an open line of communication between coding and case management," he adds.

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Get physicians in on improving documentation

Tailor education efforts to facility's needs, case mix

Adapting to the sweeping changes in reimbursement mandated by the new MS-DRG system may be like suddenly having to drive on the left-hand side of the road, says **Bert Amison**, managing director for health care advisory services at KPMG.

"There's going to be a learning curve for all hospital staff since everything has changed. Hospitals are rightfully concerned about the new system, especially that they may not document correctly in the ramp-up period. This means that they must come up with a strategic plan for adjusting to the new system and helping people get up to speed," he adds.

There's no cookie-cutter approach to education, Amison says. Any kind of education program should be based on the individual organization, its needs, and its strategic vision. Otherwise, the educational efforts will be hit-or-miss, he adds.

"Hospitals need a plan vs. just throwing education at case managers and throwing education at physicians. It's not a good idea to spend resources either internally or externally on education where

the curriculum is not tailored to the specific organization," he says.

Don't try to educate the hospital staff on the entire MS-DRG system all at once. Start with the areas where the new reimbursement system will have the biggest effect, such as your top 10 or top 20 diagnoses, suggests **Carol H. Eyer**, RHIA, senior manager of clinical compliance and reimbursement with Pershing Yoakley & Associates' Atlanta office**.**

"Offer the MS-DRG changes in small doses, starting with the areas where it will have the greatest projected impact on the hospital's bottom line, whether it's positive or negative. If you try to teach everything at once, people either won't absorb it or may tune you out entirely," she says.

Challenges to implementation

When it comes to implementing the new MS-DRG system, the biggest challenge continues to be the physicians' role in documentation improvement efforts, says Eyer.

"Case managers and the health information management staff have been the ones to sing the song that documentation is important with every quality initiative coming down the pike and each passing year. So physicians will be hearing what sounds like a reprise of the same thing, despite the fact that this is revolutionary," she says.

The challenge for physicians is not any different from what it was a year ago or five years ago, Eyer points out. They must document correctly in order for the patient's condition to be coded accurately and the hospital to be paid correctly.

Some of the new and more specific coding-related verbiage required with documentation under the new MS-DRG system may be foreign to many physicians compared to the past, she adds.

But one thing hasn't changed: Coders are not clinicians and cannot make clinical assumptions. They cannot look at the medical record, pick up on something in the chart such as a lab value or other diagnostic result and assume that the patient's condition falls into a certain severity level.

"The same official coding guidelines apply as prior to MS-DRGs. If it's not documented clearly and by the physician, it can't be coded," she says.

"Hospitals must establish a physician education program, whether it's inservice or by an outside consultant, to help physicians understand that it is their documentation, and only their documentation, that coders can use for coding," Amison says.

One of the best approaches to getting physicians on board may be to bring in an outside resource, preferably a physician who is a consultant and who can connect at the physician level to supplement the activities of both the coding and case management staff, Eyer suggests.

"The physicians have been hearing this message from the coders and case management staff for a long time. The ideal person to educate them on the MS-DRGs will be a physician who hasn't been out of practice for too long and who understands physician priorities and can speak to what is really important to them, to their patients, and to the hospital," she says.

When the information comes from a fellow physician or colleague, rather than a case manager or coder, doctors are more likely to accept the information and process it, she says.

An alternative would be to recruit a physician champion internally who could work with hospital case management, health information managemen, and coding and serve as a physician resource on documentation issues, Eyer suggests.

Hospitalists who are constantly seeing acute care patients in the hospital have a substantial opportunity to affect documentation and may become the champions you need to create an educational program internally, suggests **Deborah Hale**, CSS, president of Administrative Consultant Services Inc., a health care consulting firm based in Shawnee, OK.

Even if case managers are not responsible for physician education, they should be involved with the planning and rolling out of the initiative, especially if they already are involved in a documentation improvement program and have worked with the physicians on documentation, Amison says.

He suggests that the case managers speak for a few minutes at the inservices, tell the physicians what they may see in terms of queries, and turn it over to the speaker who is going to explain the new system.

Physician inservices don't have to be delivered by a physician; but peer-to-peer education is very important and most physicians respond better hearing it from a peer than someone in another discipline, he says.

"Physician champions can be very successful in the role as a liaison between the physicians and the case management department," he says.

Don't put physicians on the defensive when it comes to documentation, Hale says. The person who is presenting the educational session has to present the information in a way that achieves their buy-in in order to be effective, she adds.

In large hospitals, it's difficult to communicate with the entire physician staff all at once. Hale suggests starting with small groups, preferably by service line, and tailoring the education specifically to the specialty.

Involve the medical executive committee in your educational efforts because they can become the driving factor for documentation improvement, Hale suggests.

The approach to physician education depends on the organization, says Amison, who recommends tailoring the educational efforts to what has worked in the past.

"Some organizations have well-attended physician meetings. Others have found more success in having after-hours dinners or breakfast meetings before rounds for educational sessions," he says.

Keep the information relevant to the physicians, he advises.

"Talk about documentation within the specific area that makes a difference in the record so the coder has what they need. Don't overpower doctors with too much coding detail or too much information about the impact to the hospital, operationally or financially," he says.

Instead, emphasize what it means for the physician's personal profiles with managed care companies that compile preferred provider lists.

"Show them what will mean something to them in today's world," he says.

One technique for educating physicians on documentation improvement is to create case studies that typically apply in your hospital, Hale says. **(For some examples of how documentation can change reimbursement, see related article on p. 179.)**

Show the impact of documentation by using case studies with examples of how improved documentation results in better reimbursement and how it affects the case mix index and most importantly, the hospital's standing on public report cards, she says.

"Physicians have long asserted that their patients are sicker than other patients. With the new MS-DRGs they'll be able to demonstrate this more than before, provided they document accurately," Eyer says.

Eyer suggests pulling up some of the public report cards to show how they are affected by how well the physician has documented the severity of illness.

"If physicians can connect that their documentation leads to the codes that drive accurate MS-DRG assignment, and that further, this generates data accessed and published on the various health care quality and monitoring web sites, this may help them understand the importance," she says.

Drill down to specific clinical examples of how proper documentation can affect quality outcomes for the specialties of the physician group you are addressing to bring it even closer to home, Amison advises.

"Don't dwell on the financial impact to the hospital but it is a good idea to include a little of that so they understand that the hospital has a lot at stake," he adds.

Show them what the proper documentation can mean to them from a quality outcomes perspective and how it can affect physician report cards, Amison says.

"When the doctors are accurately documenting everything that is appropriate to the patient stay so that the chart truly reflects the resources spent and the conditions they considered as they worked their way through the patient care, the coders at the end of the day will do their job," he says.

(Editor's note: The views and opinions expressed herein do not necessarily represent the views of KPMG LLP.) ■

Quality initiative slashes occurrences of VAP

Interdisciplinary team changed practices in ICU

A team approach to quality measures has resulted in a significant drop in ventilator-associated pneumonia for patients in the intensive care unit at Columbus Regional Hospital (IN) and helped the hospital earn the 2007 American Hospital Association-McKesson Quest for Quality Prize.

"When we started looking at ventilator-associated pneumonia [VAP] in 2001, we had a high rate of occurrence. Our interdisciplinary team reviewed the literature to determine the best practices, compared that to what we were doing, and found areas where we could improve," says **Shannon Page**, RN, BSN, CCRN, intensive care unit-based case manager and critical care clinical

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CRITICAL PATH NETWORK™

Hospitalwide throughput initiative lowers diversion by 71%

ED CMs, admissions nurse speed process

Faced with patients waiting for a bed for hours in the emergency department and an increase in time on ED diversion, Southern Ocean County Hospital in Manahawkin, NJ, began a hospitalwide initiative to improve throughput.

The hospital had always had some problems with backup in the ED, but it was getting worse, says **Barbara Stanek**, RN, BSN, MPA, CNA, director of patient coordination.

In 2005, before the initiative began, the hospital was on diversion for 1,144 hours, or an average of three hours a day, for a revenue loss of $500 per outpatient and $5,000 per inpatient. In 2006, the hospital was on diversion only 329 hours, a 71% decrease with an increase in the volume of patients in the ED.

Revenue loss for 2005 because of backups in the ED was estimated at about $2.2 million, according to **Marilyn Butler**, RN, MSN, CCM, case management director.

The hospital has 176 inpatient beds and more than 230 physicians, with a primary service area of 110,000 residents, which swells to more than 210,000 during the summer months. In the off season, the hospital averages about 90 ED visits a day. The figure rises to 120 visits a day during the summer months. About 80% of hospital admissions come through the ED.

The hospital has a unit-based case management department with two case managers and one social worker for each 32 beds. The case managers follow all acute patients and assess them within 24 hours, either in the ED or on the unit, and develop a discharge plan within 48 hours of admission.

In addition to the inpatient nursing units and the ED, members of the throughput improvement team include representation from all hospital departments, including case management, housekeeping, laboratory, radiology, dietary, and materials management.

The team started by breaking down the time in the ED into segments — such as registration to admitting order, time caring for patients, and admitting order to inpatient bed — and looking at opportunities for cutting the time.

Creating solutions

That phase resulted in implementing case management in the ED, creating a new position for a clinical admissions liaison nurse, and developing a set of pre-printed bridging orders for basic care to be used for stable patients who need to be admitted.

The overall ED length of stay from the time patients register until they are in an inpatient bed dropped to 6.46 hours in 2006 from 7.5 hours in 2005. The figure dropped to six hours for the first nine months of 2007.

The time that elapsed between the admitting order and the time the patient was in a bed was 3.5 hours in 2005 and dropped to 2.9 hours in 2006. The figure dropped to 2.2 hours for the first nine months of 2007.

The time from the waiting area to a treatment room dropped from 37 minutes to 20 minutes. The time it took for the physician to see the patient was 64 minutes and dropped to 41 minutes. The percentage of people who left without treatment dropped from 2.1% to 1.1%.

One initiative on the front end was to bring

patients straight from the ED waiting room to the treatment area where there were open bays and conduct bedside registration.

"We shortened the triage by getting patients into the back as soon as possible when there were beds open," Stanek says.

On the front end, the hospital ED staff are looking at ways to move patients through the ED more quickly. On the back end, the case management department is working to shorten lengths of stay, Butler reports.

CMs in the ED

Two full-time case managers work in the ED on 12-hour shifts.

The ED case managers are responsible for facilitating the patient's hospitalization from preadmission through discharge from the ED. They manage the care of patients who are treated and released as well as those who are admitted, and monitor inappropriate admissions and admission status.

In addition to working with the ED staff to get the patients moved out, the ED case managers find alternative levels of care, such as rehabilitation centers and skilled nursing homes so that patients who don't meet criteria are not admitted.

The case managers have been trained to evaluate psychiatric patients so patients who are being voluntarily committed can be placed in a psychiatric facility more quickly. Before the case managers were trained, psychiatric patients would stay in the ED for long periods of time until the county mental health representatives arrived to evaluate them.

Clinical admissions liaison nurse

The hospital created the position of clinical admissions liaison nurse to manage all the admissions and transfers coming into the hospital as well as bed placement, and monitors discharges throughout the day on the floors.

"In the past, if the supervisor was busy, there was a delay because the beds became a secondary issue," Stanek says.

The position is staffed by nurses five days a week from 9 a.m. to 9:30 p.m.

"We've worked with the ED staff to identify potential admissions before they are actually admitted. The nurse knows well in advance if someone is going to be admitted and can anticipate what beds will be needed," Stanek says.

For instance, if a patient in the ED has an extensive cardiac history, the nurses can anticipate that he or she will need a telemetry bed.

"The clinical admission liaison nurses work as a team with the ED nurses, physicians, the case managers, and the inpatient units to keep things going," Stanek says.

Now, in some cases, a bed is ready for a patient once the admission order is signed.

As the role expanded, the nurses began monitoring the census in the hospital.

"They observed that problems were arising with direct admits from physician offices. They sent the patients to the admissions department whether or not we had beds or they would send them to the ED even if we did have a bed," Stanek says.

Now the physician offices call the clinical admissions liaison nurse directly and the nurse can speak to the physician to find out the patient status if necessary. If the hospital doesn't have a bed and the patient is stable enough to go home, the nurse suggests that the patient come back later when a bed is available. If the patient is not stable, the patient is referred to the ED for evaluation.

The throughput team works with the housekeeping department so that when a bed is available, the housekeeper calls or pages the admission nurse with the room number.

"It's a manual process. We don't have a bed board but the process works," Stanek says.

The team has a bed meeting every morning to discuss potential discharges.

"We evaluate bed status every eight hours to look at all patients coming into the institution. It's a constant state of flux because patients are admitted and discharged during the day," Stanek says.

The hospital's computerized medical records make it possible for any admissions nurse or supervisor to get the status of a patient in the ED or on the floor.

"They see movement on the floors. The clinical admissions nurses work out of the ED while the supervisors make rounds on the floors and look for potential discharges," Stanek says.

The case management department has worked with the hospitalists to create a set of bridging orders, which cover basic care needed for a patient to be admitted and moved to a bed.

"The order sets are for specific diagnoses when

it's better for the patient to get into a bed and the hospitalists can't get down to the ED," Butler says.

About 25% of patients admitted to the hospital are treated by hospitalists.

"As we see more and more people without medical coverage, we have more people who don't have a primary care physician and use the ED for primary care," she says.

The bridging orders are a preprinted set of orders that can be checked off by the ED physician. Patients have waited in the ED for hours until the hospitalist can call in an order.

"We are hoping this will decrease the registration to admission order time. Many times, a patient may be in the ED for several hours until we can get a physician to come in and write an order. We can't assign beds until the order is written," Butler says.

The hospital has created an alert level process that advises staff of the availability of beds. There are four alert levels, 1 through 4, all color-coded on each department's desktop.

Level 1 means that there are sufficient beds to cover the anticipated admissions. Level 4 means that the beds are full and there are not likely to be any free beds for a while. For instance, if the first square is green, it means that the inpatient side has sufficient beds. If the second square is red, that means that the ED is inundated with patients.

"Every department can see immediately where beds are available and where the backups are. To support the throughput process, each department has created interventions that they put in place depending on the latest level. Everybody in the hospital supports throughput," Stanek says.

*(For more information, contact **Marilyn Butler**, RN, MSN, CCM, case management director, Southern Ocean County Hospital, e-mail: mbutler@soch.com.)* ■

No increase in appeals reported with new IM rules

Proactive discharge planning good prevention

Despite fears that issuing the new Important Message from Medicare regulations would result in a spate of patients appealing their discharge, hospital case managers report that appeals have not increased and that the requirement for issuing the notice within 48 hours of discharge actually helps staff focus on the discharge plan.

"When hospitals have a workable discharge plan that they started developing when the patient was admitted, or shortly thereafter, patients are not as likely to appeal," says **Jackie Birmingham**, RN, MS, vice president of professional services at Curaspan Inc., a Newton, MA, health care technology firm.

"The family is going to be more comfortable with the discharge plan if you plan ahead. If the case managers make sure that patients are aware that they will have a discharge plan when they leave the hospital and that the next caretaker will know everything they need to know about the patient, patients won't be included to question the discharge, which may lead to an appeal. Patients who do question their discharge should be rare," Birmingham says.

The purpose of the requirement is to reinforce what hospitals have been telling patients about their rights to appeal for years, Birmingham says.

"Now the hospital is telling the Medicare beneficiary about their right to discharge planning and the right to appeal should make the patient feel that the timing or circumstance of his or her discharge is not satisfactory," she says, adding, "I never expected hospitals to get so overwhelmed with the process."

The most important part of the Centers for Medicare & Medicaid Services' revision of the Notification of Discharge Rights using the Important Message from Medicare is that the hospital is forced to look at how the message about discharge is delivered.

"It's really more about the message to patients than it is about the written notice. Patients deserve to be notified about pending discharges. This apparently wasn't being done and a lawsuit was filed that resulted in the new regulations. Now patients are getting the message," she says.

When nurses or case managers give patients the second notice of their discharge appeal rights at New York Hospital Queens, they find out if the patient has any issues or concerns about the discharge and work to resolve them in advance, says **Caroline Keane**, RN, MSN, ANP, CCM, director of case management and social work for the private nonprofit hospital in downtown Flushing.

"If you tell patients they are being discharged at the eleventh hour, they're overwhelmed and their first instinct is to appeal. If you're having a conversation with a patient about a pending discharge a day or two in advance, they're less apt to appeal it. It's actually in everybody's best

interest that it's done this way. It's helping us take better care of the patient in the long run," Keane says.

The best way to prevent an appeal is to be proactive with the discharge and get the family involved in discharge planning from the start, adds **Roxana Ballinger**, RN, CCM, director of care management at Chesapeake Regional Medical Center in Virginia.

"When patients are admitted, we speak to the family and give them an estimated discharge date so they have an idea of when they're going home or to another level of care. Normally, if patients or family members have a problem with a pending discharge, the case manager knows about it and 90% of the time, we can work out their concerns before a formal appeal is filed," Ballinger says.

Many of the reasons that patients file an appeal of their discharge can be tied to the lack of availability of post-discharge services, Birmingham says.

"If hospitals give patients a choice of post-discharge services in a structured manner, it would increase patient satisfaction scores and diminish appeals," she says.

"The problems arise when hospitals give patients a choice of post-acute services, as required by CMS, but the patient's choice is not available," says Birmingham.

Birmingham describes the following scenario:

The patient chooses a nursing home from a list provided by the hospital. The case manager calls and finds out there is no bed available, then goes back and tells the patient. The same thing happens with the patient's second choice. "This goes back and forth and the patient begins to become very frustrated. The patient then decides to appeal and stay until a bed is available at the nursing home he wants," she adds.

Rather than giving patients a long list of choices, Birmingham advises discharge planners to find the providers that do have beds available and are appropriate for the particular patient. Then give the patient and family members a short list of facilities that are appropriate and have beds available from which to choose.

CMS agrees with that approach, she points out. In the Aug. 11, 2004, *Federal Register,* in the final rule for the hospital inpatient prospective payment system for 2005, in the section on hospital conditions for participation for discharge planning, CMS agreed with a comment that giving patients a comprehensive list of skilled nursing facilities would be overwhelming and confusing for patients and family members, particularly since nursing home placement is usually driven by availability of beds.

"We would not expect that the patient be given an exhaustive list of SNFs with no beds available. The intent is to provide patients and their families with information in order to make informed decisions. As the discharge planner identifies which SNFs have available beds, this information should be shared with the patient and the patient's family," CMS said.

"It's so much more compassionate if the case manager sorts through what's best for the patient and what's available, then gives the patient a list of those facilities that have beds and meet their needs," Birmingham says.

Don't search based only on bed availability, she advises. "An empty bed in an SNF might not be one that can provide the necessary services for the patient. The bed must not only be empty; the facility must be appropriate for the patient," she says.

Offering a choice is critical, not only from a regulatory stance but from a patient-centered, patient-right stance, Birmingham says.

"Offering a real choice — one that is best for the patient, and working with the patient, family, and the patient's physician makes for a better and more satisfactory discharge plan," she explains.

At New York Hospital Queens, the case managers have partnered with nursing to share the responsibility of giving out the Important Message.

"It helps establish an atmosphere of cooperation among the disciplines. People expect the case managers to be the guru of the discharge but we are only part of it. Everybody has to be involved or it doesn't work," Keane says.

The case manager gives out the Important Message if a patient is going to receive post-discharge service or is being discharged to a lower level of care. If the patient is being discharged to home, the nurses distribute it.

"It's a collaborative effort. We collaborate on which patients are going to be ready to go soon, and as soon as we anticipate a discharge, we give out the letter," Keane says.

*(For more information, contact **Roxana Ballinger** RN, CCM, director of care management, at Chesapeake Regional Medical Center, e-mail: roxana.ballinger@chealth.org; **Jackie Birmingham**, RN, MS, vice president of professional services, Curaspan Inc., e-mail: jackiebirmingham@sbcglobal.net; or **Caroline Keane**, RN, MSN, ANP, CCM, director of case management and social work, New York Hospital Queens, e-mail: cakeane@nyp.org.)* ■

(Continued from page 182)

data coordinator.

The hospital reaches between 98% and 100% compliance with the recommended ventilation-associated pneumonia interventions. Before the quality improvement initiative, the staff were compliant with the recommendation that patients' heads of the bed be elevated above 30 degrees to 45 degrees about 60% of the time, Page adds.

VAP is the leading cause of hospital-acquired infections and adds considerable cost to a hospital admission, adds **Jennifer Dunscomb**, RN, MSN, CCRN, system clinical nurse specialist.

"We looked at what we could do to ensure that everyone follows evidence-based care for every patient, every time. We identified the gaps that were occurring and generated ideas to determine how we could close those gaps," she adds.

The team that designed the initiative included Dunscomb and Page; the intensive care unit medical director; licensed and unlicensed staff from the ICU; the inflectional control practitioner; and representatives from dietary, respiratory care, pharmacy, and physical therapy.

"We take an interdisciplinary approach to any type of change. Everybody on the team feels free to speak up and advocate for the patient," Page says.

Four standard practices identified

After researching and evaluating current practices, the team identified four standard practices that should be followed with ventilator patients in order to avoid VAP:

- elevating the bed between 30 degrees and 45 degrees and monitoring it every two hours during respiratory therapy ventilator checks;
- peptic ulcer prophylaxis;
- daily sedation vacations and assessment for readiness to extubate by performing daily spontaneous breathing trials;
- deep venous thrombosis prophylaxis.

Those measures were included in the Institute for Healthcare Improvement's VAP bundle in its 100,000 Lives campaign that began in 2004.

Columbus Regional Hospital uses a differentiated nursing practice. The case managers are all nurses, certified in a specialty area with at least three years' experience in the clinical unit.

The case manager looks at every patient on the unit to make sure he or she continues on the clinical pathway. They intercede in cases where patients have complex medical, psychological, or psychosocial needs. These include patients with family issues, those who are on ventilators at home, and those who are frequent admissions.

"In the ICU, the case manager is probably following 90% of the patients. They are the knowledge experts and work with the primary care nurses to coordinate care. We sustain our improvement because the case manager helps hold nurses accountable daily on the ventilator-associated pneumonia for the bundle measures," Dunscomb says.

Team approach to QI

Columbus Regional Hospital's approach to quality improvement is to make everyone in the hospital accountable for quality and involve them in the quality initiatives, Dunscomb says.

"We involved everyone, right down to the transporters and the housekeepers, in our quality initiatives. It takes a team approach to be successful," she adds.

The team developed standard order sets that include the measures and developed educational competencies for the entire staff about evidence-based care of ventilator patients. For instance, after an awareness program for unit nurses about elevating the head of the bed, the unit manager noted when nurses failed to follow the requirement and talked with them individually, notifying them of the expectation and that they would be held accountable.

"Now, we're so hardwired toward our goals that it's not even necessary for anyone to prompt the staff to ask why Mr. Smith's head is flat. Head-of-bed elevation is consistently maintained at 100%. The measures are very ingrained in our day-to-day practices," Page says.

The team made a presentation to the nonclinical leadership, breaking down each requirement and why it was important so that the nonclinical leaders could understand why the requirements are pertinent to their staff's activities. For instance, the radiology department was educated that ventilator patients' heads need to be elevated, not left flat, when they come for X-rays. The housekeepers were educated to notice if the heads of the bed were flat and point it out to the nurse.

"I met with the director who is responsible for housekeeping and asked that the housekeepers observe what is going on in the unit. Housekeepers are there all the time and are nonbiased,"

says Dunscomb.

For instance, the housekeepers noted when staff left the room breaking isolation precautions, how many times they touched the ventilator without wearing gloves, or if the staff are diligent about washing their hands.

"It's a matter of creating awareness. We all get busy but the one time someone doesn't put gloves on to change the ventilator tubing may be the time the patient gets ventilator-associated pneumonia," Dunscomb adds.

Tracking compliance

The team tracks compliance with the measures every day in real-time.

Page receives automated reports for all intensive care unit patients every morning. The reports provide information on quality indicators for patients on continuous sedation along with documentation that they have had a sedation vacation assessment, peptic ulcer disease and venous thromboembolism prophylaxis, glycemic control, as well as on ICU predicted vs. actual length of stay and predictive mortality information used daily for the ICU interdisciplinary rounds. The respiratory therapists provide documentation on the head-of-the-bed data and help evaluate breathing trials to assess readiness to be extubated.

"One of the first trends we noted relative to prophylaxis is that patients were coming to the ICU after surgery without anticoagulation prophylaxis ordered," Page says.

The team talked with the surgeons and created standardized order sets that include deep vein thrombosis (DVT) prophylaxis.

"Our DVT initiative has been filtered into other committees, such as the surgical care improvement committee. Instead of looking at separate protocols for surgery and the ICU, we are working to accomplish our goals from a systematic approach," Dunscomb says.

An intensivist manages a significant number of patients in the unit but other physicians, including surgeons, cardiologists, and internal medicine physicians also manage patients on the unit. The intensivist is the team's physician champion. His responsibilities include assuring the treatment of patients using evidence-based standards and holding other physicians accountable for their practice.

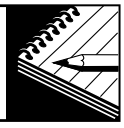
"If the physician doesn't order a component of the recommended care, there is a mechanism in place to hold them accountable. The nurses and case managers can make recommendations and suggestions but if the physician chooses not to do it and doesn't document why, our hands are tied. That's how our physician champion can work with the physicians to change their practices," Dunscomb says.

The ICU interdisciplinary team holds daily rounds led by the medical director. Participants include the staff nurse, respiratory therapist, pharmacy representatives, and case management.

The team sees every patient, evaluates the plan of care for effectiveness, and revises interventions as indicated to optimize outcomes in alignment with the patient's and the family's goals, Dunscomb says.

"It's a great educational opportunity for the nurses involved. We often take this opportunity to update the family on the patient's progress when the entire team is available for questions," Page says. ■

GUEST COLUMN



Honing your role as care coordination consultant

Get your voice heard

By **Patrice Spath**, RHIT
Brown-Spath & Associates
Forest Grove, OR

It's common for case managers to say, "Oh, I wish I were a consultant." Yet, case managers already have jobs in which they do much of what a consultant does. Look at the list below and check off the consulting activities that you already do as part of your work responsibilities:

- Assess what's going on in your job and in your organization.
- Look for lessons learned and apply them to other activities.
- Look for and assess quantitative data about the organization.
- Measure your performance.
- Continually learn.
- Give advice.

Case managers are internal care coordination consultants. In this consulting role, case managers

offer many long-term benefits to the organization and, ultimately, to patients. This role demands a range of skills and knowledge. It also requires that case managers seize every opportunity to build widespread understanding of care coordination issues, even during brief openings in committee meeting discussions.

Consider this scenario: You are sitting in a meeting of an ad hoc task group formed to evaluate ways of improving patient satisfaction. The group is mapping out a plan for expanding the organization's patient-centered care initiative. The charge is that by the second year of implementation, patient satisfaction scores will be greatly improved. You have been asked to participate in the task group for several reasons including your expertise in care coordination. The hospital's patient-centered initiative provides a prime opportunity for you to influence the quality of patient care services.

The second meeting of the task group is devoted to discussions of potential changes in the process for discharging patients. The group members state their likes and dislikes, horror stories, and successes. The group is in an action mode and you are concerned that they might move too quickly with some big decisions that turn out to be strategic missteps. You hear lots of discharge planning ideas around the table but you feel many of the proposed changes ultimately won't be workable or may actually reduce patient satisfaction. How do you get the attention of the group for a few minutes so that your opinions can be heard?

As with all consulting work, the challenge is figuring out how to influence decisions within a short amount of time. Meetings are often fraught with power struggles, competing priorities, and a mix of analytical styles and personal biases. Plus, there is the added pressure of limited time. Regardless of these constraints, you don't want to miss the opportunity to help the group begin thinking about patient discharges in a different way. To make your best shot in the meeting consider the following five questions:

• What information would be most useful to the group right now?

Select and prioritize your key points before beginning to speak. Don't make the mistake of launching into a mini-seminar on discharge planning models. Sometimes a well-placed sentence or short story has more impact. Avoid blurring your message by covering too many aspects of the discharge process. In your five-minute speech, you can't cover everything from "assessment" to "planning" to "plan implementation." To committee members not familiar with the discharge planning process, it can all sound like a mishmash of jargon and platitudes.

CNE *questions*

21. The new MS-DRG system replaces 538 DRGs with how many MS-DRGs?
A. 652
B. 745
C. 825
D. 750

22. Under the new MS-DRG system, some conditions do not have to be documented by a physician in order to count as a CC.
A. True
B. False

23. After a quality improvement program at Columbus Regional Hospital, the compliance rate with recommended interventions to prevent ventilator-associated pneumonia climbed to what percentage range?
A. 98% to 100%
B. 90% to 95%
C. 95% to 98%
D. 97% to 98%

24. After the research stage of Columbus Regional Hospital's, which of the following became standard practices?
A. Elevating the bed between 30 degrees and 45 degrees and monitoring it every two hours during respiratory therapy ventilator checks.
B. Peptic ulcer prophylaxis.
C. Deep venous thrombosis prophylaxis.
D. All of the above

Answer Key: 21. B; 22. A; 23. A; 24. D.

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. **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. ■

• **What framework might help us move forward?**

Often a discussion begs for a framework to link ideas and extend the thinking. In the meeting, committee members are advocating specific "pieces" of the discharge process — strategies for identifying patient needs, expeditious ways of arranging for services, etc. If you speak up with just one more new idea without a framework for tying all of the pieces together, you could actually add to the disagreements rather than increase everyone's understanding.

For example, a common framework for showing the three phases of a change process is initiation, implementation, and institutionalization. Use that framework to discuss how each of the new ideas — including yours — will affect outcomes and patient satisfaction. Not every idea you propose will be embraced by the committee. Avoid falling in love with your ideas. Remember that when you're a consultant, whether you're working inside or outside the organization, you are not in charge. Consultants assist, advise, add expertise and experience, diagnose, or help find solutions to problems. Your role is not to make decisions but to add knowledge and help equip a committee or leader to decide.

• **What evidence or rationale might be useful?**

You may or may not be called upon to give an in-depth explanation of the rationale for various changes to the discharge planning process. However, it is important to your credibility as a consultant to be prepared to do so. If you propose any paradigm-busting ideas about care coordination issues or process revisions, expect hard questions and challenges.

Before any meeting, think about why you would advocate particular case management or care coordination process changes. If you're drawing from personal experiences, be able to explain all aspects of the experience clearly. The committee will want specifics, including the chronology of the project and how you tracked its impact on patient outcomes, including satisfaction.

In addition to personal experiences, your ideas might be guided by research findings that have impressed you. If you decide to refer to research, be cautious. Health care professionals can be hard sells when it comes to knowledge derived from research and theory. Select only strong, recent studies done by respected researchers with a sample group and context similar to your facility and patient population. If you quote statistics, know how the calculations were done.

Quoting from The Joint Commission standards or Medicare Conditions of Participation can be useful; however, you need to be able to explain the rationale behind these requirements and how to design programs that will satisfy these requirements.

• **What concrete examples will help emphasize my point?**

Concrete examples, real stories, and illustrations are valuable tools for consultants. For example, if you're pushing for case managers in the emergency department, share examples of how this has worked at other facilities. Collect good examples, stories, and illustrations. Practice using them so you can explain them without hesitation and without rambling. The feedback you get from the group will help you determine whether the ideas are "keepers" for your facility.

• **What exactly can the group do next?**

Committees often need information and a plan before they can make their decisions. You might offer to bring articles or books to enhance their knowledge, arrange a field trip for them to see a particular case management model in action, or bring in a speaker who has experience in a needed area. Remember that, as a consultant, your job is to help others succeed. You succeed when you have built the capabilities of the group. If you do your job well, the group will need you less and less as the improvement project moves forward. ■

AMBULATORY CARE
QUARTERLY

Initiative sparked by close call with DNR wristband

Effort has implications for access

A "near-miss" in which a nurse at a Pennsylvania hospital incorrectly placed a "do not resuscitate" (DNR) wristband on a patient has prompted an Ohio initiative aimed at implementing statewide standardization of colored wristbands.

Based on the Pennsylvania incident — which

occurred because the nurse worked at multiple hospitals that used different-colored bands to designate a DNR order — an Ohio task force looked at how the process was handled by that state's providers, says **Rosalie Weakland**, director of quality improvement for the Ohio Hospital Association (OHA). Fortunately, she notes, another nurse at the Pennsylvania facility caught the mistake just in time to resuscitate the patient.

In surveying Ohio providers, she adds, "we found 19 different colors [for wristbands], with 28 different meanings. Sometimes the same color was used for two things. For example, emergency department patients had yellow wristbands, and then when they became inpatients, a yellow wristband was for a person who was at high risk for a fall."

The task force, convened by the Ohio Patient Safety Institute (OPSI), set an ultimate goal of eliminating all wristbands except those used for patient identification, in favor of electronic tracking systems, Weakland says. But because many providers are not ready for that step, she adds, an interim goal of standardizing and reducing the colors used for wristbands to four was established.

The OPSI now recommends that all Ohio providers adopt the following standard wristbands: 1) white/clear for patient identification; 2) red for a known allergy; 3) yellow for a high fall risk; and 4) green for blood products (if a patient is supposed to get platelets or a unit of blood).

A national standard

"My ultimate mission is a national standard," Weakland notes. "Health care professionals go across the nation and, depending on locations, hospitals transfer patients across state borders." Different colors between states can lead to problems, "so we're trying to get our bordering states to have consistent colors."

The first thing you can do regarding the issue, she suggests, "is try to promote a standardized wristband for patient identification. I personally recommend that all [providers] go with white in all locations — ED and ambulatory surgery, for example — not just for inpatients."

Depending on the setting, staff could potentially also look at DNR wristbands, Weakland says, "because a lot of registrars ask [about DNR instructions] as an initial question. If that is the case, be aware of the [type of] wristband that is appropriate for their state."

Some registrars also are in the position of asking about patient allergies, she says, in which case they should be aware of the appropriate wristband for that condition. "Red tends to be the wristband color for [allergies] across the country, DNR is mostly purple, and yellow is consistent for fall risk."

Some states, however, use colors differently, Weakland says, including many that indicate the need for blood products with a red wristband. Ohio is the only state that is required by law to indicate a DNR order with white paper inside of a clear wristband, she points out.

State activists hope to get that law changed, Weakland adds, and because it is under review, the task force is not making a recommendation regarding DNR wristbands at this time.

The contention of the Ohio task force — which comprises representatives from hospitals, home health agencies, ambulatory facilities, and hospice

CNE 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

- ■ Finding community resources for complex patients
- ■ Improving communication among various disciplines
- ■ How a physician advisor can assist your department
- ■ Advocating for patients who need palliative care and hospice

organizations — is that the number of different wristbands used should be limited to four in order to avoid confusion, she explains.

Some hospitals use additional wristbands to indicate things such as which side of the body is scheduled to receive surgery or that a particular limb should not be used to draw blood, Weakland says, but her belief is that having too many increases the chance of error.

"The fewer the better," she says. "These [four] are the high-volume ones. If we [replace the bands with] technology, the fewer we have to delete, the better."

While leading-edge hospitals at present are moving toward bar coding as the alternative to banding, Weakland notes, "technology changes so fast that there may be something additional that will be used."

Another task force recommendation that relates to registration personnel, she adds, is that patients remove community wristbands such as the "Live Strong" band inspired by Lance Armstrong during their hospital stay.

Access staff should "start sending that message during registration," Weakland suggests. "In an emergency, even though those bands are made from different materials, you could have confusion. Encourage patients to remove [community wristbands] and send them home, or save them until after discharge."

(Editor's note: More information is available at www.ohiopatientsafety.org. ***Rosalie Weakland*** *can be reached at rosaliew@ohanet.org.)* ■

HOSPITAL CASE MANAGEMENT™

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