

SECOND
EDITION

Avoidable Day Analyzer

Data Identification Tools
for Effective Case Management

CMS GMLOS	PAD Indicator	# Cases > CMS 90% LOS	% Cases > CMS 90% LOS	Days Savings Opportunity	Cost Savings Opportunity \$
4.7	0.70	165	7%	1,642	\$656,600
5.0	0.70	127	6%	1,513	\$605,360
4.7	0.40	132	6%	834	\$333,600
4.8	1.70	192	10%	3,118	\$1,247,120
4.7	2.60	168	11%	3,874	\$1,549,600
4.9	1.90	188	11%	3,211	\$1,284,400
4.8	1.80	194	9%	4,036	\$1,614,240
n/a	1.32	1,166	8%	18,227	7,290,920
				1,142	\$456,960
				262	\$104,960
				136	\$0
				386	\$1,754,400
					\$989,100

Gayle Riley, RN, PHN, MPA-HSA

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+HCP Pro

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Tools and Templates on the CD-ROM

Files Contained on Your CD-ROM

To adapt any of the files to your own facility, simply follow the instructions below to open the CD. If you have trouble reading the forms, click on “View,” and then “Normal.” To adapt the forms, save them first to your own hard drive or disk (by clicking “File,” then “Save as,” and changing the system to your own). Then change the information to fit your facility, and add or delete any items that you wish to change.

The following file names on the CD-ROM correspond with tools listed in the book:

<u>File name</u>	<u>Document</u>
Fig 4-3.pdf	PAD Code Data Collection Mini Chart
Fig 4-4.pdf	Recognition Data Collection Mini Chart
A1.doc	Quick Reference Guide
A2.xls	A Sample Audit Spreadsheet
A3.rtf	Sample Delay Codes
A4.rtf	UR Committee Peer Review Policy & Procedure

The following file names are bonus tools found only on the CD-ROM. They are organized by the chapter to which the material relates:

<u>File name</u>	<u>Document</u>
Chapter 2	
BaseDRG.xls	The Base DRG Spreadsheet
PADIndrpt.xls	The PAD Indicator Report
Samplerpt.xls	Sample PAD Indicator Report
Chapter 5	
PADdbase.mdb	PAD Access Database
PADsample.mdb	Sample PAD Access Database

Installation Instructions

This product was designed for the Windows operating system and includes Word files that will run under Windows 95/98 or later. The CD will work on all PCs and most Macintosh systems. To run the files on the CD-ROM, take the following steps:

1. Insert the CD into your CD-ROM drive.
2. Double-click on the “My Computer” icon, next double-click on the CD drive icon.
3. Double-click on the files you wish to open.
4. Adapt the files by moving the cursor over the areas you wish to change, highlighting them, and typing in the new information using Microsoft Word.
5. To save a file to your facility’s system, click on “File” and then click on “Save As.” Select the location where you wish to save the file and then click on “Save.”
6. To print a document, click on “File” and then click on “Print.”

About the Author

Gayle Riley, RN, PHN, MPA-HSA

Gayle Riley has been a leader in case management for more than 25 years. She made her mark creating a hugely successful medical management and case management program for Catholic Healthcare West (CHW)—one that helped the San Francisco–based system find \$18.4 million in annual cost savings, and \$21.6 million annually in new revenue from increased admissions and efficiency.

Riley also developed an electronic avoidable day program for all of CHW's hospitals, and an electronic physician practice analysis severity-adjusted system that provided information to physicians relative to their efficacy in length of stay and costs when compared to the average physician in the state of California.

In addition, Riley joined with Gloryanne Bryant, CHW's corporate director of coding and health information management (HIM) compliance, to create a systemwide partnership of case management nurses and HIM coding professionals that greatly enhanced the accuracy of physician documentation in capturing the severity of the patients served.

As lead director for care management, Riley supported the directors of clinical quality improvement and pharmacy and therapeutics through managing support staff and analysts, and overseeing systemwide conferences and seminars. Before joining CHW, she served as the regional director of continuing care services for St. Joseph's Regional Health System in Stockton, CA.

Riley earned her bachelor's in nursing at California State University-Stanislaus, and her master's degrees in public administration and health services administration from the University of San Francisco. She is now retired and lives with her husband, Marv, in Lodi, CA.

Acknowledgments

I would like to express appreciation and gratitude to all of the wonderful people at Catholic Healthcare West (CHW) that I have had the pleasure to work with during the past 25 years. In the beginning, there was Liz Mitchell, a boss and mentor, who allowed growth through dreaming. Then there was Gary Spaugh, another boss and mentor, who allowed the dreams to come to fruition. And, of course, Earl Richardson, Susan Watson, and Susan Thomas, all of whom worked diligently and ingeniously in helping me implement the dream of a combined hospital, physician group, and community case management process for our senior HMO patients in a five-hospital healthcare system, and then helped me transport it to other hospitals and communities that, upon viewing our success, wished to employ an identical program.

At CHW corporate, I would like to thank my fellow directors, Tracy Sklar and Neil Massoud, who were with me at the start of the corporate care management department. Also, Maggie Hoi, who was instrumental in the development of our massive educational programs/seminars component, and Tracy Kiritani, Eric Tom, and Casey Merickel, the analysts (later directors) who helped me create the Opportunity Index and Documentation Improvement Analysis spreadsheets, the automated Avoidable Day Database, and the severity-adjusted Physician Practice Analysis tool, respectively. Thanks to sweet and calm Natalia Wasylyszyn for keeping my hours, days, weeks, and head straight. And the very gifted Mary Carol Todd, who took over for me when I needed to semiretire and allowed me to work with her for two and a half more years, while I (we) honed the rest of the processes presented here in this book. Also, I have a great deal of gratitude to Gloryanne Bryant for being an extremely knowledgeable partner in documentation improvement and to Karen Zander for her consulting expertise and support for the criteria patterns (“so simple, and yet so powerful”). And finally, George Bo-Linn, my boss and chief medical officer (senior vice president) at CHW, for his unwavering support and unerring guidance as we led care management and all of CHW to understand and embrace our medical management methodologies.

On a personal note, I am grateful to my wonderful husband, Marv, and my beautiful daughter, Jennifer Fancher, for allowing me the time needed to develop this incredible career. Marv, a college professor, always did more than asked and kept the hearth warm for our family. And Jenni fulfilled every mother’s dream by maturing into a considerate, confident, and lovely woman.

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And finally, this book would be incomplete without crediting the work of Elgin K. Kennedy, MD, who created the concept of avoidable days. In addition, I absolutely need to thank all of the great people I have worked with at HCPro, Inc., including Bryan Cote and John Gettings for the first edition, and most recently, Julie McGinley, my editor, Craig Gorton, and Chris Arenburg, whom I worked with for this second edition. They are all extremely creative and have made writing this book a fairly painless process.

Introduction

Editor's note: Truly unique case management solutions are incredibly hard to come by. It was at the American Case Management Association Conference in 2004 that this solution was discovered and later turned into the book and CD-ROM you are now holding in your hands.

From Conference Room 4B Emerges a Case Management Innovation

On the last day of the American Case Management Association's 2004 meeting, about 200 case managers packed room 4B to witness the unveiling of one of the great comeback stories in U.S. healthcare—okay, so maybe that's a stretch—but in case management, success is measured one saved day at a time until the practice becomes routine. And Gayle Riley knew it. Riley, the author of the methodology featured in this book, peppered the audience with statistics and strategy, teasing them every few minutes by saying, “But wait, the most amazing thing is still to come.”

Pinched for time, Riley couldn't deliver the details of her “amazing thing.” Such is the trouble with conferences. The attendees left inspired, but wanting more. That's why HCPro turned to Riley for this book, teaming with her for the how-to behind the story—the innovative concepts and instant tools to make it happen. Riley was the driving force in leading Catholic Healthcare West (CHW) to \$18.4 million in annual cost savings, greater than a 52,000 annual bed-day increase, and \$21.6 million in new revenue annually due to increased admissions.

Riley worked with HCPro staff members for months following the conference to build tools that could help other organizations apply her methodology. The tools are based on materials given to all conference attendees by Riley and Mary Carol Todd of CHW to adapt for their own purposes. The result is the CD-ROM included with this book, the Avoidable Day Analyzer.

Since its debut in 2004, this book and the accompanying tools have been updated to become powerful weapons against current case management concerns, such as recovery audit contractors, hospital-acquired conditions, increased costs, increased bed gridlock, and increased length of stay.

Featured are the Following Chapters and Tools:

Chapter 1: “Moving from an Ordinary Case Management System to an Extraordinary One,” is an overview of what the book and the CD-ROM will do for you and your organization. It is geared toward hospital senior administration, especially CEOs and case management/utilization management (CM/UM) directors and speaks to the very large improvements that can be made in the financial and quality arenas.

Chapter 2: “The PAD Indicator Report,” will explain in detail how CEOs can measure the effectiveness of a hospital or hospital system’s CM/UM department(s). The potential avoidable day (PAD) indicator, an original term coined by Riley, will provide medical staff leaders and senior hospital leadership with the number of Medicare PPS patient days the hospital can potentially save, the monetary value of those days, as well as bed-day savings for the projection of additional annual admissions that your hospital will be able to accommodate. This chapter features the following tools on the CD-ROM:

- **The Base DRG Spreadsheet.** An original preformatted report created by Riley and HCPro’s Craig Gorton, containing all of the diagnosis-related groups (DRG) needed for computation of the PAD indicator, including the geometric mean length of stay (LOS) and 90th percentile LOS as provided by the Centers for Medicare & Medicaid (CMS) for the CMS fiscal year 2009 (October 1, 2008–September 30, 2009).
- **The PAD Indicator Report.** An original preformatted report created by Riley and refined by Gorton that will compute a hospital’s PAD indicator, the monetary value of the days you will save, and the additional bed days your hospital will gain.
- **A sample PAD Indicator Report.** A spreadsheet with fictitious data is also included for reference.
- **A Medicare Reference Guide.** A guide to the *Federal Register* to find all the information needed for subsequent years of using the PAD indicator and Base DRG Spreadsheet.
- **A quick reference guide** for all column and row definitions in the PAD Indicator Report, as well as the Base DRG Spreadsheet and the Medicare Reference Guide, as described in this chapter (Appendix 1).

Chapter 3: “Conducting Your Validation Audit,” provides step-by-step instructions for the CM/UM director about how to conduct a validation audit. As explained in Chapters 2 and 3, the PAD indicator is just a number, although extremely accurate. The audit will help you determine your true potential savings and provide case studies to help convince and educate all stakeholders in the importance of the new processes you will be adopting in your facility. This chapter features the following tool on the CD-ROM:

- **A sample audit sheet.** This sample tool can be customized and used at your organization to audit medical records and help validate your PAD indicator (Appendix 2).

Chapter 4: “Ensuring Success by Documenting, Collecting, and Educating,” reviews every step in the utilization review (UR) process while teaching CM/UM directors and staff members how to document to the criteria, act on the documentation findings, and route charts for peer review. This chapter features the following tools on the CD-ROM:

- **Delay coding options.** Suggestions for PAD codes relative to ancillaries, case management, nursing, and physicians. These are already in your PAD Access database but should also be included with the UR sheet for the CM/UM nurses (Appendix 3).
- **A sample of UR data collection tools.** These small charts can be embedded into your current review sheets to standardize your collection of PADs and will be the source used for data entry into your PAD Access database.
- **A sample policy and procedure.** This UM policy gives your hospital procedures for consistent, reliable UR case referral for medical staff review and action as part of an effective case management program. It contains a schematic of criteria patterns, created by Riley, that will objectively identify cases for your UR and quality improvement committees and recommendations for other objective identification methodologies for adaptation by your hospital (Appendix 4).

Introduction

Chapter 5: “Avoidable Day Tracking; Access Database Education and Data Input Information,” provides step-by-step instructions for customizing and managing your PAD database, including inputting your PAD data, issuing recommendation and notification letters and monthly, quarterly, and annual reports for hospital departments and medical staff committees. This chapter features the following tools on the CD-ROM:

- **PAD Access Database.** An original Access database created by HCPRO’s Orly Boston and Diane Stoloff with Riley’s expert guidance and refined and updated by Chris Arenburg.
- **Sample PAD Access Database.** We added example data to a PAD database to give you a better idea of what your data might look like.

It is difficult, admittedly, to put an author’s passion into a CD-ROM. But we hope that the solution this provides can inspire some amazing changes in your organization. As always, if you’d like to discuss how to roll this out in more detail, don’t hesitate to contact us at jmcginley@hcpro.com.

Julie McGinley
Editor, HCPRO, Inc.

CHAPTER 1

Moving From an Ordinary Case Management System to an Extraordinary One

CHAPTER 1

Moving From an Ordinary Case Management System to an Extraordinary One

LEARNING OBJECTIVES

At the end of this chapter, the reader will be able to:

- ▶ Recognize the negative effect avoidable days have on patients
- ▶ Identify effective measures of success for a case management program

Your Medicare patients account for more than 40% of your patients, and about 30% of their acute care days may not be medically necessary, according to internal audits of hospitals with length-of-stay (LOS) problems.

This book will give your organization a system for measuring case management effectiveness and tools to collect and code data to help you identify clinically potential avoidable days (PAD), such as the ones described in the scenarios on the following page, and introduce a process to reduce them.

One major health system, Catholic Healthcare West, a hospital system headquartered in San Francisco, used this process and found \$18.4 million in annual cost savings and \$21.6 million annually in new revenue due to increased admissions at its hospitals after increasing bed availability. And that was only the beginning.

IMAGINE THESE SCENARIOS

An elderly Medicare patient who lives with her husband is admitted to a hospital with pneumonia. She's given IV antibiotics, IV fluids, and O₂/NC. By the second day, her O₂ SAT is 97; she is afebrile, ambulating, and eating well. On the third day, when she should have been discharged, all stats remain the same. On the fifth day, the patient trips over an IV stand in her room and dislocates her hip. An alternative scenario with a similar patient who also reaches discharge status on the third day is one in which the patient experiences inflammation, redness, and swelling at her IV site and an increase in temperature on the fifth day. These are actual cases and can have a dramatic effect on hospital reimbursement.

Measuring the Success of Your Case Management Department

How does the CEO, chief operating officer, chief financial officer, chief nursing executive, or case management (CM) director of a hospital or hospital system know whether the CM/utilization management (UM) department is working effectively? Refer to Figure 1.1.

FIGURE 1.1 ► **MEASURES OF SUCCESS**

Indicates success?		Potential measures of success
YES		Minimal denials from third-party payers
YES		Minimal denials from Medicaid
	NO	Active PAD program
YES		Senior HMO LOS is < 1.5 days lower than Medicare PPS and the 30-day readmission rate meets performance improvement indicators
	NO	CM/UM nurses use nationally recognized medical necessity criteria
YES		Minimal amount of recovery audit contractors (RAC) identified as overpayments, or your hospital wins > 60% of first appeals
	NO	Medicare PPS LOS is < 5.9

Why would having an active PAD program not be a measure of success?

Not all PAD programs are created equal. The following causes of avoidable days are typically included in a PAD program:

- Late radiology tests
- Delays in physical therapy
- Late physician rounds

However, the bulk of avoidable days and the crux of most hospitals' problems are the clinically unnecessary days, which are harder to identify.

Why would the use of medical necessity criteria by CM/UM nurses not be a measure of success?

The author has audited more than 50 hospitals, large and small, and has never worked with a hospital CM/UM department that used the criteria correctly, consistently, and effectively—even with annual training. How to use medical necessity criteria to meet all three of these objectives is discussed in more detail in Chapter 4.

How would medical necessity criteria help you be successful with RAC audits and not with reducing LOS?

Most CM/UM nurses focus on third-party payer patients because they are required, per contracts, to work with outside utilization review (UR) personnel for the prevention of denials. There is no daily UR oversight body for the Medicare PPS patients; therefore, they are likely to be a lower priority, except for admission reviews. Now that we have RACs, CM/UM nurses must set as a priority all Medicare PPS admissions to determine medical necessity for inpatient status. And at the end of the stay, the CM/UM nurse will respond to the physician's discharge order and arrange for postdischarge care. The problem lies with the continued stay reviews not being a priority and not being done effectively, resulting in:

- Elderly patients being put at unnecessary risk for nosocomial infections, iatrogenic events, and falls, hereafter referred to as hospital-acquired conditions (HAC)
- Unnecessary use of precious acute care beds, leading to bed gridlock during high-use seasons

Chapter 1

- Unnecessary consumption of Medicare reimbursement that could be used for the hospital's community health improvement efforts
- Misuse of the Medicare patient's finite acute hospital days (important to the patient)

Why would having a Medicare LOS of < 5.9 not be a measure of success?

Let's suppose, for example, that your tertiary hospital (i.e., one that has an open heart surgery program) has an LOS of 5.9. You might consider that to be good. But what if the Centers for Medicare & Medicaid Services' (CMS) geometric mean LOS (GMLOS) for your hospital's specific Medicare PPS population is 4.8? (GMLOS is a number CMS calculates and will be further described in Chapter 2.) Most hospitals do not pay attention to this difference, but it is very important, more so now with the new CMS Medicare Severity diagnosis-related groups (DRG), which have increased the explanation of variance in hospital resource use relative to the CMS DRGs by 9.41%.*

*Ingenix (2009). DRG Expert 2009: A Comprehensive Guidebook to the DRG Classification System. Eden Prairie, MN: Ingenix.

Case Study

MEASURING THE SUCCESS OF HOSPITAL D

Please look at the following example in Figure 1.2—an excerpt from a sample PAD Indicator Report Excel spreadsheet that is explained in detail in Chapter 2.

Hospital D had 3,500 Medicare PPS discharges in fiscal year (FY) 2007, with a PAD indicator of 1.1. If this hospital's average LOS (ALOS) was 4.8 instead of 5.9, this report reveals that there would be:

- Savings of \$1.54 million dollars annually, using the monetary value of \$400/day saved
- 3,850 additional bed days available annually, which would allow a minimum of 600 additional patient admissions (85% occupancy and 5.4 ALOS) and the revenue associated with those admissions

FIGURE 1.2 ► SAMPLE PAD INDICATOR REPORT

Hospital name	Cases	ALOS	CMS GMLOS	PAD indicator	# cases >CMS 90% LOS	% cases >CMS 90% LOS	Days savings opportunity	Cost savings opportunity \$400
D	3,500	5.9	4.8	1.1	235	6.7%	3,850	\$1,540,000

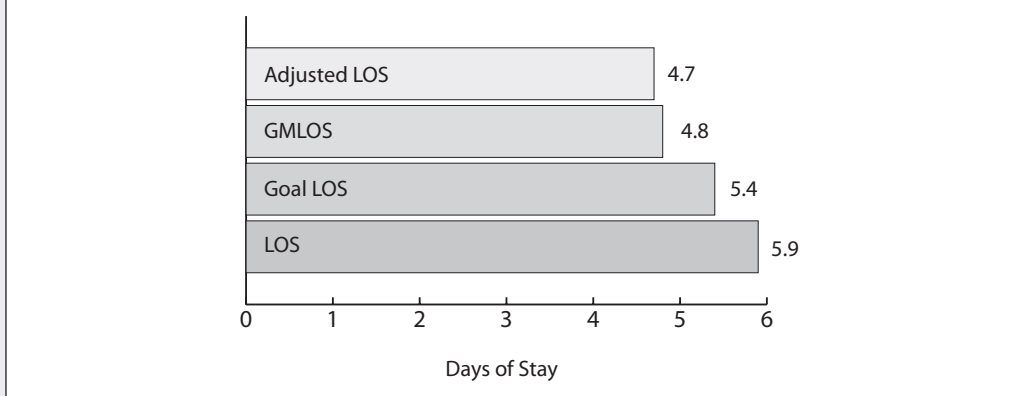
The hospital CEO had set a goal for the CM department to earn a PAD indicator of 0.6, which would require a drop in the hospital's ALOS by 0.5 days, resulting in an LOS of 5.4. In response, the CM director said the case managers were already capturing all avoidable days and that the patient population was too sick to have such a low PAD indicator (or a lower LOS). A validation audit was performed. (See Chapter 3 for more information on validation audits.)

The validation audit indicated that not only was the goal LOS reachable, but that the adjusted LOS (possible LOS achieved after removing the number of avoidable days found in the audit) was 4.7 (0.1 days below the CMS GMLOS). Therefore, a goal LOS of 5.4 days for FY2008 was not only realistic, but future goals could be set for further efficiency. This is represented in the graph in Figure 1.3.

Case Study

MEASURING THE SUCCESS OF HOSPITAL D (CONT.)

FIGURE 1.3 ► VALIDATION AUDIT RESULTS



Hospital D's scenario poses two questions:

1. Why is there such a discrepancy between which LOS is truly within reach and the LOS the CM director thought was within reach?
2. How does a CM director reach the goal LOS while improving the quality of care and increasing patient safety?

The answers to these questions are contained within this book and accompanying CD-ROM.

Note: Hospital D's postaudit action plan and result are discussed in Chapter 3.

In summary, the Avoidable Day Analyzer will help:

- CEOs measure the effectiveness of a hospital or hospital system's CM/UM department(s) by using the PAD Indicator Report, as discussed in Chapter 2
- CM/UM directors conduct a validation audit that will affix a number to the potential total Medicare PPS days the facility could save and provide medical staff leaders and senior hospital leadership with an annual cost savings amount associated with that number, as well as bed-day savings for projection of additional annual admissions, as discussed in Chapter 3

Moving From an Ordinary Case Management System to an Extraordinary One

- CM/UM directors educate staff on appropriate UR documentation and collection of PAD data obtained through the identification of clinically avoidable days, and monitor their effectiveness for continued success, as discussed in Chapter 4
- CM/UM directors set up a PAD program or enhance their current program with the use of the PAD Access database for reporting the data, as discussed in Chapter 5

And finally, but most importantly, the Avoidable Day Analyzer will bring UM issues to the forefront of quality and peer review with objective criteria by providing:

- The medical staff with a new peer review resource to improve patient safety and quality of care, which involves the objective identification of charts that exceed established “Criteria Pattern” thresholds, as discussed in Chapter 4.
- CM/UM directors with an objective methodology for reviewing HACs and determining whether the conditions were acquired during clinically avoidable days of stay. Since Medicare will no longer allow payment of a higher-paying MS-DRG when the complication or comorbidity is determined to be a HAC, this additional responsibility truly brings CM/UM departments into the respected fold of quality improvement. Additionally, in the future:
 - CMS will consider decreasing a hospital’s MS-DRG payment if yet-to-come benchmarks for HACs are exceeded
 - CMS will also consider publishing the rates of HACs for public consumption (*Federal Register*/Vol. 73, NO 161/Tuesday, August 19, 2008/Rules and Regulations)

HACs will occur, even with increased hospital and medical staff efforts toward prevention. But one thing is certain: A HAC that occurs when the patient should not even have been in the hospital is absolutely preventable, such as in the scenarios presented at the beginning of this chapter.

Why LOS and not cost/day

Author's note: I have met hospital executives who believe cost per day is more important than LOS. I believe that it is a physician and hospital responsibility to provide all necessary treatment for an acute admission to assist the patient toward a quality discharge (i.e., the patient meets discharge screens and is discharged to an appropriate setting). In reducing LOS, the cost per day will probably increase, but cost per admission will decrease. By reducing LOS, which usually targets approximately 20%–25% of the admitting physicians, a hospital will decrease radiology tests, labs, pharmacy, nursing hours, and ancillary services such as respiratory and physical therapy.

IMAGINE THIS SCENARIO

A 67-year-old female is admitted for CHF. During the patient's stay, she had a CT of the brain with and without contrast, an upper GI, a lower GI, ABD scan, and blood cultures X3 (twice), with no indication in the chart as to medical necessity for any of the above. All tests were negative, and the patient stayed eight days, six of which did not meet medical necessity criteria. The patient met discharge screens on day two and should have been discharged on day three to go home with her daughter.

This true scenario may seem extraordinary, but it is not. As an example of the objective criteria previously described, the CM director would tag this chart for peer review by the UR committee because it meets the first criteria pattern and represents unnecessary utilization (see Chapter 4). And if the patient had experienced a HAC during any of the days four through eight, the chart would have been directed to the quality assurance/PI committee for further review, as clearly such an occurrence should never have happened.

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