

# Healthcare Benchmarks and Quality Improvement

The  
Newsletter  
of Best  
Practices



## IN THIS ISSUE

- Will new tool aid quality managers in identifying patient harm trends? . . . . . cover
- Award-winning facility uses mentoring program to enhance new employee training . . . . . 99
- GE makes investment in low-cost EMRs for hospitals . . . . . 102
- Claims data analysis helps hospital recoup revenue . . 103
- Use data for operational changes, quality . . . . . 104
- Paper highlights initiatives and interventions. . . . . 106
- TJC to improve top four challenging requirements . . . . . 108

SEPTEMBER 2009

VOL. 16, NO. 9 • (pages 97-108)

## Premier/IHI algorithms automate process for identifying patient harm

*Tool's results agreed with full chart review 76.2% of the time*

An automated process for tracking rates of patient harm developed by Charlotte, NC-based Premier Inc. and the Institute for Healthcare Improvement (IHI) in Boston has been tested and compared against a manual full chart review. The automated tool's results agreed with full chart review 76.2% of the time; in cases in which the results did not match, it was found that 84% had issues with coding.

"I thought the results were pretty good," says **Glenn Crotty**, MD, chief operating officer at the Charleston (WV) Area Medical Center. The facility is a participant in Premier's QUEST: High Performing Hospitals collaborative, which provided the data for the research. "You are basically taking a training tool and trying to make it be sensitive *and* specific, which is quite a challenge."

"About two years ago, Premier set about trying to define what ought to be included in high-value health care," explains **Richard Bankowitz**, MD, MBA, vice president and medical director with Premier. "We brought together a group including top-performing hospitals from the CMS [Centers for Medicare & Medicaid Services]/Premier High Quality Incentive Demonstration project, Premier staff, staff from IHI, and CMS, and the group proposed that in order to evaluate health care, you needed at least five high-level metrics — adherence to evidence-based care practices; cost

## Key Points

- No recognized standard for determining harm currently exist.
- Harm data can be used to improve quality of care.
- Accurate POA coding is critical to get true picture of patient harm.

NOW AVAILABLE ON-LINE! Go to [www.ahcmedia.com/online.html](http://www.ahcmedia.com/online.html).  
Call (800) 688-2421 for details.

and efficiency; avoiding preventable mortality; patient experience; and avoiding harm. At that point we had the challenge of defining harm and measuring harm."

That's when a working group of 165 hospitals from among the participants in QUEST agreed to be measured in these five areas and to be open and transparent about the results. "A harm workgroup was formed to come up with a way of measuring harm that could be done across the whole collaborative," Bankowitz shares. "We had discussed this with IHI and determined there was not a good, agreed-upon standard of measuring harm. The IHI method required manual chart reviews, and our hospitals asked us not to

impose any more data collection burdens on them."

Accordingly, Premier and the IHI developed 26 algorithms to automate the process for identifying patient harm.

Crotty further explains the sensitivity/specificity challenge inherent in such an effort. "In the sensitivity parts you want to be able to capture as many potential harm events as possible without sacrificing the specificity, which is to accurately determine true harm and not so many false-positive harms that you have to go chase them," he says. "You can end up with publicly reported data that are too sensitive and not specific enough. That's what we're trying to learn; where is that 'sweet spot'? This is the first iteration, and it's a pretty good first iteration."

"We defined what we could get from automated and ICD-9 discharge data, plus data we have in our safety surveillance and infectious disease surveillance tool," adds Bankowitz. "The third element is the patient charge data and chartmaster data that we have from all our participating hospitals; we constructed the algorithms based on these datasets. Then, we set about to validate how good the tool was, based on the gold standard — chart review aided by the IHI Trigger Tool [for measuring adverse drug events]."

"We are validating the tool against full chart review *and* against IHI's tool so there will be three-way validation," adds **John Martin**, MPH, director of Premier Research Services.

## Collecting the data

How, exactly, are the data collected? "Premier has these tools at its disposal," Bankowitz explains. "Our hospitals send data to us just about every month, and what we do is run the data through these algorithms to determine the incidence rates of these conditions." Then, he says, each hospital's rates are compared against the distribution of the data. "So we know that a given hospital is in the fifth percentile, the 10th percentile, and so forth," says Bankowitz. "What we're trying to do is eliminate harm; our goal is to get to zero incident rates."

Hospitals can use those data to help achieve this goal, adds Crotty. "We will take the areas that suggest we have an issue, we will do chart reviews on those particular areas in our own organization in order to be able to further validate the data, and if the data are pretty close to

**Healthcare Benchmarks and Quality Improvement** (ISSN# 1541-1052) is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices. USPS# 0012-967.

**POSTMASTER:** Send address changes to *Healthcare Benchmarks and Quality Improvement*, P.O. Box 740059, Atlanta, GA 30374.

### Subscriber Information

**Customer Service:** (800) 688-2421. **Fax:** (800) 284-3291. **E-mail:** [customerservice@ahcmedia.com](mailto:customerservice@ahcmedia.com). **Hours of operation:** 8:30-6 Monday-Thursday, 8:30-4:30 Friday, EST.

**Subscription rates:** U.S.A., one year (12 issues), \$549. Add \$17.95 for shipping & handling. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are \$92 each. (GST registration number R128870672.)

**Photocopying:** No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact AHC Media LLC. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. World Wide Web: <http://www.ahcpub.com>.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Steve Lewis**, (770) 442-9805, ([steve@wordmaninc.com](mailto:steve@wordmaninc.com)).

Senior Vice President/Group Publisher: **Don Johnston**, (404) 262-5439, ([don.johnston@ahcmedia.com](mailto:don.johnston@ahcmedia.com)).

Associate Publisher: **Russ Underwood**, (404) 262-5521, ([russ.underwood@ahcmedia.com](mailto:russ.underwood@ahcmedia.com)).

Managing Editor: **Jill Robbins**, (404) 262-5557, ([jill.robbins@ahcmedia.com](mailto:jill.robbins@ahcmedia.com)).

Copyright © 2009 by AHC Media LLC. **Healthcare Benchmarks and Quality Improvement** is a trademark of AHC Media LLC. The trademark **Healthcare Benchmarks and Quality Improvement** is used herein under license. All rights reserved.



### Editorial Questions

For questions or comments, call **Steve Lewis** at (770) 442-9805.

on target, we will put in improvements to remedy the issue," he says.

"These are certainly preliminary results, so one can only draw small conclusions," cautions Martin. "However, we *are* finding they are doing a good job of identifying specific harms. To a QI person, this reduces the time they have to spend manually going through charts and then finding that information."

"The tools we developed can still be very helpful in shifting the effort away from discovery of harm into areas of improvement," adds Bankowitz. "We're trying to get hospitals away from spending time on data collection and as much as possible spending time on actual improvement methodologies."

### **POA coding critical**

The Premier researchers also found that correct coding in the cases where the tool's findings did not match charts would have increased the match rate to nearly 100%. Of particular concern to CMS, for example, is POA, or present on admission, coding. CMS requires POA flags for all diagnoses on Medicare claims, which are used, in part, to identify hospital-acquired conditions and determine reimbursement.

"When we did the study, we found that at least one-third of 'complications' were not actual complications — they are present on admission," says Bankowitz. "So the POA flag is *very* important, even in areas where you think things may be obvious or clear. Basically, it's important to use POA flags, and hospitals apparently need to spend more time educating coders."

POA coding is certainly important to Crotty. "We have deployed 16 registered nurses to look at the charts, not just for POA, but to begin the coding process up front when the patient comes in rather than on the back end, so we can have a dialogue with the physician on the particular problems the patient is having," he shares. "The problem is that unless you do something like this, the coding conventions and how the doctors write and document the records do not always match. In other words, the coding convention for hospitals and what they have to bill according to Medicare conventions do not match totally what doctors write in doctor language."

This, he continues, is one of the key themes he has communicated to IHI and Premier. He has asked them to help advocate that CMS and other policy makers develop a common language.

Crotty offers the following example: A patient comes in with massive hemorrhaging in the colon, which could be from a diverticular bleed, the rupture of a small vein, cancer, Crohn's disease, and so forth. "If the patient has bled and their hemoglobin has dropped from a normal level of 12 for women or 15 in men down to six or seven, and the doctor writes 'GI bleed, will transfuse,' the coders can't code any of that," Crotty explains. "They have to say, 'Anemia from gastrointestinal bleeding due to' whatever the particular problem was; it has to be *that* specific." Doctors know this intuitively, he says, and in their minds, they code the right thing in their language.

While waiting for this "language" problem to be solved, "We continue to work on coding, and refining it," says Crotty. "We have conference calls every month and a meeting a couple of times a year, trying to make the coding data better and better."

Meanwhile, the initiative continues. "Once we get complete results of the validation study, we'll determine the predictive value of the measures we've constructed, and concurrent with that, we'll send the results out to approximately 200 hospitals," says Bankowitz. "Many are going back to their records and comparing results and learning a lot about improving their methods. And we're attempting to construct a composite index that would roll up a total of all these measures. We'd like to have one composite index of harm to use as the high-level metric in that area."

*[For more information, contact:*

**Richard Bankowitz**, MD, MBA, Vice President and Medical Director, **John Martin**, MPH, Director, Research Services, Premier, Inc., Charlotte, NC. Phone: (877) 777-1552.

**Glenn Crotty**, MD, Chief Operating Officer, Charleston Area Medical Center, Charleston, WV. Phone: (304) 388-7438.] ■

## **Mentoring program enhances CM training**

*Mentoring key in success of award-winning facility*

A mentoring program for staff members who have already completed orientation is seen as a key strategy in the programs of Carolinas Medical

Center (CMC) in Charlotte, NC, which was recently named the winner of the 2009 Franklin Award of Distinction by The Joint Commission and the American Case Management Association.

An on-site evaluation of CMC's case management service model validated that the services met or exceeded the award's criteria for excellence. Criteria included:

- The case management service demonstrates that practice is interdependent and not the function of one person or discipline;
- The service model demonstrates respect for distinct professional identities and skills;
- The practice of case management is the catalyst for stronger relationships to achieve the best care for patients and families;
- The practice of case management provides leadership, competence, and expertise in the solution or resolution of identified problems;
- The case management service has evolved through evaluation and innovation;
- The patient care provided achieves clinical, operational, and/or quality outcomes;
- Case management practice is validated by measurable and reportable outcomes;
- Improved clinical outcomes are documented to the extent that improvement can be replicated in other hospitals or health systems.

"As we embarked on a shared governance model, a piece of what was found by the orientation council was that after orientation, employees felt the need for extended resources and assistance," says **Barb DeSilva**, assistant vice president for clinical care management. "Case management is an extremely autonomous function; they are the only one in the unit. Many have had clinical experience but not case management experience, so they are looking for leadership in guiding them through their professional development; they want people who role modeled the position."

There's a huge investment involved in training these people, she continues, so keeping turnover low is crucial. "It takes a long time to master the industry; they have a lot to master, such as payers, resources, and managing capacity, so to get a new team member fully proficient takes a couple of years," says DeSilva.

### ***Creating the program***

In creating the mentoring program, "we modeled it after some of the other programs in the literature," says **Regina Osman**, RN, MSN,

## **Key Points**

- Orientation program may not offer sufficient training.
- New staff request go-to person for everyday questions.
- Mentors, mentees meet regularly on social basis.

ACM, CPUR, manager, clinical care management. "We discovered what was research-based and what worked; we wanted to be as effective as possible."

What she found was that after new employees finish orientation (which is six to eight weeks at Carolinas) they wanted to have a "go-to" person.

"They wanted someone more at the employee base level, rather than having to come to management," she adds. "They need nurturing and support." It's not that managers aren't available, she continues, "but it would be better if they could have a peer to bounce ideas off of, a mentor they could go to with questions and network and share time away from the workplace."

The program was launched in the spring of 2008. In selecting the mentors, Osman looked for strong leaders with an extensive knowledge base who could play a nurturing role. "Our mentors have years of experience in the field, and have been viewed as role models not only by the employees in our departments but within the entire hospital system," she notes. "They have years of experience as nurses and social workers, good leadership skills, and good mentoring and preceptor [training] skills."

In pairing mentors and mentees, the facility developed some tools that enabled it to look at personality traits as well as at clinical skills. "Instead of just saying, 'You go with her,' or 'You seem to like each other,' we matched folks with similar backgrounds in clinical areas and areas of expertise, and also considered their personalities," Osman explains.

After a year together, it is up to the mentor and mentee to determine if they want to continue with the commitment, says Osman, who notes that new teams are created as needed. "Right now we have a meeting set up to match six new employees with mentors," she shares. She currently has 10 mentors in the department. "They can have up to two mentees at a time; if they

## Mentee Commitments

- I am committed to fostering a mentoring relationship with my mentor that will be professionally and personally beneficial to both of us and to CHS.
- I am committed to initiating contact with my mentor, scheduling meetings with him/her and arriving promptly for our meetings.
- I understand that I may need to be flexible and understanding of my mentor's schedule.
- I am committed to meeting with my mentor at least once a month.
- I am committed to attend programs and events associated with Case Management, especially if my mentor is attending.
- I am committed to maintaining my mentor's confidences, as him/her is committed to keeping mine.
- I am committed to learn from my experiences in the mentoring program to improve my self and my performance.
- I agree to complete an evaluation of the Clinical Case Management mentoring program at the end of the program year.

Source: Carolinas Medical Center, Charlotte, NC.

## Mentor Commitments

- I am committed to fostering a relationship with my mentee that will be professionally and personally beneficial to both of us and to CHS.
- I am committed to responding to my mentee when he/she contacts me.
- I am committed to sharing my knowledge with my mentee about the CHS & the Clinical Case Management professional environment and introducing to her to key resources within CHS, as appropriate.
- I am committed to meeting with my mentee at least once a month.
- I am committed to attend programs and events associated with Case Management, especially if my mentor is attending.
- I am committed to maintaining my mentee's confidences, as she is committed to keeping mine.
- I will notify management of any significant concern I may have about my mentee, my ability to serve as a mentor or other matters associated with the Clinical Case Management mentoring program.
- I agree to complete and evaluation of the Clinical Case Management mentoring program at the end of the program year.

have more than that, they may lose effectiveness," she adds.

### **Formal, informal meetings**

The mentors and mentees get together and communicate on a number of different levels, says Osman. "On a day-to-day basis, the mentee knows the mentor is available by e-mail, pager, or phone if questions come up," she says. "But the 'meat and potatoes' of the program is that they have lunch together one or two days a month and do activities together. They go to team building or case management meetings outside of the hospital. They may have a dinner, or socialize, and pursue educational opportunities at that time."

The mentors, she notes, continually look at activities in the hospital they can attend with their mentee. "Some even went to wine tastings after work," she adds, noting that they are required to get together at least once a month. **(See box above.)**

Measuring the success of the program "takes some effort on my part," Osman concedes. "I try to meet quarterly with the mentors and get feedback on an individual basis to see how things are

going. I'm also rounding at least on a weekly basis, so I get informal feedback from the mentees."

There are now some recent graduates and feedback on the program, says Osman. She says they appreciated the opportunity to have a strong go-to person. "In this field, you can't learn everything in six to eight weeks," she notes. "With their mentor, they can ask questions, troubleshoot difficult discharges and other problems. A lot of folks who just completed the program say they do not want it to stop; they want to know their mentor is still available to them."

Although the program is time-consuming for the mentors, Osman says, "this is a priority for them. They look at their schedules and see if they can plug in even just 30 minutes. We also allow them flexibility in scheduling assignments if they need some time."

Osman is convinced the program contributes to improved quality of care. "I think it is strengthening these new employees to be the best case managers they can possibly be," she says. "We give them the skills and knowledge to be successful now more than ever; we take the time and effort to make it work for our new employees because we value them."

[For more information, contact:

**Barb DeSilva.** Phone: (704) 355-3191; E-mail: [barb.desilva@carolinas.org](mailto:barb.desilva@carolinas.org). ■

## GE program could boost EMR adoption

*Assess current processes before starting EMR*

In the first phase of its “healthymagination” program, which will eventually represent a \$6 billion commitment to improve access, affordability, and quality of health care, GE has launched Stimulus Simplicity, which is designed to provide hospitals and physicians with an easier route to EMR (electronic medical record) adoption.

One of the greatest challenges to EMR adoption, especially for rural facilities, has been the financial requirements, and that is what GE is seeking to address. As a joint offering of GE Healthcare and GE Capital, it contains two core elements — a commitment to ensure the EMRs are certified (a precursor to federal stimulus reimbursement eligibility) and an interest-free loan with deferred payments.

GE notes that uncertainty about future standards has been another impediment to EMR adoption.

However, says **Patrice L. Spath**, of Brown Spath Associates, Forest Grove, OR, “certification has not been agreed upon yet.” Under the HITECH Act of the American Recovery and Reinvestment Act (ARRA), federal stimulus funds won’t become available for EMRs until 2011, and the federal government has yet to set specific guidelines for determining what constitutes a “qualified” system.

However, GE is attempting to overcome this challenge by offering a “HITECH Warranty” for its Centricity EMR and Centricity Enterprise solutions to facilities and physicians that participate in the program.

### **Critical financial aid**

GE Capital is offering zero-interest funding with deferred payments to qualified buyers so they can have immediate access to this technology without up-front capital costs.

“This gives a small, rural clinic like ours a

## Key Points

- Hospitals with tight budgets will benefit from interest-free loans.
- Warranty offers protection for future certification requirements.
- Expert warns that technology is no guarantee for quality improvement.

once-in-a-lifetime opportunity to bring our patients the type of technology they’d typically have to travel for,” said **Stephanie Wooton**, administrator of The Hazard Clinic, in the Appalachian region of Eastern Kentucky (among the first to qualify for the interest-free opportunity), in a statement released during the program launch. “Now, not only do we expect the Centricity EMR to save us money by increasing efficiencies, it will empower our staff to deliver the top-notch care our patients deserve. Frankly, that’s the most exciting part.”

Wooton says her facility has ordered the hardware and is expecting to go live in about two months.

“The way they’re doing the loan was really a big help,” Wooton adds. “We would not have been able to upgrade at this time without special financing; we do not have to pay any finance charge — it’s interest-free until we get our first stimulus bonus [from the government].”

### **A captive audience?**

The catch is that the funds can only be used to invest in GE’s EMR products, GE Centricity EMR and Centricity Enterprise solutions. The Centricity Enterprise system integrates core clinical processes for orders, results, pharmacy and care documentation, in concert with administrative/financial processes for scheduling, registration/admitting, charging, and billing.

But as Wooton points out, in order to be eligible for those aforementioned stimulus bonuses, you have to have a qualified EMR. “We currently do have an EMR, but it won’t be a *qualified* EMR,” she notes. “This is much better and helps us go paperless with prescriptions as well as charting.”

Tracking care of patients will be superior, she continues. “With activities such as diabetes management, glucose management, or lipid therapy, we’ll be able to benchmark that on a graph and show patients where they are at and where we

want them to go — in other words, whether they are on the right track or not. And all of the lab work can also be tracked and graphed, which provides a visual for the patient while we explain to them why we are choosing a specific line of treatment and why we think that their therapy is or is not working.”

Besides, notes Spath, such an arrangement may not be entirely unique. “This is one of an emerging number of opportunities you will see vendors providing to health care clients,” she says. “Organizations looking to automate their systems should explore the various options and see which one makes financial sense to them.”

Even more important, she adds, hospitals must assess the current state of their processes before moving ahead with an investment in an EMR. “People should not be automating until they *improve and streamline* their current processes,” she advises. “Automation should not drive how we improve things, but rather it should be used to enable us to do what we want to do more efficiently.”

It’s also important to remember that automation does not necessarily improve quality of patient care, warns Spath. “It is still the ‘people’ component that needs to be taken into consideration,” she explains. Spath points to recent publicity about the Department of Veterans Affairs, which has been accused of possibly exposing patients to HIV and other infectious diseases from equipment used for colonoscopies at three Southeast hospitals. “The VA has been automated for years, but [if this is true], they may not have been disinfecting scopes,” she offers. “Everything can be perfectly automated, but people still have to do the right thing.”

For Wooton’s part, she is convinced that quality of care at Hazard will be improved. “There will definitely be better quality of care,” she asserts. “The system has a lot of preventive care elements built into it and will send us reminders to send to patients — for example, it is time for their mammogram or to have their PSA checked.”

It also will ensure better nursing care, she continues, especially because the clinic makes house calls. “We visit patients who can’t come to our doctors, and this system will be mobile, so providers who go into homes will be able to have the same information they have in the office — which is a really, really big quality factor,” she concludes.

[For more information, contact:

**Patrice L. Spath**, Brown Spath Associates, P.O. Box 721, Forest Grove, OR 97116. Phone: (503) 357-9185.

**Stephanie Wooton**, The Hazard Clinic. Phone: (606) 439-1316. E-mail: Stephanie@hazardclinic.com.

For more information on the Stimulus Simplicity program, go to: [www.gehealthcare.com/usen/hit/hitech\\_act.html](http://www.gehealthcare.com/usen/hit/hitech_act.html).] ■

## Claims data analysis helps hospital recoup revenue

*Appeals, following underpayments generate income*

By analyzing claims data to assure that the hospital was reimbursed appropriately and aggressively appealing all denials and underpayments of claims, DCH Health System in Tuscaloosa, AL, was able to generate a 1.25% increase in net patient revenue.

The additional revenue comes from appealing denials by commercial insurance companies and Medicare, denials that result from the Medicare Administration Contractor (MAC) audits, as well as following up on underpayments by insurers, says **Brian Pisarsky**, RN, BS, ACM, CPUR, director of case management services at DCH Regional Medical Center and Northport Medical Center.

“Our revenue integrity division of the case management department pays close attention to all of the hospital’s claims. If we determine that we were underpaid or not paid, we appeal the case,” he adds.

### ***Creation of revenue integrity division***

DCH Health System created the revenue integrity division to look for sources of lost reimbursement in October 2008. The division is staffed by nurses and professionals from the hospital business office and works in the case management department.

“The case management staff in my department were already working closely with business office personnel on denials and appeals. We put them together into one department that combines expertise in claims and billing with expertise in medical necessity issues,” Pisarsky explains.

The revenue integrity division is staffed by

three revenue integrity nurses and four revenue integrity coordinators who have business office backgrounds.

“The beautiful part for us is the marriage between the financial and the medical. There are claims issues that may not make sense if you don’t have a financial background and others that are confusing if you don’t have a medical background. Our team talks to each other continually and works very closely to ensure that we are paid appropriately,” Pisarsky says.

All of the hospital’s contracts with insurers are loaded into the computer system. As reimbursement comes in, the computer system compares the claims the hospital submits and the reimbursement received to the insurance company’s contract to ensure that the hospital has been paid appropriately.

If a claim has not been paid appropriately or has been denied, the revenue integrity department either issues a formal appeal or calls the insurance company to find out why the claim wasn’t paid.

For instance, if the hospital’s contract with an insurer calls for \$5,000 in reimbursement for a particular claim and the hospital receives only \$4,500, it shows up on the computer analysis.

If the analysis determines that the hospital has been underpaid for a claim, the revenue integrity staff drill down to find the cause and follow up with the appropriate hospital department to get additional information before contacting the insurance company.

The revenue integrity team contacts the utilization review staff to ensure that all of the services the patient received were pre-certified and reviews the record to determine if there were medical necessity issues.

“A portion of the unpaid claims involve medical necessity or pre-certification. As soon as they are identified, someone from the department talks to the insurance company. We talk back and forth on any inappropriate payment and take it to whatever level of appeal we need to in order to get it paid,” he says.

If it is a medical necessity issue, a revenue integrity nurse reviews the patient record and contacts his or her counterpart at the insurance company.

“When there is a medical necessity issue, it’s more effective to have a nurse talk to another nurse because they can talk about the medical issues as well as the billing issues,” Pisarsky says.

When insurance company contracts are up for

## Key Points

- DCH Health System generates a 1.25% increase in net patient revenue by appealing denials by commercial insurance companies and Medicare.
- The system also followed up on underpayments from insurers.
- DCH creates revenue integrity division.

renewal, the hospital’s contracting staff use the data to negotiate contracts. For instance, if the contracting staff have data that show that the insurer consistently underpaid claims, it may be able to negotiate a higher payment amount or a change in the contract provisions.

Pisarsky uses the data to educate his staff when analysis shows that there were problems with documentation or utilization management.

“If we identify patterns in the denials that are due to our practices, we develop quality improvement and process improvement initiatives to correct the problem,” he says.

*(For more information, contact: **Brian Pisarsky**, RN, BS, ACM, CPUR, Director of Case Management Services, DCH Regional Medical Center and Northport Medical Center. E-mail: bpisarsky@DCHSYSTEM.com.) ■*

## Use data for operational changes, quality

*Up-to-minute info allows you to head off trends*

Case management outcomes can be a powerful tool for identifying the need for operational changes or process improvements throughout your hospital, as well as demonstrating the value of case management.

“By using our electronic case management system, we can track and trend data based on a variety of factors. Having up-to-the-minute data enables us to respond more quickly and try to head off trends that would be difficult for our hospital financially,” says **Kathy Rickard**, RN, BSN, MBA, associate director, clinical resource management and social work at the Hospital of the University of Pennsylvania.

An electronic data management system is

the key to being able to analyze data and create reports in a timely manner, she adds.

“We used to collect information on paper and cobble together a report. Now our ability to document concurrently and analyze data electronically has enabled us to notice trends and respond much more quickly than in the past,” Rickard says.

Analyze your denials data to determine which physicians have a high number of denials and track denials by payer to determine if there are arbitrary denials; pass on the information to your finance department to use during managed care contracting, suggests **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY.

At the Hospital of the University of Pennsylvania, the clinical resource management department tracks denial patterns and obtains information on the cost of denials on a monthly basis from the business office. The information is used to spot trends among physicians or payers and take steps to correct problems, Rickard says.

“We break it down so individual physicians can see exactly what their performance is and the cost of the denials. We show them whether they had denied days or if the entire course of care was denied by the insurer,” she explains.

### **Track denials**

The department notifies the hospital’s managed care contracting staff when the hospital is getting denials from a particular insurer for a condition or procedure for which it previously was approved.

Measure the effect your physician advisor has on denials as well, Cesta says. Track the intervention of the physician advisor and whether he or she had an impact on getting it reversed.

You can determine the dollar amounts and what department is involved.

If you don’t have a cost accounting system, it’s impossible to determine the costs that case management has affected. Work with your financial department to determine the cost of care and use that to demonstrate an overall reduction of cost where case managers affected patient flow, length of stay, and resource utilization, she suggests.

At the Hospital of the University of Pennsylvania, the clinical resource coordinators go on daily rounds and notify the treatment team if an insurer

## **Key Points**

- Ability to document concurrently and analyze data electronically highlights trends
- Track interventions of physician advisor to determine if he or she has impact on getting denials reversed.
- Drill down to understand of delays.

is denying or downgrading a case.

“The clinical resource coordinators also work with the physician advisor to get any additional information needed that would keep the case from being denied. They work with the treatment team to get the patient on the right level of care as quickly as possible,” Rickard says.

The department does the same with avoidable days, creating reports for physicians and working with them to align the resources and decrease avoidable days, she says.

Case managers should track avoidable days on a daily basis, by identifying gaps in care or delays in service through their own review process while they are making rounds, Cesta says.

Categories in your avoidable day report could include: internal system delays, such as waiting for an operating room; external delays caused by lack of available resources in the community; payer delays; and physician delays.

Break down your data. For instance, include a chart that shows the reasons for avoidable days. Break it down into categories, such as patient/family (no rehab coverage; family can’t be reached, etc.); payer (Medicaid pending, insurance issues); and provider (delay in switching from IV to PO medication, covering MD will not discharge patients).

Drill down to understand the causes of delays and break them down into the time of day or time of the week. For instance, patients waiting for a particular service over the weekend affects length of stay as well as cost, Cesta says.

Administration can use the information you provide to make changes, such as considering extending the hours of the cardiac catheterization lab.

“Insurers expect a hospital to provide all the services 24 hours a day, seven days a week. It’s a balancing act to figure out which services we need to have available. We track when certain procedures don’t happen on the weekends and use the data to determine if it’s physically and financially possible to increase the hours of that

particular service,” Rickard says.

Discharge delays may be due to the lack of resources in the community or the patient’s inability to pay for them, or because physicians are not discharging patients in a timely manner, Cesta points out.

“Keep track of delays that are outside the control of the case management department but have an impact on your outcomes,” she says.

Inappropriate admissions are going to be a focus of quality improvement organizations in the future, Cesta says.

Break out the inappropriate admissions from your denials and take a broader look at them and the impact they have on an organization, she suggests.

“A lot of times patients are admitted inappropriately for social reasons and the case managers have problems discharging them to a safe environment,” she says.

Inappropriate admissions affect patient safety because nonacute patients are exposed to an acute care environment, she adds.

Use the data you collect to make changes in your case management procedures, Cesta suggests. For instance, although Medicare doesn’t define the length of observation but says it expects in the majority of cases that the physician can make the decision about whether to admit the patient within 24 hours.

“If a hospital is exceeding 24 hours in observation in the majority of cases, the case management department should determine why and make changes. It’s not good for the patients or for the hospital in general,” she says.

Readmissions or emergency department visits are affected by other departments in the hospital but have relevance to case management, Cesta says.

Rickard’s department tracks readmissions using a web-based tool that provides timely information about readmissions, which the case management team uses to find the cause of the readmissions and determine ways to prevent them in the future.

“Directors of case management need to know why patients are returning to the hospital because it may be an indicator of a failed discharge plan,” Cesta says.

She suggests that case management directors review patients who are readmitted within 24 hours, the next day, within 15 days, and within 30 days and drill down to determine why the readmissions occurred. ■

## Paper highlights initiatives and interventions

*Initiatives have been sustained over time*

About 12 years ago, **Cynda Hylton Rushton**, PhD, RN, FAAN, and others at Johns Hopkins set about to examine the issue of nurse self-care and the quality of care being delivered in pediatric palliative care. These individuals wanted to foster a culture of self-care, and as a consequence, developed four interventions for the pediatric unit. The description of those initiatives and the level of participation in the initiatives was captured in a published paper titled “Interdisciplinary Interventions to Improve Pediatric Palliative Care and Reduce Health Care Professional Suffering.”<sup>1</sup>

The first step in the development of these initiatives was to conduct an assessment of the quality of care that was being delivered, at a baseline level.

“The impetus for the assessment was a question about, were we providing the kind of quality care that we aspired to in our institution,” Rushton recalls. “And so we undertook a process of talking with clinicians and patient families to see where we were doing a good job and where we had opportunities for improvement.”

### **Four initiatives developed**

To improve the quality of care given to dying children and their families, the Johns Hopkins Children’s Center (JHCC) had developed a pediatric palliative care program, the study notes.

However, the initial assessment found “significant distress among health care professionals,” according to the paper. Rushton and her team set about developing programs toward the goal of alleviating this distress.

The assessment survey was developed “after a thorough review of the literature on family-centered care and ethical guidelines for the treatment of children near the end of life, addressed issues specific to pediatric decision-making, as well as a wide range of ethical and legal issues in end-of-life care,” the article states.

“Although the needs assessment underscored the importance of caregiver suffering, its not a new concept,” the authors write. “Suffering and loss are intrinsic and inevitable dimensions of

## Key Points

- Research team talked with clinicians, patient families to undercover areas that needed improvement.
- One initiative was interdisciplinary team meetings called patient care conferences.
- Health care professionals learned that ‘physical, emotional, social, and spiritual responses they experience after patient deaths were normal.’

caring for children with life-threatening conditions.”

According to the article, “the team’s underlying hypothesis is simple: Health care professionals will provide better care and support to seriously ill children and their families when they feel supported personally and professionally in their work.”

The action plan developed by the JHCC included the following goals:

- “Increase their competence and confidence in providing pediatric palliative care;
- Increase their ability to manage responses of grief;
- Restore and maintain their sense of professional integrity”

The first initiative in the quality improvement program was the establishment of the Compassionate Care Network (CCN), which “provides an open forum for interdisciplinary networking and education.”

The goal of the CCN was to “to integrate palliative and end-of-life care information and expertise across all units in the Children’s Center.” Recruitment targeted “key clinicians and leaders in the JHCC,” with attention focused on recruiting diverse disciplines. At the time the paper was published in 1996, there were 69 members of the CCN, including physicians (22%), nurses (49%), social workers (13%), child life specialists (8%), and other health care professionals (7%).

“In its first two years, the network sponsored three intensive training sessions and held six quarterly meetings,” the article states.

The second intervention was the organization of Palliative Care Rounds (PCR), which were “monthly educational sessions [that] used the familiar model of attending rounds.” To accomplish this, the health care providers identified a patient case “that exemplified the need for palliative care and/or end-of-life care.”

“Often, a physician resident or fellow presented the medical facts of the case, the goals of care for the patient, and members of the interdisciplinary team shared psychosocial, emotional, and spiritual information about the patient and family.”

The 79 participants reported the PCR program provided reinforcement of their mission, by stating such things as “learned feelings of other team members” and “shows need for pastoral care perspective,” and “learned specific ways to help patient and family in terminal phase.”

The third initiative was patient care conferences (PCC), interdisciplinary team meetings that were “designed to help identify and clarify goals and plans for care for individual patients.”

The format for the PCC included “patient demographics, reason for the conference, summary of the child’s illness, identification of patient/family/staff needs and issues, creating a palliative care plan, formulating a discharge plan, and follow-up.”

“The Family Care Coordinator (FCC) played a vital role in case finding and in implementing the patient care conference intervention,” the article states, and this “highly competent and respected nurse” had responsibility for “identification of family needs and actual or potential conflicts between families and the health care team.”

The fourth initiative centered around bereavement debriefings, and the format was adapted from the “traditional critical incident stress debriefing model.”

“Initially designed to address responses to

## COMING IN FUTURE MONTHS

■ Surgical quality: Measuring outcomes vs. processes

■ How to “break the mold” in your patient safety efforts

■ Software improves patient satisfaction at discharge

unusual situations, the sessions were adapted to help health care professionals realize that the physical, emotional, social, and spiritual responses they experience after patient deaths were normal, natural responses to situations they regularly encounter.”

Rushton says the initiatives developed and implemented by her team have been sustained over time, and the team was pleased with the results.

The “environment of interdisciplinary support” established by the initiatives allowed the health care professionals “a safe forum within which to experience interdisciplinary dialogue that witnessed and honored emotions, intellectual confusion, shared vulnerability, and grief,” according to the article.

## Reference

1. Cynda Hylton Rushton, et al. “Interdisciplinary Interventions To Improve Pediatric Palliative Care and Reduce Health Care Professional Suffering.” *J Palliat Med.* 9;4: 922-933. ■

## TJC to improve top four challenging requirements

The Joint Commission (TJC) is conducting an extensive review of its National Patient Safety Goals (NPSGs) to identify how to increase the value of the requirements in helping organizations provide safe, quality care. According to recent field input on the NPSGs and the standards, the four most challenging requirements are:

- NPSG 8, medication reconciliation;
- The Universal Protocol, in particular, the site marking requirement;
- NPSG.02.03.01, reporting of critical tests, results and values;
- Standard PI.04.01.01, staffing effectiveness.

Initial suggestions from the field for improving these requirements include making them less prescriptive and using clearer language. Specific feedback on the critical test results requirement included suggestions for a more limited scope. Feedback on the staffing effectiveness standard revealed that implementation is difficult and costly for organizations while yielding little value.

## EDITORIAL ADVISORY BOARD

**Kay Beauregard, RN, MSA**  
Director of Hospital Accreditation  
and Nursing Quality  
William Beaumont Hospital  
Royal Oak, MI

**Kathleen Blandford**  
Vice President of  
Quality Improvement  
VHA-East Coast  
Cranbury, NJ

**Mary C. Bostwick**  
Social Scientist/  
Health Care Specialist  
Malcolm Baldrige  
National Quality Award  
Gaithersburg, MD

**James Espinosa**  
MD, FACEP, FFAFP  
Director of Quality Improvement  
Emergency Physician Associates  
Woodbury, NJ

**Ellen Gaucher, MPH, MSN**  
Vice President for Quality  
and Customer Satisfaction  
Wellmark Inc.  
Blue Cross/Blue Shield of Iowa  
and South Dakota  
Des Moines, IA

**Robert G. Gift**  
Practice Manager  
IMA Consulting  
Chadds Ford, PA

**Judy Homa-Lowry, RN, MS, CPHQ**  
President  
Homa-Lowry Healthcare Consulting  
Metamora, MI

**Sharon Lau**  
Consultant  
Medical Management Planning  
Los Angeles

**Philip A. Newbold, MBA**  
Chief Executive Officer  
Memorial Hospital  
and Health System  
South Bend, IN

**Duke Rohe, FHIMSS**  
Performance Improvement Specialist  
M.D. Anderson Cancer Center  
Houston

**Patrice Spath, RHIT**  
Consultant in Health Care Quality and  
Resource Management  
Brown-Spath & Associates  
Forest Grove, OR

The Joint Commission will engage focus groups on these issues and will invite field comment on proposed revised requirements via web-based surveys. ■

**To reproduce any part of this newsletter for promotional purposes, please contact:**

*Stephen Vance*

**Phone:** (800) 688-2421, ext. 5511

**Fax:** (800) 284-3291

**Email:** stephen.vance@ahcmedia.com

**To obtain information and pricing on group discounts, multiple copies, site-licenses, or electronic distribution please contact:**

*Tria Kreutzer*

**Phone:** (800) 688-2421, ext. 5482

**Fax:** (800)-284-3291

**Email:** tria.kreutzer@ahcmedia.com

**Address:** AHC Media LLC  
3525 Piedmont Road, Bldg. 6, Ste. 400  
Atlanta, GA 30305 USA

**To reproduce any part of AHC newsletters for educational purposes, please contact:**

*The Copyright Clearance Center for permission*

**Email:** info@copyright.com

**Website:** www.copyright.com

**Phone:** (978) 750-8400

**Fax:** (978) 646-8600

**Address:** Copyright Clearance Center  
222 Rosewood Drive  
Danvers, MA 01923 USA