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Confront data challenges for 'present on admission' before it's too late

Conditions may be wrongly identified as hospital-acquired

Making sure that conditions that are "present on admission" (POA) are identified as such. Using newly acquired data to identify potential quality issues. Dealing with physicians who refuse to conform to new documentation requirements. These are three big challenges quality professionals are facing, in light of new requirements for reporting of POA data by the Centers for Medicare & Medicaid Services (CMS).

CMS will not pay for these eight preventable conditions unless they are documented as POA: objects left in patients during surgery, air embolism, blood incompatibility, catheter-associated urinary tract infections, pressure ulcers, vascular catheter-associated infections, mediastinitis after coronary artery bypass graft surgery, and patient falls.

Data submitted in fiscal year 2008 will be analyzed by CMS, and may potentially be incorporated into future POA regulations. (For more information, visit www.cms.hhs.gov/HospitalAcqCond.)

"Be a proactive advocate for data quality in your organization to assure high levels of data integrity in POA reporting," says **Carol Spencer**, RHIA, manager of professional practice resources at the American Health Information Management Association.

Your organization should already have done an internal assessment to determine its capacity to meet the new requirements, says **Beth Feldpush**, senior associate director for quality at the American Hospital Association. "This really requires a coordinated approach among the hospital staff, with nurses, physicians, medical coders, and billing staff — even the software vendors that hospitals contract with for their billing systems," she says. "They will all have to work together to implement this successfully."

Here are steps to take now:

- **Analyze, trend, and report findings.**

"We are doing a monthly analysis of cases which are identified as not being POA, to learn if any patterns or trends exist," says **Cindy Dougherty**, RN, CPHQ, director of quality measurement and improvement at Northwest Community Hospital in Arlington Heights, IL.

Cases that trigger the "N" (not present at the time of inpatient admission) indicator are reviewed to determine if improvements are needed in documentation or adherence to established policy and procedure, says Dougherty.

If case-specific data aren't being entered into a database, then data collection and tracking systems will be necessary along with report writing capability, says Spencer. This could be part of the health information abstracting system, or a separate Excel or Access database.

"We have been tracking our internal data on adverse events and complications, and will continue to do. But we will now distinguish between those that are reported as 'POA' and those that were not present on admission," says **Sharon Kostroski**, vice president of quality and safety at St. Joseph's Hospital in Marshfield, WI.

Collect case-specific information on all "N," "U" (documentation is insufficient to determine if the condition is present at the time of inpatient admission), and "W" (the provider is unable to clinically determine if the condition is present on admission) assignments.

This is imperative for root cause analysis and trending, so improvements can be made in the quality of care, documentation, and accuracy in POA assignment. "CMS anticipates a steady downward trend of 'U' assignments," says Spencer. "Without facilities reviewing and trending for themselves, this could leave a facility exposed for a potential audit."

• Educate physicians about new documentation requirements.

"We have had to provide education and follow-up with our medical staff regarding the need to document in a way that clearly defines whether or not a condition was present on admission and the consequences of not documenting accurately," says Kostroski.

Use a variety of instructional methods and techniques, and give one-on-one education to physicians when possible, recommends Spencer.

A common problem is that several days after admission, physicians may start documenting conditions that were not mentioned in the history and physical (H&P) report or initial progress notes. "It is difficult to determine if the condition is hospital-acquired, or if the physician simply noticed it later and now is addressing it," says Spencer.

Conditions such as anemia, electrolyte deficiencies, and various cardiac arrhythmias are likely not hospital-acquired, and were actually chronic conditions that just weren't addressed before the lab values came back. "These cases would be queried, and thus answered 'U' until the physician answers the query," Spencer says.

Create physician query forms for the eight hospital-acquired conditions required for reporting in fiscal year 2008, advises Spencer. The format will vary from organization to organization, depending on the degree of electronic system implementation.

"Some are initiated to the physician concurrently while the patient is in the hospital and some are initiated retrospectively but before the bill drops," says Spencer. "Some query forms are open-ended questions and some are check-off boxes. The key is to not 'lead' the physician to a particular response."

• Be prepared to add additional conditions.

Coding staff are reporting data on every diagnosis, but clinical teams may be focusing solely on

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the required eight conditions. "The challenge is to keep a pulse on not only those eight conditions, but also be prepared to react to additional conditions that may be added next year," says Spencer.

• Consider reducing productivity requirements of coders.

This may be necessary, as coders now spend more time reviewing nursing admission assessments and diagnostics such as lab reports. Catheter-associated urinary tract infections and pressure ulcers are the most commonly queried conditions of the eight.

"If documentation supports a potential query, then this also takes additional time," says Spencer. "The challenge is to provide quality-coded data, meet productivity requirements, and adhere to billhold demands."

• Determine what data will be collected and entered into the POA database.

"This is another important exercise not to be overlooked," says Spencer. "If your facility has not performed this important function, then this is a good agenda topic for your next interdisciplinary POA meeting."

You'll need to determine what kinds of reports will be run, how often, and who will receive them. "Being able to understand the data and report the results is a key step in performing root cause analysis and implementing process improvements," says Spencer.

During a root cause analysis, analyze data on the nursing unit, the attending physician, whether a case was queried, the coder, the POA assignment, whether the case was rebilled, the potential financial impact, the potential quality impact, the payer, and the root cause.

Data also can be analyzed by ICD-9-CM code and reported by high frequency codes of "N," "U," or "W" to identify potential areas for education and training. Determine if the issue is related to coding, physician documentation, systems design and interfaces, or policies and procedures, says Spencer.

• Ensure documentation is captured at the time of admission.

Forms may need to be revised, such as adding a prompt for a skin examination to the H&P. "This will assist in data capture at admission," says Spencer. "Adding a physician signature line to wound care assessments is another avenue for securing physician documentation for POA assignment."

• Establish an interdisciplinary workgroup.

"The scope of individuals within the organization that impact or have the potential to impact POA is great," says Dougherty.

Involve health information management, coding, nursing, infection control, wound care, surgery, medical staff, and administration. "Also include patient satisfaction, in order to track and trend problem areas, in an effort to address quality issues and prepare for the potential reimbursement impact next year," says Spencer.

• Avoid erroneous identification.

Without appropriate documentation and assessment, organizations may be identifying conditions as hospital-acquired when they are not. "This is a potential problem for many, if not all, organizations," says Spencer.

Spencer recommends performing interdisciplinary concurrent, prebill, or retrospective quality review, with a "zealous and ongoing" program for education based on the findings.

Since every code requires a POA indicator, and current documentation practices produce variable and oftentimes ambiguous results, it may be impractical to query for *all* conditions or diagnoses in question. "Thus, there is a chance that an 'N' may be assigned to a condition that was in fact present at the time of admission," says Spencer.

To address this, perform prebill review of all "N" responses, and if that is not feasible, do a retrospective review of all "Ns," advises Spencer.

There also is a risk of assigning a diagnosis or condition as a "Y" (POA) when in fact, if documentation was more clear and specific, it would have been answered as an "N" or "U" and submitted to the physician for a query.

Capturing these "missed opportunity" cases for retrospective audit is important, to ensure administrative-coded data are submitted with high levels of data integrity, says Spencer.

"Our greatest challenge for reporting these conditions is having complete and accurate documentation in the medical record, specifically around pressure ulcers," reports Dougherty.

The problem is that a thorough skin assessment is not routinely completed or incorporated into the physician routine physical examination; yet it is for nursing. "If nursing identifies the presence of a pressure ulcer, the physician is reluctant to document this because they did not actually visualize the pressure ulcer," Dougherty explains.

Currently, nursing and clinical documentation specialists interact with physicians by providing either verbal or written prompts. "A solution being considered is photographing the affected area and placing the picture on the chart for the physician to take into account when document-

ing," says Dougherty.

To address this, some facilities are requiring a skin assessment as part of the H&P, and others are requiring the physician to review and sign off on the wound care nursing note. "For this reason, the nursing documentation and wound care documentation is becoming more sophisticated to support accurate POA assignment," says Spencer.

Another problem is that urinary tract infections may not necessarily meet the Centers for Disease Control and Prevention's definition, yet if one is documented by the physician, physician's assistant, or nurse practitioner, it is coded as such.

"This is an educational issue, and one that we have involved multiple disciplines for input," says Dougherty. Clinical documentation specialists have designed educational posters for display in the medical staff lounge, and presentations on POA are delivered at scheduled staff meetings.

Also, when the source for a bacterium on a patient is unclear, physicians may arbitrarily assign it to the vascular catheter. "If a physician attributes the presence of an infection to the vascular catheter, it is coded as such, regardless if the link is confirmed," says Dougherty. As a result, it gets identified as a vascular catheter-associated infection, which may or may not be accurate.

"The physician has made that link based on his or her clinical judgment, regardless of what the lab indicated," says Spencer.

The coder cannot make that link without the physician documentation, but the infection control nurse may be able to assist when cultures have a contaminate. "This type of documentation issue is best handled by a clinical pertinence peer review — another physician reviewing the record — as coders do not typically query once documentation is present in the record," says Spencer.

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For POA, put focus on patient care not billing

Quality professionals must take the lead

When it comes to requirements for "present on admission" (POA), the focus too often is on reimbursement instead of patient care, according to some quality improvement experts.

"It is time for hospitals to quit focusing on the billing and technical aspects of the POA indicators," argues **Nancy McLean**, RN, BSN, MHSA, senior consultant at Courtemanche and Associates in Charlotte, NC. "POA is *not* a billing issue — it is a clinical quality initiative," she says. "It is time for quality professionals to take the lead and change the focus to prevention."

Since July 2007, most organizations have focused on improving licensed independent practitioner (LIP) documentation to capture as many diagnoses as possible on admission. "But when we are reporting a condition as either POA or a health care-acquired complication, it is too late to impact potential reimbursement or try to figure out how to recover uncompensated dollars spent in the treatment of health care-acquired complications," says McLean.

The loss of revenue will come from two sources, says McLean: the no pay POA complications and the resulting change in case mix index from inability to bill for secondary diagnoses that are hospital-acquired.

"We need to redirect our energy to elimination of hospital-acquired complications," she says. "It is also time for the quality professional to take the lead and change paternalism to partnership, and change the POA focus from billing to prevention."

The quality professional must lead the way in establishing the organization's POA priorities. "Quality professionals should think of a way they can add in the information that they learn from this effort to their ongoing quality improvement activities," says **Beth Feldpush**, senior associate director for quality at the American Hospital Association.

Answer these questions, advises McLean:

- What has your organization done to prevent the occurrence of health care-acquired complications?
- Have you developed plans of care that focus on prevention?
- Are you still accepting health care-acquired complications as inevitable, an annoyance, something that can be fixed with drugs or treatments, or normal complications of a condition in certain

age groups?

• Are you paternalistic toward the patient or are you partnering with the patient? Are you complacent or are you proactive?

Request that the finance department provide you with the history of incidences of billing for the identified DRGs that will no longer be reimbursed. "Look at national data on discharge incidence of the identified POA," says McLean.

In 2000, the incidence per 100,000 discharges of decubitus ulcers was 21.96. "This was the highest of all the POA indicators selected for no payment this year," says McLean. "Review the data with leaders, and develop actions that focus on prevention."

The elimination of decubitus ulcers should be on your performance improvement plan for this year, and you should answer these questions, says McLean:

• What is the organization's incidence of pressure ulcers? What is the incidence of the other POA complications?

• Is the elimination or at least reduction of pressure ulcers on the performance plan this year?

• What has the organization put in place to reduce the incidence of pressure ulcers?

• Is the organization's focus on wound healing or on skin integrity?

• Have we completed a literature search and sought out best practices and evidence-based literature on prevention of skin breakdown and treatment of pressure ulcers?

• Does the organization have evidence-based wound treatment protocols approved by the medical staff?

• Is there a certified wound care nurse on staff?

• Is there an automatic consult to the skin integrity team when a patient is identified as at risk for skin breakdown?

• Has the medical staff changed the history and physical requirements to include an examination for skin breakdown? Do the history requirements include a history of prior skin breakdown?

• How does the organization respond when an LIP orders a wound treatment known to be detrimental to wound healing?

• How has the organization's budgeting process changed to accommodate resources needed to clinically reduce or eliminate the eight health care-acquired complications identified by CMS?

• Does the organization have a performance improvement team actively working on each of the POAs this year — or at least on the ones with the highest incidence in the organization?

Health care-acquired complications have been accepted as inevitable over the years, says McLean. "Sadly, we have to be forced into improving the quality of care we provide by CMS taking away reimbursement dollars," she says.

Reshape your performance improvement plan to focus on the list of POAs for 2008 and to begin addressing the POAs coming in 2009. "We know what complications are not being reimbursed — CMS provided us with a list," says McLean. "Stop the complication from occurring. The organization's reimbursement won't increase, but expenses will decrease. We may even improve the bottom line."

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Consider informed consent issues with QI initiatives

More clarity is needed

A group of hospitals implements an inexpensive, evidence-based intervention to prevent costly, potentially fatal infections in acutely ill patients. Investigators monitor the results and find a significant improvement in infection rates that is sustained over time.

Doesn't this sound like a quality improvement "success story?" Unfortunately, government regulators shut the program down, claiming that the rights of patients and clinicians were violated.

The intervention was part of a hospital quality and safety initiative at Michigan hospital intensive care units. The program involved a five-step approach developed by a Johns Hopkins faculty member, including wearing sterile gloves and gowns prior to inserting intravenous lines.[1]

The study investigators used statistical methods to study the impact of the intervention on infection rates across all the ICUs. An infection control practitioner in each hospital provided the investigators with data from each ICU on the rate of infections at the beginning of the intervention, and periodically for up to 18 months after. Each of the participating hospitals used a quality improvement process, with teams working together to introduce best practices and make them routine.

In response to an anonymous complaint alleging that the research was conducted without

prior approval by an institutional review board (IRB) and without the informed consent of the human subjects who participated (both patients and clinicians), the Department of Health and Human Services' Office for Human Research Protections (OHRP) investigated, and found the program was not exempt from the regulations.

Now, advocates are appealing to OHRP to rethink its policy. "We have confidence that OHRP will see that their original decision, while perhaps following the letter of the law, was formed in a vacuum — without regard for the fact that the program does not pose a threat to patients and is proven to save lives, easily and efficiently," says **Karen Linscott**, acting CEO of the Leapfrog Group. "A severe blow to patient safety will be dealt if decisions like this are upheld."

What is impact on QI?

There is "serious concern" over this incident among quality professionals, who are wondering about the implications for their own QI activities, says **Joe McCannon,** vice president at the Institute for Healthcare Improvement.

QI initiatives must be designed with ethical considerations in mind, and there are certain types of research that do need to be subjected to IRB review, with informed consent obtained.

"But there are other types of work, like the work that we do, with tactics such as checklists and other foolproofing techniques, that involve measuring and managing existing processes and trying to make them more reliable," says McCannon. "We are not introducing new medicines or technologies."

If new approaches are being tested, with different types of care assigned to different groups for research purposes, IRB review would likely be required.

"But the typical QI activity focuses on refining existing, established, evidence-based best practices and making sure those practices are done more reliably," says McCannon. "Those activities don't need to be subject to that type of review."

According to OHRP, if any hospital or ICU decides to implement the use of checklists or other measures only for the reason that it believes those measures will improve the quality of care provided, they may do so without consideration of the regulations for the protection of human research subjects. (To access the announcement, go to www.hhs.gov/ohrp. Click on "OHRP News" on the left and under "Recent Announcements" select "January 15, 2008.")

OHRP says the regulations do not apply when institutions are only implementing practices to improve the quality of care, but if institutions are planning research activities examining the effectiveness of interventions to improve the quality of care, then the regulatory protections do apply, to protect the rights and welfare of human research subjects.

"OHRP hopes to close this case in the near future," says **Ivor A. Pritchard**, MD, OHRP acting director. "We recognize that some people in the field are having difficulty determining when the regulations apply. We are working hard to develop ways to clarify when the regulations apply and when they do not."

Clearer guidelines are needed for human subjects review and informed consent is necessary, says McCannon. "The fact that OHRP has taken this action is making people stop and say, 'Let's try to be more clear about when stringent review of QI activities is necessary, and when in fact, it's not necessary and can freeze or slow down the pace of important work," he says.

Reference

1. Pronovost P, Needham D, Berenholtz S, et al. An intervention to decrease catheter-related bloodstream infections in the ICU. *N Engl J Med* 2006;355:2725-32).

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A report on the Ethics of Using QI Methods to Improve Health Care Quality & Safety *can be downloaded from the Hastings Center web site (www.thehastingscenter.org). Click on "Publications," "Special Reports" and scroll down to the report title.]* ■

Nursing rounds: A 'win-win situation' for quality care

Simple, low-cost practice is having a dramatic impact

Would you like to decrease falls and nosocomial skin breakdown, reduce the frequency of patients' call light use, and increase satisfaction of both patients and nursing staff? After a 2006 study linked these and other benefits to nursing rounds, a growing number of organizations are

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Magnet facility credits communication for success

Designation result of sharing of best practices

Baptist Health System of Jacksonville, FL, has become one of only 13 health care systems nationwide to achieve recognition from the American Nurses Credentialing Center (ANCC) as a Magnet health care system, an international quality designation considered the "gold standard" for nursing and clinical care. According to researchers, Magnet facilities have lower mortality rates and higher patient satisfaction, and also outperform other facilities in recruiting and retaining nurses.

The application and appraisal process extended over a four-year period and included reviews of Baptist Medical Centers (Downtown, South, Beaches, and Nassau), Wolfson Children's Hospital, and Baptist Home Health Care.

Baptist Health leaders believe their unique communications strategies were a key to successfully implementing QI processes across the system. "Over and above our meeting their standards, [the appraisers'] comments focused on the engagement of the entire organization and the innovation around communication," says **Diane Raines**, RN, MSN, senior vice president and chief nursing officer.

"One of the things that makes this award unique is that we applied as a health system — so we had to have the same [quality] across all five hospitals, including home health," adds **Kristin Vondrak,** MSN, ARNP-BC, AOCN, CNA, system director of clinical quality and Magnet program coordinator. "We acculturated quality into the system and we were able to demonstrate that."

This approach is not something that was just developed for the Magnet process, adds **Keith Stein**, MD, FCCM, FCCP, senior vice president and chief medical officer. "It's not like we had to start from a blank slate; this honor recognizes a 50-year-plus history of our culture characterized by excellent communications and inter-disciplinary cooperation for which we have been recognized in other ways," he says.

In addition to the historic culture of quality, however, Baptist Health did introduce some important innovations during the four-year period. "Three years ago we called together a clinical quality and technology committee formed by representatives from each of the facilities," recalls **John Wilbanks**, FACHE, chief operating officer. "One of the first bits of work sanctioned and authorized by that committee was quality dashboards for each hospital, which we use as a method for evaluating parameters the committee deems significant." The committee recommended the most pertinent and valuable parameters, and reports to each hospital board on a quarterly basis.

"The dashboards look like Excel spread sheets presented in tabular form," explains Stein. "Color coding reflects how close we are to achieving targets or benchmarks."

Stein says that of a total of 800 parameters used by the system, two dozen of the more "overarching" parameters have been selected for board review. "Most recently we have talked about putting them on our internal portal for staff and physicians," he adds.

The dashboards are used on multiple levels, adds Vondrak. "In addition to system-wide reports that go to the board, they are also facility-specific and unit-specific," she explains.

Numerous vehicles developed

Through the Magnet process, Vondrak says, an internal infrastructure was developed, made up of several high-level committees — system and facilities, education, research, process improvement, community and family partnership, and clinical practice. "We developed a bi-directional approach to reporting — up to the executive level and down to the bedside," she says. "We communicate quickly and often, through our *CNO Newsletter*, **[see excerpted sample, pg. 36]** 'Care Connection,' 'Vital Signs,' the 'Baptist Health Blitz', and the 'Pharmacy Tablet' — many tools to communicate to many disciplines."

As the dashboards are facility-specific, the process improvement council can readily learn the different hospitals' internal best practices and then share them with the rest of the system, adds Vondrak. "In the context of the PI council, we have issues in common across all facilities, so we

benchmark internally and externally," she explains. "So, we move not only knowledge but processes around the system, by moving internal process experts to places that need their help."

"Within the five hospitals there will be someone who exhibits best practices, and they become our internal expert," adds Raines. "Their expertise can also be shared in writing, or put on-line. Or, they could become the faculty for the next education session."

This works on a team level as well, says Raines. "Take fast-track [units] in the ED," she says. "We have a team that perfected that approach, and this internal team moves around to help us refine the approach, measure the impact, and continue to improve."

"One of the key things is that the information is driven down," adds Vondrak. "Since all councils are interdisciplinary, they communicate to the ancillary departments as well."

Raines explains how specific QI initiatives unfold at Baptist Health. "One of our quality goals is the prevention of pressure ulcers," she shares. "So, we bring together our nursing leadership and conduct an extensive review of best practices (both internal and external) around that goal, and the tools needed to audit their own work units. So, each of them learns the best practices, takes that back and works with their staff. In addition to that, we have specific programs for staff members on the topic; they can go on-line and access information relative to best practices."

The leaders agree the Magnet process itself actually led to further innovation. "I think the

Critical Success Factor of Quality

Critical Success Factor	Strategic Focus Area	Nursing Leadership Goals	Why This is Important
QUALITY	Deliver superior patient care by relentlessly driving to improve clinical quality	**Goal 1:** Improve CMS Indicators for CHF to target: **98% compliance with indicators (there are four).** **ONE:** Patients must have an assessment of the left ventricular function on the chart (either an echocardiogram or a cardiac cath). **TWO:** Patients need to be on ACE or ARBS medications for CHF. While these two are medically driven, nurses can check the charts and remind the physicians if they are not present. **THREE:** Adult smoking cessation counseling done and documented **FOUR:** Discharge instruction must address **ALL of the following:** 1. Diet 2. Activity 3. Follow-up appointment 4. Medications 5. Weight monitoring 6. What to do if symptoms worsen	**Goal 1:** In all of our adult settings, patients with congestive heart failure are prevalent. They may be admitted with other diagnoses but have underlying CHF. Our management of CHF is reviewed by the Centers for Medicare & Medicaid Services to determine if we use evidence-based practice to maximize the patient's outcome and minimize their return to the hospital. The nursing actions that will be measured are well within the realm of professional nursing practice and are critical for the patient's continued health. These are not arbitrary indicators but rather ones that we know will make a difference in a patient's clinical course. Please make sure to focus on these indicators with our CHF patients and make sure to chart your actions appropriately.

Source: Baptist Health System, Jackonsville, FL.

Magnet process allowed us to make great strides, and sometimes forced us to have conversations about where we needed to go,"says Wilbanks.

"The connection here was that striving for Magnet designation as a system gave us a platform, and helped create the vehicles to improve communication," adds Raines.

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CM department scores big on member satisfaction

Multidisciplinary team collaborates on patient care

Blue Cross Blue Shield of Rhode Island's case management department consistently scores in the 90th percentile on satisfaction surveys sent to members who have completed a case management program.

The 2006 surveys show 99% of respondents reported being treated with dignity and respect; 97% rated their experience "good to excellent;" 98% reported being able to reach the case manager by telephone; 93% reported usually or always receiving a return phone call within 24 hours; 93% said the education they received helped improve their health habits; and 96% would recommend the service to family and friends.

The not-for-profit managed health care plan has been recognized by J.D. Power and Associates for providing an outstanding experience to its PPO members and received an "excellent" rating from the National Committee for Quality Assurance (NCQA). In addition, the case management department was one of the first three Blue Cross plans nationwide to receive the highest accreditation from URAC.

The case management department's multidisciplinary team collaborates to provide all the services that members need to learn to manage their health, says **Yvette Chartier**, RN, BS, CCM, CPUR, manager of case management for the Providence-based health plan.

The integrated case management department includes RN case managers, social workers, dieticians, tobacco cessation specialists, and RN health coaches who are experts in working with members on specific diseases, such as asthma, diabetes, or cardiac conditions. They can call on the medical director, staff pharmacists, and other resources within the company to help meet the needs of the members, Chartier says.

"The nurses in our program have an average of 18 years of clinical experience.

We have nurse case managers on staff who have specialized in pediatric care management, oncology management, and management of transplant patients so they have the expertise to coordinate the care for these patients," she adds.

Having all the disciplines in one department makes it effective for the team to collaborate on patient care, Chartier says. In addition, the health plan contracts with an external vendor for behavioral health services and dedicated behavioral health case manager on site at the health plan.

"Our staff can collaborate with the behavioral health case manager and co-manage members with both behavioral health and medical issues," she says.

The health coaches focus on specific conditions and provide telephone coaching, monitoring, and evaluations.

When members have more than one chronic condition or comorbidities, the team determines whether the member would be better served if the case manager or the health coach was in charge.

All of the staff are cross-trained to handle any needs the members may have, allowing continuity of care when a member's care is being coordinated by one team member and he or she develops an additional condition.

For instance, if a health coach is already working with a member on diabetes control and the member fractures his or her hip, the health coach could continue to manage the members.

The case managers have basic knowledge of community resources, such as medication assistance or Meals on Wheels, but also consult with the team's social workers for additional help.

Members eligible for case management are identified by through health risk assessments, predictive modeling, and claims information triggers that identify patients with certain diagnosis codes, and those who have been admitted to the hospital. Customer service representatives identify issues that members need help with when they talk with members on the telephone and uti-

lization review nurses refer members for case management services.

"We have worked with our provider community to help increase the number of referrals from physicians," Chartier says.

Introducing a member

When a member is identified for case management, a nurse calls them and begins to establish a relationship.

"There is a lot of concern when members get a call from their health insurer. The role of the case manager during this phone call is to explain how we are there to help them navigate the complex health care system," Chartier says.

The health plan contracted with an external vendor to train the case manager on effective ways to educate members about the services that the health plan can offer. "As nurses we are not as comfortable with marketing as we are with patient care. We wanted to give the nurses skills to help them engage the member and see the benefits of participating in our programs," she says.

If the member expresses interest in participating in the case management program, the case manager completes telephone assessment to help the member identify potential areas where the health plan can be of assistance. The assessment includes information on the member's medical condition, medications, and psychosocial, and behavioral issues.

The member is then assigned to the team member who can help with their problems.

"This is where having an integrated team is of benefit. The member might need to speak with the dietician for help with nutrition or may need to work with a social worker to coordinate community resources," Chartier says.

The case managers have been trained on motivational interviewing and readiness to change and use this knowledge to help the members set goals.

The nurses match the members' readiness level to the types of interventions that will benefit them. Many of the goals revolve around providing education about their condition, diet, and exercise. The case managers work with members on medication compliance, helping them understand how to take medication correctly and to understand side effects.

"We educate the member to talk to the physician for an alternative if they experience side effects, rather than stop taking the medication," she says.

In other cases, the case manager may work with a member who is recovering from a catastrophic injury or undergoing treatment for cancer or another condition. For instance, a member going through chemotherapy and radiation treatment might not understand the treatment regimen and the side effects the medication may cause. The case managers educate the members about what to expect from their treatment and when they should call the doctor if they are experiencing certain symptoms, Chartier says.

"Members who are seriously ill or going through chemotherapy may not be thinking about what questions they should ask the doctor. The case managers are here to help them understand their disease and their treatment and to be prepared so they can make the most of the next doctor's visit," she says.

One of the triggers for referral is when members have had two hospital admissions within a six-month period.

If a member agrees to participate in the program, the case manager contacts the member's physician to collaborate on a treatment plan.

The health plan has made a concerted effort to promote a collaborative relationship with physicians. In 2004, the health plan started reimbursing providers $50 for a telephone consultation. As a result the physician collaboration rate increased from about 23% to as high as 60% some months.

The case manager faxes the physician a form, which lists all the medications the member has reported taking and any other issues or potential problems. "We fax them in advance to let them know that we will be contacting their office within 24 hours and ask them to let us know if there is a better time to communicate with them," Chartier says.

When the case managers call the physicians, they review the medication and make sure the member's self-reported medication plan matches what physician's file, such as the member is taking the appropriate dose at the appropriate time.

"Many times, if a member has just been discharged from the hospital, the primary care physician may not be aware of new medication," she says.

The case managers discuss the members' goals with the physician and find out how they can help reinforce the treatment plan .

The average members stay in case management for four to six months, Chartier says.

"At the outset of the relationship, the member sets individual goals and they are discharged from case management when they complete the goals unless they are willing to work on other goals," she says. ■

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implementing this practice.[1]

"Since the article was published, I have had 1,143 requests from hospitals and nursing managers from all over the U.S.," reports **Christine Meade**, PhD, the study's lead author and researcher with the Studer Group, of Gulf Breeze, FL,

At Sharp Memorial Hospital in San Diego, hourly rounding was implemented for 800 nurses and nursing assistants in all inpatient units. Nurses ask patients about the four "Ps:" pain, position, need to go to the bathroom (potty); and proximity (convenient location of everything the patient needs). Before nurses leave, patients are asked: "Is there anything else I can do for you before I go?"

"Since patient falls are often related to unexpected trips to the bathroom, these rounds anticipate the need and help prevent falls," says **Jennifer Jacoby**, RN, chief nursing officer. Nurses were given one-on-one instruction on what to do during hourly rounding, with follow-up meetings with managers to validate their progress.

A second contributor to falls is reaching for something too far from the bed, so assuring needed items are in proximity assists this. "Position helps prevent skin breakdown, and pain inquiry assures we are managing pain ahead of the curve," says Jacoby.

At St. Rose Dominican Hospital- Siena Campus in Henderson, NV, nurses do hourly rounding to check for pain, potty, and position, and document pain levels on a white tracking board in the patient's room. "We have had some excellent results and have decreased our falls," says **Teressa Conley**, vice president and chief operations officer.

After nursing rounds were implemented on the med/surg units at Northeastern Hospital-Temple East in Philadelphia, safety and satisfaction improved. "Initially we were only looking to improve patient and employee satisfaction," says **Elizabeth Ructor**, RN, nurse manager. "But when our Press Ganey scores soared from 68-72% to 98% in all areas of the questionnaire, we realized the impact rounding produces. We soon realized as well we were having a tremendous impact on pain control."

Because of toileting every hour during the rounds, fall rates decreased "a whopping 65%" and injuries related to falls dropped as well, says Ructor. "We came to understand how far reaching rounding really is and the impact it has on so many other areas of care," she says. "Weekly comparison of unit scores prior to rounding told the story. Rounding is absolutely best practice."

Nursing rounds are a "win-win situation" for everyone — patients, staff and the hospital, says Ructor. "The patients love knowing someone will be returning to see them in a scheduled timeframe," she says.

Since patient needs are met during each period of rounding, unless it's something emergent, patients refrain from using the call bell. "Nursing staff have less interruptions, less distractions, and less running around," says Ructor. "The nursing assistants do the bulk of the rounding, and even they find that patient care time is less interrupted, because they don't have to stop what they are doing to constantly answer bells."

The hospital has markedly decreased the number of falls with injuries. "Hopefully, litigation costs are lowered, not only because of decreased falls, but also because having a better experience makes it less likely that someone will sue for other issues," says Ructor.

At Medical University of South Carolina in Charleston, nursing rounds have resulted in a 15% to 70% decrease in call lights, with marked improvement of patient satisfaction scores on many units. "It is worth the effort!" says **Marilyn J. Schaffner**, PhD, RN, administrator for clinical services and chief nursing executive. "There are many reasons to do it, and no reason not to do it."

After rounding was implemented at St. Rose Hospitals—deLima Campus, there was a dramatic decrease in call light use. "On my 20-bed intermediate care unit, call lights used to be constantly going off," says **Wendy Lincoln**, RN, MSN, director of critical care services. "Now, the call lights go off five or 10 times in a 12-hour shift. They are the exception rather than the norm." White boards were customized to include a space where the patient/family can write down "questions for my doctor" to increase patient participation in care.

Collect data to show impact

As for what data are needed to demonstrate the impact of nursing rounds on safety, Meade suggests the following: a record of call lights, rounding logs that nursing staff must sign, the number of falls, the number of medication errors (both dosage and wrong medication), decubitus ulcers, surgical wound site infections, peripheral and central line site infections, and a number of other infections.

At Sharp Memorial, fall rates are compared to other hospitals in California through data from the California Nursing Outcomes Coalition. "Overall, the fall rate and number of pressure ulcers is lower than 90% of other hospitals in the

state," says Jacoby.

Fall rates and pressure ulcer rates are measured, along with questions from the hospital's patient satisfaction survey about response to call light and management of pain.

At Medical University of South Carolina, the patient's overall satisfaction with discharge is tracked, with current scores compared to baseline scores prior to implementing hourly rounding. "I believe we can positively impact the discharge process if the nurses and clinical associates continue hourly rounding even after the discharge order is written," says Schaffner. "I sense the patient's dissatisfaction with discharge is about a lack of effective communication with the patient and their family members." A number of other metrics were measured before and after implementing hourly rounding, including staff satisfaction, steps walked by nurses, and patient falls.

Northeastern's fall rates were compared before and after the rounding program was implemented, and include every fall and near fall incident report, comparison of injury vs. no injury, where the fall, occurred and other details of the event.

"Had I realized the far-reaching impact rounding has, I would have liked to have data comparing medication errors prior to rounding and since rounding was initiated," says Dructor. "I believe it has decreased errors, simply because the nurses are not interrupted and distracted while dispensing medications, but I have no hard data to back it up," she says. "I would encourage someone who has yet to begin rounding to keep that piece in mind."

Reference

1. Meade CM, Bursell AL, Ketelsen L. Effects of nursing rounds on patients' call light use, satisfaction, and safety. *Am J Nursing* 2006: 106(9);58-70.

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Proposed additions to 2009 patient safety goals

Below are some of the proposed additions to The Joint Commission's National Patient Safety Goals (NPSGs) for 2009, with challenges outlined for each:

• The patient should be involved in the identification process when possible.

"I don't believe there is any surprise here," says **Kathleen Catalano**, RN, JD, director of health care transformation at Plano, TX-based Perot Systems. "This has been a running theme throughout all of the NPSGs."

This is probably already included in your organization's policy and procedure for improving the accuracy of patient identification. "Tracking that this has occurred will probably be accomplished through direct observation and documentation," says Catalano.

• Eliminate transfusion errors related to patient identification.

This would require matching the patient to the blood product and the blood product to the order, with a two-person verification process or an automated identification technology such as bar-coding. "Also, when the two-person verification process is used, both individuals must be qualified to perform the tasks at hand," says Catalano.

• Implement best practices to prevent multiple drug-resistant organism infections.

The 16 implementation expectations for this goal include education of health care workers, patients, and families; implementation of hand hygiene guidelines, contact precautions for patients with methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile*–associated

disease (CDAD), a MRSA surveillance program; implementation of a laboratory-based alert system that identifies new patients with MRSA; a CDAD surveillance program; and effective cleaning and disinfection of both patient care equipment and the patient care environment.

"These programs have already been instituted across the country. Increased monitoring may now be required but, in essence, this is in place," says Catalano.

• Prevent catheter-associated bloodstream infections.

"There are 13 implementation expectations for this goal, and all should be the practice in hospitals today," says Catalano. "These would be implemented collaboratively through infection control, patient care, and the quality department."

• Prevent surgical site infections.

Infection control, perioperative areas, and the quality department will need to work together to be certain that surgical site infection rates are measured, compliance with best practices is monitored, and the overall effectiveness of prevention efforts evaluated, says Catalano.

• Perform modified medication reconciliation processes in settings where medications are not used, are used minimally, or prescribed for a short duration.

This will impact ambulatory care, urgent and emergent care, office-based surgery, outpatient radiology, and behavioral health care. "Here, when no changes are made to the patient's current medication list or when only short-term medications, such as five days of an antibiotic, are prescribed, the patient is provided a list containing the short-term medication additions," says Catalano.

If any long-term chronic medications are prescribed, a complete list of reconciled medications is provided to the patient, family, and primary care provider or original referring provider.

"It is likely that most organizations have set up a medication reconciliation task force," says Catalano. "This task force could be resurrected to determine how the organization will address the additions to the NPSGs. The quality department, as a member of the task force, would help in determining measurement of the NPSGs components."

• Patients must be provided with information on infection control measures for hand hygiene practices, respiratory hygiene practices, and contact precautions.

"Tracking of how often the information is actually provided will be one piece of the puzzle," she says. "The other, that naturally follows, is assessing whether or not the patient and family understand the information provided. This will probably involve questioning of the patient and patient's family to seek their level of understanding."

Organizations also must provide surgical patients with information on the prevention of adverse events in surgery. "The organization will need to determine how this information will be dispersed to its surgical patients. The quality department will have to help develop a tracking mechanism that will work for the organization," says Catalano.

• There are new requirements for the Universal Protocol.

Quite a few revisions and additions have been made to the Universal Protocol in an effort to clarify the requirements, says Catalano. These revisions and additions must be taken seriously by the perioperative team, and by any other staff involved anywhere in the facility where procedures are performed. "They, along with the quality department, will need to develop measures for tracking of these important revisions and additions," says Catalano.

There are also new requirements for the final "time out" verification immediately before starting the procedure. "There needs to be an interactive verbal communication between team members and the ability for any team member to express concerns about the procedure verification," says Catalano.

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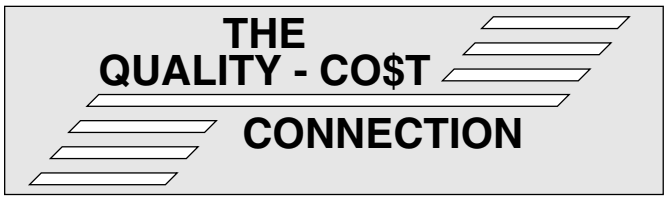

Comply with anticoagulant management requirements

Follow phase-in schedule

By Patrice Spath, RHIT
Brown-Spath & Associates
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Improving the safety of using medications has always been a National Patient Safety Goal.

Each year the goal is reviewed by The Joint Commission and requirements are adjusted based on current priorities. The 2008 addition to Goal 3 — organizations must "reduce the likelihood of patient harm associated with the use of anticoagulation therapy" — resulted from an increasing awareness of harmful medication errors involving this type of therapy.

Anticoagulants are high-alert medications that carry a significant risk of causing serious injuries or death to patients if they are misused. Errors with these products are not necessarily more common than with other drugs, but when used or omitted in error, anticoagulants can cause life-threatening or fatal bleeding events or thrombosis.

In 2007, MEDMARX reported that from Jan. 1, 2001, through Dec. 31, 2006, 9,316 medication errors related to anticoagulants were reported to the program. This does not include errors involving heparin lock flushes. Performance deficit (40.6%) was the most frequently reported cause of all anticoagulant errors. When combined with errors caused by procedures or protocols not being followed (23.9%) this accounts for almost two-thirds of all errors associated with anticoagulants, which can be attributed to causes related to human factors issues. Other frequent errors included communication failures, omitted or inaccurate order transcription, computer entry failures, and knowledge deficit.

The anticoagulation management requirement of The Joint Commission has a one-year phase-in period with defined expectations for planning, development, testing, and milestones at three, six, and nine months in 2008, with the expectation of full implementation by Jan. 1, 2009. Hospitals must comply with the requirements at each milestone. For example, if a hospital is surveyed in May, it will receive a requirement for improvement (RFI) if it fails to meet the April 1 benchmark.

To comply, hospitals must start now to ensure full implementation by 2009. Anticoagulation therapy is a high-risk treatment because of the complexity of dosing and monitoring. This is a significant issue that requires a collaborative, system-wide effort to successfully address. The first step is to establish multidisciplinary team comprised of: a representative from administration; chief medical officer; representative from nursing management; representative from pharmacy management; quality improvement professionals; at least two nurses from different specialty areas who administer antithrombotic drugs; at least two

CNE *questions*

9. Which is recommended to improve documentation showing whether conditions were "present on admission?"
A. Collect case-specific information on all "N," "U," and "W" assignments.
B. Increase productivity requirements of coders.
C. Avoid giving physicians one-on-one education about documentation requirements.
D. Inform coders that reviewing "U" assignments is not necessary.

10. Which is recommended to improve data capture at the time of admission, for "present on admission" conditions?
A. Revising the History & Physical form to prompt for a skin examination.
B. Adding a physician signature line to wound care assessments.
C. Implementing a concurrent process to investigate "present on admission" queries.
D. All of the above.

11. Which quality improvement activities require human subjects review and obtaining informed consent?
A. All initiatives involving the use of checklists with the goal of improving the quality of care provided.
B. Initiatives examining the effectiveness of interventions to improve the quality of care, with different care given to different groups.
C. All hospital-based quality initiatives involving infection control.
D. Any initiatives with the goal of ensuring that evidence-based best practices are done more reliably.

12. Which is a result of nursing rounds, according to organizations which have recently implemented this practice?
A. The number of patients falls increases initially.
B. Patient call light use tends to increase because nurses are viewed as more available.
C. Frequency of call light use is reduced.
D. Overall nursing satisfaction decreases due to more interruptions.

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

CNE instructions

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

pharmacists (clinical and distribution) who are involved in antithrombotic therapy; representative from the clinical laboratory; representative from dietary services; at least one active staff physician, preferably a hematologist, internist, or hospitalist; and representative from the antithrombotic team and/or clinic (if team or clinic exists).

This team should carefully map out a strategy for compliance and periodically meet to monitor implementation and evaluate the effectiveness of the interventions. It is important to identify who will take the lead in overseeing implementation.

Although not required by The Joint Commission consider establishing a standing task group or committee that meets regularly to analyze errors and adverse events involving anticoagulation therapy and implement improvements. This team also should be charged with evaluating the literature for new evidence-based practices and technologies and incorporating findings into the facility's practices.

Develop explicit organizational policies and procedures regarding anticoagulation therapy and services that include at least documentation of:

- indications for anticoagulation;
- target INR (International Normalized Ratio) range and dosing policies;
- notification of dietary department for all patients on warfarin, with appropriate monitoring of drug-food interactions and patient education;

Once protocols and management strategies have been established, develop and implement staff education strategies. Individuals involved in caring for patients on anticoagulation therapy should receive education in anticoagulation management, including training in the application of practices or tools used in caring for patients on this type of therapy. Teaching should be repeated as needed to ensure that all new employees are instructed and to reinforce learning with experienced staff. If physicians occasionally order non-formulary antithrombotic drugs establish a process by which pharmacists can provide nurses with information on these drugs before dispensing the products to patient care areas for administration.

Provide attending physicians with education on the problems and potential pitfalls of managing anticoagulation therapy, including best practices. This information can be communicated via laminated cards, e-mail, grand-rounds conferences, and one-on-one discussions.

Develop educational strategies for patients and their caregivers. They should receive information

Resources

Examples of hospital anticoagulation guidelines and protocols can be found on-line at:

- University of Washington Medical Center Anticoagulation Services
http://www.uwmcacc.org/
- Venous thromboembolism safety toolkit
http://vte.washington.edu/
- University of Utah Pharmacy School
http://uuhsc.utah.edu/pharmacy/rxweblinks/rxlink28.html
- Brody School of Medicine, East Carolina University
http://author.ecu.edu/cs-dhs/internalmed/Anticoagulation.cfm

CNE objectives

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

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

COMING IN FUTURE MONTHS

■ Identify your organization's most vulnerable patient populations

■ What to measure when evaluating care of pediatric patients

■ Proven methods to eliminate hospital-acquired pressure ulcers

■ How to make sure you're giving physicians the best data

■ Use a trauma rounding checklist for dramatic improvements

about the purpose, action, and side effects of the therapy as well as information about the specific drugs being used, including the generic and brand (if applicable) names, strength/dose, and frequency/duration of use. Patients should receive verbal and written patient education materials appropriate to their language and reading level with an assessment of their understanding. Below are topics that should be discussed with the patient or caregiver at discharge:

- drug interaction screening with patient's current drug regimen;
- herb interaction screening with herbals the patient may be taking;
- dietary considerations;
- importance of maintaining anticoagulation;
- signs of hypercoagulation;
- importance of compliance and follow-up monitoring;
- importance of medical alert identification.

Prior to discharge, patients on anticoagulant therapy should have a confirmed appointment scheduled with the lab, physician, or antithrombotic clinic and the importance of keeping appointments is discussed in discharge instructions.

By Oct. 1 the hospital must be pilot testing the anticoagulation management program in at least one unit. The purpose of this pilot test is to determine how well it is working and what, if any, components need to be revised. Evaluating the effectiveness of the program requires collection of performance data. Examples include:

- Number of adverse drug events involving anticoagulant therapy (e.g., incidents involving high Warfarin overdose or overlooked drug interaction necessitating abrupt discontinuation of Warfarin or more frequent monitoring; bruising or bleeding from anticoagulation therapy treated with vitamin K; a PTT greater than 100 seconds; INR greater than "x" as defined by facility; platelet count less than 100,000/mm3; permanent patient harm or death.)
- Instances of noncompliance with prescribing and administration guidelines/protocols (e.g., patients with no INR monitored as required; failure to notify dietary department for all patients on Warfarin; failure to monitor food-drug interactions.)

(Editor's note: For more resources and recommendations to prevent anticoagulant medication errors recently published by the American Society of Health-System Pharmacists visit our site, www.ahcmedia.com. Select this issue of Hospital Peer Review.) ■