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Training Library Presents

First Point of Contact – Surgery
And Better Practice Concepts for UR

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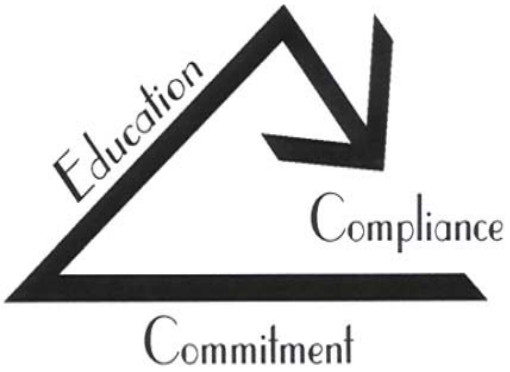

Where do the patients come from? Two hot spots for referrals into "a bed"

- ER & Inpt surgery
- Attack these two places with a pro-pt status focus, not placing and chasing.
- Develop internal flows to attack:
  - ER - how much UR coverage ? 24/7? or utilize ER lead RNs or house supervisors. No pt is given a bed without pt status 'blessed.' Integrated CDI program will help with cross training.
  - Inpt surgery – all daily inpt surgery schedules are reviewed by UR to review outpt being scheduled as outpt.
  - Involve the internal UR leaders and PA for patterns.
  - Sr leadership will have to be prepared to push thru the regulation with any problematic providers.

Let's get started- Certification process- It is the 'why..because"

- Lots of 'chatter' but evaluate this process flow.
- 1st question: Can the pt go home safely from the ER? Assess the reasons the provider (ER doc consults with the provider directing care) and document same. (Risk factors, history of like condition with outcome, presenting factors, plan)
- 1st question: if not on the inpt only list, does the surgeon 'attest' that the pt will need 2 MN to resolve/recover from the surgery?
- 2nd question: If no, move to OBS and evaluate closely/ER. If no, start surgery as outpt, watch for the unplanned event and then assess- 2 MN? If yes, move to inpt with other elements of the inpt certification. If no, move to obs and watch closely for the rapid discharge or if unable to , move to inpt if a 2nd MN is required.

Surgery scheduling joins the UR team

- Inpt only – scheduling gets CPT code, researches, notifies UR if problems.
- Outpt surgeries being scheduled as inpt – scheduling notifies UR of a potential problem.
- BAD HABIT FIXED: Will it take 2 medically appropriate midnights for this surgery/post surgery?
- PATTERNS – UR tracks and trends concerns/non-compliant surgeons.
- Physician advisor – involved as needed for peer to peer intervention, education, etc.
- UR committee – patterns are presented with assistance/intervention requested.

"Meeting Criteria" – means?

- It never has and never will mean – "meeting clinical guidelines" (Interqual or Milliman)
- It has always meant – the physician's documentation to support inpt level of care in the admit order or admit note.
- SO –if UR says: Pt does not meet Criteria – this means: Doctor cannot certify/attest to a medically appropriate 2 midnight stay – right?
- 11/1/2013 Section 3, E. Note: "It is not necessary for a beneficiary to meet an inpatient "level of care" by screening tool, in order for Part A payment to be appropriate"
- Hint: 1st test: Can attest/certify estimated LOS of 2 midnights? THEN check clinical guidelines to help clarify any medical qualifiers… but the physician's order with ROA – trumps criteria.

UR Better Practice Ideas

- Conduct time study to determine full scope of current work.
- GOAL= reallocate work to maximize RN's clinical skills, more interaction, more coverage
- More clerical work to clerical staff – fax/send to payers, daily reconciliation with payers, follow up , etc.
- LPN does payer clinicals/if required.
- Work with providers to tell the story better – from the beginning.
- Join the Denial Prevention Team!
- Identify a dedicated Outpt Ambulatory Treatment unit/ATU – recovery, extended recovery/planned beyond routine, Obs, outpt scheduled treatment/blood.
- Assign Hospitalist and UR to ATU.
- UR – high focus daily.
- Review every Certification form/process upon placement in the unit
- Aggressively watch every outpt after the 1st midnight. Convert or safely discharge.

Bad habits – Attack them

- After an uneventful, but late outpt invasive procedure, physician orders to '**stay the night'.** This is a FREE service as the pt has no medical reason to be in a bed. Time to discharge .
- Liability risk for having a non billable pt in the hospital.
- **Have the pt stay the night** and do the test in the am or Mon/wkd.
- What is the clinical reason to 'stay the night?" If not an unplanned event leading to OBS, a FREE service.
- Is there another clinical reason to be in a bed? Document it well with correct status…

At risk examples – outpt procedures

- Outpt surgery.
- After routine recovery (up to 4-6 hrs), doctor orders the pt to 'stay the night."
- What did the doctor really want? Who is reviewing every 'pt in a bed' after the 4-6 hrs of RR? Why still in house?

- Cath Lab
- Doctor has routinely had the patient the pt stay overnight. Historically billed a a 1 day inpt stay.
- Explore options – inpt, outpt or obs

WINS with the 2 midnight rule– Don't be afraid of your inpt…

- Certification form – always. Consistently start and clarify the pt story.
- UR in the ER – always involved prior to placement.
- Hospitalist – always see the pt rapidly/less than 2 hrs from referral to inpt.
- Integrated CDI program – one ongoing audit, one voice for ed
- Dedicated beds for OBS. OBS hasn't changed at all. UR assigned to closely monitor every OBS that exceeds the first midnight.
- Grow an internal physician advisor—NOW! Ongoing education, UR support/intervention = effective change
- Actively involve nursing as the eyes of the pt story 24/7.
- Actively involve surgery scheduling to 'spot' any common outpt surgeries being scheduled as inpt.
- Beef up the UR committee
- Beef up the UR 's role, separate from case mgt. Front end…

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