Courtemanche & Associates
Healthcare Synergists

C&A E-Newsletter

March 31, 2010

Register Now for the 2010 C&A Annual Conference

"Partnering for Patient-Centered Care"

This year's conference will be held in **Baltimore, Maryland,** from **April 26-28, 2010**.

Visit our web site for more details and registration information.

Check Out C&A's Newly Revised Publications!

All New - CMS CoP Compliance Forecaster

C&A Announces 2009-2010 Best Practice Partners!

Winning Organizations to Present at C&A's Upcoming Annual Conference

Courtemanche & Associates is pleased to announce its Best Practice Partners to be recognized at our annual conference, "Partnering for Patient Centered Care" to be held in Baltimore, Maryland in April. The winning initiatives were selected based on their ability to demonstrate a direct impact on patient care through the many facets of the patient-centered care model including involvement of leadership, collective and collaborative decision-making, financial stewardship and clinical quality and outcomes. The Innovation Award Winner demonstrates particular creativity and uniqueness by addressing healthcare's most challenging issues through replicable and sustainable improvement.

Innovation Award - HeartLink Tel-Assurance Program, Inova Mt. Vernon Hospital
The HeartLink Tel-Assurance Program, implemented for heart failure patients post-discharge, utilizes interactive voice response and web-based technology to manage the care of heart failure patients in their homes. Participants report their health status daily to a computerized system through the phone or Web and a nurse care manager reviews the data for clinical variances. Enhanced self management skills, improved quality of life, and decreased hospital admissions and associated costs are the goals of the program.

Best Practice Award - Multi-disciplinary Team for Prophylactic Anticoagulation Orders, Ephraim McDowell Regional Medical Center
This innovative approach to meet this National Patient Safety Goal began with creation of a multidisciplinary team which identified five key process opportunities to improve. The team modified risk assessment scoring and reporting, the role of the physician and pharmacist in ordering prophylactic anticoagulation orders and labs for monitoring therapy, the role of nurses, pharmacists and pharmacy students in providing patient education and led to the creation of a new pharmacy-based outpatient anticoagulation clinic service.

Best Practice Award– Joint Replacement Center, North Broward Medical Center
The team created a comprehensive Joint Replacement Center using a multi-disciplinary approach to achieve success. The program includes both pre-operative and discharge classes, a clubhouse for group meals and therapy and reunion lunches. Results included an increase in the percent of patients discharged home, decrease in length of stay, increase in customer service and an increase in compliance with surgical care core measures.

Life Safety Document Review Organizer System

Simplifying Regulatory Compliance: A Crosswalk of TJC & CMS Requirements

A Quick Reference for Hospital Accreditation

2010 S.O.A.R to Succes (Score Ongoing Accreditation Readiness)

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Mock Surveys

C&A can customize a mock survey to assess your organization according to TJC accreditation standards, providing you with an accurate picture of current compliance, opportunities for improvement, and a comprehensive

Best Practice Award – Free Standing Emergency Department, Inova Emergency Care Centers
In an Emergency Department, safety, quality of care, treatment and customer service are the focal points of Patient-Centered Care and a patient's overall length of stay (LOS) directly impacts these factors. This Free Standing Emergency Department (ED) serves a local suburban community that sees 38,000 patients per year. Through initiatives focused on Patient Centered Care, this ED was able improve their wait times for improved patient outcomes and customer satisfaction, and increased retention among staff.

C&A is pleased to host our 2010 Best Practice Partners and looks forward to them presenting their unique strategies for improving healthcare at our conference. Join us in Baltimore on April 27-28, 2010 to learn more about these creative innovations and best practices as well as learn the latest updates on the requirements of The Joint Commission and Centers for Medicare & Medicaid Services.

Fostering Proactive Infection Prevention through Regulatory Collaboration

Reduce the Risk of Healthcare Acquired Infections

By: Judy B. Courtemanche, RN, MS
Sharon Dills, MSN, RN
Nancy McLean, RN, BSN, MHSA, NHA

The following is the first of a two part article on reducing the risk of healthcare acquired infections through compliance with accreditation standards and regulatory requirements.

Abstract:
The infection control process in many hospitals is undergoing metamorphoses away from control and into prevention. In the past, the focus was on severity indices of illness as a probability measure of an adverse outcome during the natural course of a disease or condition. Today, third party payers are forcing hospitals to refocus their energies on preventable medical errors and complications by withholding payment when certain events occur in the hospital. This change has been stimulated by rising healthcare costs for preventable conditions. A 2007 Leapfrog Group survey of 1,256 hospitals found that 87% of those hospitals do not consistently follow recommendations to prevent many of the most common Hospital acquired infections (11). The resources available to infection prevention professionals need to be reallocated to prevention efforts. The role of the infection prevention professional is spotlighted in hospitals based on new federal regulations and additions to The Joint Commission's National Patient Safety Goals and Standards. The complacency surrounding healthcare acquired infections is no longer acceptable. The industry must mobilize to prevent infections instead of treating them as complications which are unfortunate when they occur, but can be easily treated. This mobilization can only be accomplished through a strong partnership with the last member of the healthcare team added to the triad of governance, hospital administration and the medical staff to form the final point on the diamond of healthcare.

Key Concepts:

- Healthcare Acquired Conditions (HACs) are conditions that occur to a patient during treatment and services in a healthcare institution. HACs raise the costs of healthcare by requiring additional use of

mock survey report which can assist with fulfilling your PPR.

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medical resources and increased length of stay. Costs to the community and individual in lost productivity and increased use of healthcare outpatient resources often accompany HACs.

- Potentially preventable complications (PPCs) are hospital acquired conditions or diseases that have the potential to be prevented if the organization is focused on a culture of patient safety.
  Paternalism is an approach to personal relationships where the desire to protect or advise results in the neglect of individual choice or personal responsibility.
- Partnering is joint involvement in an activity with partners sharing the same outcome goals.
- Core Measures are a list of patient conditions that each hospital that receives Medicare reimbursement must collect data on and submit the results quarterly to the Center for Medicare and Medicaid Services and the Joint Commission. Each core measure condition is supported by a list of measures that are evidence based that when followed yield the best outcome.
- Present on admission (POA) refers to medical conditions manifested by the patient at the time of a hospital admission.
- Evidence Based Guidelines (EBGs) are treatment guides supported by a body of research that result in the best patient outcome.

Background:
The Balanced Budget Act (BBA) requires the Center for Medicare and Medicaid Services (CMS) to look at methods for reducing Medicare costs. Initial actions included the implementation of Diagnosis Related Groups (DRGs) and attempts to assign Severity of Illness Indices. The Severity of Illness Indices became less of a focus as DRGs were expanded to account for severity and differentiation by age, co morbidities and complications. The legislature has moved to a focus on Potentially Preventable Complications. The opportunity to reduce Medicare costs by eliminating payment for Hospital Acquired Complications has taken center stage. This article focuses on this emerging initiative which includes a heightened focus on hospital acquired infections.

A review of the literature demonstrates that throughout the 1990's a body of evidence began to develop in medical journals on Potentially Preventable Complications (PPCs) and Healthcare Acquired Conditions (HACs) in both the United States and Canada. These studies included examination of disease specific complications as well as all PPCs from identified populations. In 1999 the Institute of Medicine published "To Err is Human." (7) This report spurred action throughout the medical, academic and political communities. The report stated that 98,000 deaths occur in hospitals annually from medical errors. The estimated overall costs of these errors is estimated at being between $17 and $29 billion dollars with hospital acquired infections accounting for an additional $5 billion a year to healthcare costs in the United States. Additional studies on costs of PPCs and HACs followed with proposed methodology to reduce these preventable costs. A 2005 study of a comparison between admission diagnoses and discharge diagnoses from all Medicare hospitals in California led to the identification of a Present on Admission (POA) indicator.

POA became the focus of the healthcare industry in the Deficit Reduction Act of 2005(2) and was signed by the President on February 8, 2006. POA required the Secretary of the Department of Health and Human Services to identify at least two medical conditions when not present at the time the patient was admitted would be considered Hospital Acquired Conditions (HACs) and result in non-payment for treatment of these conditions. The Act required that the conditions selected by the Secretary meet all three of the following requirements;

1. Are high cost, high volume or both
2. Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; and
3. Could reasonably have been prevented through the application of evidence-based guidelines.

The Secretary was charged in 2006 with selecting the conditions by October 1, 2007. Part of the strategy employed by the Budget Deficit Reduction Act was to require the Secretary to partner with the Center for Disease Control in identifying the conditions.

Basic Principles:
The conditions selected for both 2008 and 2009 are listed in Table 1 and 2 (5). Hospitals reimbursed under the Diagnosis Related Groups, Prospective Payment System are not reimbursed for the conditions listed if the conditions were not present in the patient at the time of admission.

TABLE 1

Year	Condition	Associated DRG's
2008	Object left in during surgery	998.4, 998.7
	Air Embolus	999.1
	Blood Incompatibility	999.6
	Catheter Associated Urinary Tract Infections	996.64, 112.2, 590.10, 590.11, 590.2, 590.3, 590.80, 590.81, 595.0, 597.0, 599.0
	Pressure Ulcers - Stage III and IV	707.23, 707.24
	Vascular Catheter Associated Infections	999.31
	Surgical Site Infection after CABG	519.2, 36.10-36.19
	Falls and Trauma	800-829, 830-839, 850-854, 925-929, 940-949, 991-994

TABLE 2

Year	Condition	Associated DRG's
2009	Manifestation of Poor Glycemic Control	250.10-250.13, 250.20-250.23, 249.10, 249.11, 249.20, 249.21
	Surgical Site Infections following Orthopedic Procedures	996.67, 998.59, 81.01-82.08, 81.23, 81.24, 81.31-81.38, 81.83, 81.85
	Surgical Site Infection following Bariatric Surgery for Obesity	287.01, 998.59, 44.38, 44.39, 44.95
	DVT/PE following TKR and Hip Replacement	453.40-453.42, 415.11, 415.19, 81.51-81.52, 81.54, 00.85-00.87

The POA requirements were initially viewed as a billing issue. The identification of the conditions and the Diagnosis Related Groups associated with them result in non-payment of services for the identified conditions. The focus of CMS and the hospitals receiving Medicare/Medicaid payments under the Prospective Payment System was on how to capture all diagnoses at the time of the admission and how to correctly identify conditions that are present on admission based on the new indicators required to be used to code POA status on the Uniform Bill (UB 2004.) However, POA is not a billing or reimbursement issue: it is a quality issue.

Table 1 and 2 depict the twelve Potentially Preventable Complications (PPCs) which are the HACs selected in 2008 and 2009 by CMS. (4) The first three HAC's on the 2008 list are also considered "never events." No additional never events were added in 2009.

The CMS present on admission "never events" listed in the table above include: object left in during surgery, air embolism and blood incompatibility. Logically, these three conditions can never be present on admission: they occur from or during medical treatment, and therefore always result in non-payment. The remaining conditions may or may not be present on admission and if there is clear documentation in the medical record that they were present at the time the decision was made to admit the patient then treatment is reimbursed. If the documentation does not support the conditions were present at the time of admission then they are considered hospital acquired and treatment for the conditions is not reimbursable. The three "never events" selected by CMS as HACs to be included in the 2008 and 2009 list of non-payment should they occur are not related to infection prevention or control.

The remaining nine HACs are the conditions that have the most effect on hospital reimbursement. Examination of the remaining nine, demonstrates that five of the nine conditions or 56% are Infection Prevention related. The influence of the Centers for Disease Control and Prevention (CDC) in the selection of HACs for both 2008 and 2009 is apparent. The increased emphasis in the medical community on prevention of infections reflects both the growing concern around Multi Drug Resistant Organisms (MDROs) and the rising cost of preventable conditions. The federal government's Present on Admission Indicator Requirement Program focuses attention on common concerns. The list of POAs places the Infection Control Practitioner and Nurse in the organization's spotlight. The first challenge for these professionals is a mental and clinical practice shift from "control of infection" to "prevention of infection."

For years the Infection Control resources in hospitals have focused on early identification of infections to control the spread of infection and eliminate identified infections through the use of antibiotics and appropriate precautions. These resources have included staff, education, facilities and technology to support the infection control efforts. Hospitals have well developed systems in place for internal control of infections, including identification and notification of appropriate staff once identified, implementation of isolation practices to prevent transmission, and the development of plans of care and treatment. These established systems must be reviewed and new systems developed to transform the "control" focus to a focus of "prevention."

There are commonalities among the five infection prevention conditions selected by CMS. Catheter associated UTI's, vascular catheter associated infections, surgical site infections after CABG, surgical site infections following orthopedic surgery, and surgical site infections following bariatric surgery share the following characteristics.

1. All are preventable
2. The host is rarely the source
3. All increase hospital length of stay
4. The focus on all has been control and early treatment
5. All have been routinely tracked and reported by the Infection Control staff

These commonalities can assist the Infection Prevention Officer in proactive risk assessment and determining priorities. The starting point is a campaign to change the mindset of the organization from reactive to proactive.

In a future issue, Part 2 of this article will provide information on the reasons to focus on the reduction of healthcare acquired infections and recommended actions for the organization that wants to excel in the provision of safe healthcare.

References:

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2. CMS Office of Public Affairs. Quality Measures for Reporting in Fiscal Year 2009 for 2010 Update, April 14, 2008

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4. Federal Register / Vol. 73, No. 84 / Wednesday, April 30, 2008 / Proposed Rules

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6. Identifying Potentially Preventable Complications Using a Present on Admission Indicator. John S. Hughes, M.D., Richard F. Averill, M.S., Norbert I. Goldfield, M.D., James C. Gay, M.D., John Muldoon, M.H.A., Elizabeth McCullough, M.S., and Jean Xiang M.S. Health Care Financing Review/Spring 2006/Volume 27, Number 3

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8. 2008 The Joint Commission on Accreditation of Healthcare Organizations. 2009 Comprehensive Accreditation Manual for Hospitals

9. www.cms.hhs.gov/HospitalAcqCond/

10. www.cms.hhs.gov/apps/media/fact_sheets.asp.

11. www.leapfroggroup.org/media/file/Leapfrog_hospital_acquired_ infections_release.pdf Leapfrog Group Hospital Survey. (2007). The Leapfrog Group 2007.

12. www.qualityforum.org NQF (2008) National Quality Forum website

13. www.cdc.gov Centers for Disease Control and Prevention. (2008).

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Were You Aware?

- The Joint Commission has published revised standards for MS.01.01.01 (formerly MS.2.10). This standard, and the associated elements of performance, has been under review by a task force for approximately two years. This standard relates to self-governance of the medical staff and its relationship and accountability to the governing body of the healthcare organization. See a future edition of C&A News for detailed information on how to apply these requirements, which become effective March 31, 2011, in your organization.

- Medical records must be completed within 30 days of discharge. This is both a CMS and TJC requirement. Healthcare organizations should track their medical record statistics using TJC's form which also describes the scoring methodology for RC.01.03.01, EP4. (This form can be downloaded from TJC's website or from the C&A Client Library.) It should be noted that the situational decision rule previously associated with medical record delinquencies has been removed.

- Related to TS.03.01.01, for procedures in which a tissue-based or cellular-based product is aspirated or otherwise retrieved from a patient, processed by an external lab or other company and then reimplanted (i.e., chondrocytes), the hospital is not considered a distributor. (Courtesy of a response from the TJC Standards Interpretation Group)

- Reminder! Organizations are required to provide The Joint Commission, through their Account Representative, with information regarding changes to their application within 30 days of that change. This includes information related to change in ownership or location, significant increases or decreases in volume, additions or deletions of a type of service or site of care, and acquisition or deletion of an organizational component. Joint Commission will review this information and make a determination if an extension (or intra-cycle) survey is necessary. Failure to alert TJC of these changes could result in loss of accreditation.

- Medical equipment brought into the hospital by patients for their own use, i.e., insulin pumps, ventilators, etc., are subject to some of the same medical equipment requirements as hospital-owned equipment, including EC.02.04.01, EP3 and EC.02.04.03, EPs 2 and 3. If organizations allow the use of patient-owned medical equipment policies need to define the parameters associated with that and address these elements of performance. Consideration should also be given to staff competency and availability of resources to fix equipment should it become broken and other safety issues.

Hello and Goodbye - Staffing Changes at C&A

Join Us in Welcoming Two New Members to the C&A Team!

Ronda Katzman is our new **Accounts Manager** and will be happy to assist C&A clients with accounts payable, accounts receivable, and any questions or concerns related to invoices and purchase orders. Ronda comes to C&A with a strong background in business and finance management. Ronda can be reached at ronda@courtemanche-assocs.com, 704-573-4535.

We'd also like to welcome **Senior Consultant, Cathy Pilone** to the talented cadre of expert consultants on staff with Courtemanche & Associates. Cathy is a seasoned nurse executive with a strong background in behavioral health, nursing leadership, quality improvement and patient safety. She is a certified Six Sigma Black Belt. Cathy can be reached through C&A's New Jersey office at 973-257-5013, cathy@courtemanche-assocs.com.

Also, please join us in sending well wishes to **Barry Nance, Director of Operations**, as he pursues a career change into the field of nursing. We thank Barry for his many contributions to the company and wish him the best of luck in all future endeavors!

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