Health Care Visions News
From The Cardiovascular Specialists

3RD QUARTER 2003

Then and Now

Saint Anthony's Health Center

In the fall of 2000, Saint Anthony's Health Center in Alton, IL asked Health Care Visions to assess the needs of their service area and work with them to determine whether they should expand their cardiovascular program. Saint Anthony's was offering diagnostic cardiac catheterizations and had recently upgraded their cath lab camera to provide "state of the art" imaging capability.

There are three questions that Health Care Visions answers when assessing/evaluating a hospital for cardiovascular services:

1. What is the demand? If this is not adequate, there is no need to go on to the next two questions.
2. What is the physician/medical staff support? As we all know, hospitals are totally dependent on collaboration and referrals with their medical staffs.
3. What would be required from a clinical/ operational perspective and what financial resources would be required?

In Saint Anthony's case, the demand was very evident. They have an older population base and while the overall population was projected to decrease, the over 45 year old cohort was expected to grow considerably. Evidence of a high number of transfers of patients with a CV diagnosis led Saint Anthony's Senior Administration to question if they could continue to meet their mission without being able to care for the patients who were presenting to their facility.

The second question was harder to assess, because of some changes in the medical staff composition. Several cardiologists were in personal transition and this was adversely affecting referral patterns.

The third question was also a "gray" area. While the hospital had a good track record for caring for sick patients, all patients requiring advanced cardiovascular care had been transferred to "tertiary" centers. So that growing CV services would require significant staff additions and medical coverage.

Now we can fast forward to the spring of 2003. Saint Anthony's Health Center asked Health Care Visions to return to their hospital and conduct a repeat assessment. What a difference a couple of years can make!

Today, Saint Anthony's continues to have the demand (everyone we counted in 2000 is older and more at risk for CV disease). They continue to have a significant number of patients present for CV treatment, as this is their hospital of choice.

The difference that Health Care Visions assessed was in the way they systematically went about implementing a plan to address Questions 2 & 3. Communication and collaboration with cardiology groups in the St. Louis area permitted an increase of cardiologists on the medical staff and even with medical staff changes, the volume of patients and procedures has grown.

The second significant development at Saint Anthony's was the introduction of an active Hospitalist Program. This has permitted the

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Inside This Issue:

Message From The President

Barb Sallo

We often get questioned on "Benchmarks". What should we use? How do we make the *famous* Top 100 Hospitals? How do we know we are doing well (or not so well)?

Cardiovascular care is easier to measure than other services because most of the customers/consumers are over 65 years old and are covered by Medicare which provides significant publicly available information. The biggest issue is that information takes so long to collect/distribute, consequently, by the time it is accessed by hospitals it can be over two years old.

The Centers for Medicare/Medicaid Services (CMS) has been giving good guidance to hospitals on "measures" since 1992 when it launched the Health Care Quality Improvement Program. This program permits collaboration with the medical community in an educational, penalty-free environment to develop, conduct, measure and evaluate health care quality improvement projects. The National Acute Myocardial Infarction Project (www.nationalheartcare.org) started in 1999, has thirteen performance measures and criteria and provides a good start for self assessment.

Recently, the CMS Quality Initiative has a significant benchmark of its own. As of the end of June 1,014 hospitals—including nearly 200 hospitals involved in a three-state pilot project—have volunteered to participate. Although May 30th marked the deadline to report performance data for display on the Centers for Medicare & Medicare Web site this July, there is still time for hospitals to volunteer their participation. For more on The Quality Initiative: A Public Resource on Hospital Performance, visit www.aha.org.

These are two examples of self assessment initiatives. A good preparation for the day when the public and payors demand to know how good you really are---you will be able to show them.

June 5th Audio Webcast: CV Performance Audit

The June conference had the most ever participants. This indicates that many CV program leaders are seeking methods to validate "how they are doing". HCV was delighted to have the opportunity to present our CV program assessment tool.

Phil Laux, Barb Sallo & Cyndi Havrilak

Favorable feedback indicates that the information was useful. The challenges that HCV faces with our conferences are the inability to interface with a diverse audience and to present information that is relevant to all. The best advice we can give you is to look at our webcasts as a way to obtain information that may be of value to your specific program. Utilize the opportunity to share your specific program strengthens and experiences with us to provide learning opportunities.

We have some good suggestions for future topics so stay tuned for information on the October event.

Then and Now

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family practice and internal medicine physicians—the life blood of a hospital—to maintain busy practices and to have a level of comfort that Saint Anthony's is prepared to care for medically complex patients.

The third question surrounds those issues related to do more staffing and dollars. Saint Anthony's has already implemented another upgrade to their cath lab and has prepared itself to need very little additional equipment to perform coronary and peripheral interventions in their lab.

So what did we recommend?

Saint Anthony's has spent the last two years getting ready for the future. They are ready to meet the current needs of the medical patients that they see every day, and they are also poised to move to a more advanced program.

The follow up assessment permitted the hospital to measure and evaluate the progress that they made in their cardiovascular services. They are prepared to move to a "service line" approach and will be seriously considering the need to provide advanced cardiovascular care with an interventional program. Congratulations Saint Anthony's Health Center on your hard work and good results.

Open Heart Surgery: Streamlining the Preoperative Process

Open heart surgery is a major event for patients, their families, and hospitals. Delays in surgery cause emotional distress for the patient and their family and increase the cost to the hospital. Investing time to detail the patient flow processes involved in the preoperative preparation will assist in eliminating process gaps and identifying opportunities to improve organizational communication, patient care and satisfaction.

Cyndi Havrilak

Development of standardized preoperative open heart surgery orders help to create common practice routines that can reduce errors, improve the staff education, and reduce organizational costs by eliminating unnecessary tests and improving staff efficiencies. The orders sets are approved by the appropriate organizational committees, explained to the staff, and then distributed to the appropriate departments for implementation.

Some of the most common causes of delays are from inaccurate completion of blood bank procedures, long turnaround times for patient reports, a lack of chest film, scheduling delays for patient testing and lost sections of the patient's medical record. Once process gaps are identified, it is important to develop a workable solution and education plan.

Due to the need for a number of tests and significant patient education, it is recommended to schedule the preadmission appointment prior to the day of surgery. This provides the time to review the test results and provide comprehensive clinical education to the patient. Frequently included with the diagnostic testing are consultations for anesthesia and other services, an insurance assessment and completion of history and physical by a physician assistant /certified nurse practitioner (if this has not been provided by the physician's office).

A standardized patient education session is a major component to surgical preparation. While the patient education session should be brief to lessen the anxieties of the patient, it should review the major care components such as monitoring, invasive lines, tubes, and alarms. A tour of the post op recovery unit allows the patient and their family to visualize the high level of care that will be provided. It starts their surgical experience off on a favorable note.

For all open heart surgery patients, test results should be reviewed with abnormal results provided to the surgeon as quickly as possible. Any preoperative indication of infection warrants physician notification such as an elevated temperature and abnormal blood or bacteria counts in the urinalysis. Carotid studies should be anticipated for patients presenting clinical symptoms or those of a specific age (commonly >65). Missing or delayed chest x-ray reports along with the films for posterior anterior and lateral views can be a source of open heart surgery delay. The films are needed and reviewed in the surgical suite helping the physician determine the depth of the incision. The chest views enable the surgeon to determine the heart size, pulmonary vasculature, and possibility of calcification in the aorta.

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A comprehensive preadmission process for open heart surgery patients sets the stage for preventing post operative complications and improving patient outcomes. Due to the complexity of open heart surgery and the expense to perform the procedure it is prudent for the organization to ensure that the candidates are adequately assessed, well educated and prepared both clinically and psychologically for the event. An efficient preadmission process can reduce costly delays and improve patient and family satisfaction. For these reasons it is of value to the organization to invest the time to guarantee the preadmission processes are smooth and efficient.

Humor is Healthy…

A hospital posted a notice in the nurse's lounge saying: "Remember, the first five minutes of a human being's life are the most dangerous."

Underneath, a nurse had written: "The last five are pretty risky, too."

Live Today
Cherish Yesterday
Dream Tomorrow

-Unknown

The Financial Corner

Medicare Final Rule: Change in Methodology for Determining Payment for Extraordinary High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient Prospective Payment Systems

Phil Laux

The U.S. Centers for Medicare and Medicaid Services (CMS) will change the way it reimburses hospitals for extraordinary high-cost cases (cost outliers). The new rules are effective on October 1, 2003.

Recent analysis by CMS indicates that some hospitals have taken advantage of two vulnerabilities in the current methodology to maximize their outlier payments. One vulnerability is the time lag between the current charges on a submitted bill and the cost-to-charge ratio taken from the most recently settled cost report. The second, in some cases, is that hospitals may increase their charges so far above costs that their cost-to-charge ratios fall below three standard deviations from the geometric mean of cost-to-charge ratios, therefore, a higher statewide average cost-to-charge ratio is applied. CMS is revising the methodology to ensure that outlier payments are made only for truly expensive cases.

The three changes CMS is making will better target outlier payments to the most costly cases. First, fiscal intermediaries will no longer assign the statewide average cost-to-charge ratio in place of the actual cost-to-charge ratio when the hospital's actual ratio is more than three standard deviations below the geometric mean cost-to-charge ratio. Second, they will be implementing the use of the most recent tentatively settled Medicare cost report to determine a hospital's cost-to-charge ratio. Lastly, outlier payments may be subject to reconciliation when the cost report corresponding with the outlier cases is settled, using the actual cost-to-charge ratio calculated from the final settled cost report rather than the cost-to-charge ratio from the latest tentative settled cost report at the time the claim is processed.

Under the new rules, CMS estimates a reduction in outlier payments of $150 Million for the remaining two months in 2003. For most hospitals this final rule will not have an impact on their 2003 outlier payments. CMS is instructing fiscal intermediaries to focus on hospitals that appear to have disproportionately benefited from the time lag in updating their cost-to-charge ratios.

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