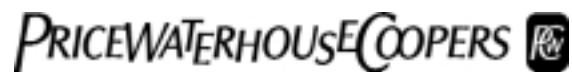


Patients or Paperwork?



The Regulatory Burden Facing America's Hospitals



PricewaterhouseCoopers (PwC) was commissioned by the AHA to ask some of America's hospitals about their patient care and paperwork experience. PwC provides objective analysis to support AHA policy development. As a research and consulting organization, it does not advocate for or endorse positions on specific policy issues.



The Case for Regulatory Reform and Relief in the Health Care Field

Perhaps no human service touches the lives of all of us so deeply as health care. Our society holds a special place for the people and institutions responsible for it. They are closely monitored and evaluated by local, state and federal regulators, who are charged with protecting the public and, in some cases, ensuring that public funds are spent wisely and in the public's best interest.

But those who give care—hospitals, physicians, nurses and others—are increasingly concerned that health care regulation is out of control and has lost a sense of fairness and common sense. It is time for dramatic change. Should all regulations be eliminated? **No.** The issue is not whether to regulate, but how. Just as hospitals, physicians and nurses constantly work to ensure that what they do benefits patients first and makes prudent use of resources, government must do the same.



*The issue is not whether to regulate, but **how**.*

A Sea of Paperwork

The people who take care of people know first-hand that many of today's health care regulations are too complex and inefficient, yet new ones are imposed on the system every day. Health care workers strive to keep up with these regulatory requirements but are frustrated when their time and energy is diverted from their primary purpose—providing quality health care to patients—to trying to decipher and comply with the bureaucratic controls that often seem detached from good care and efficient use of resources.



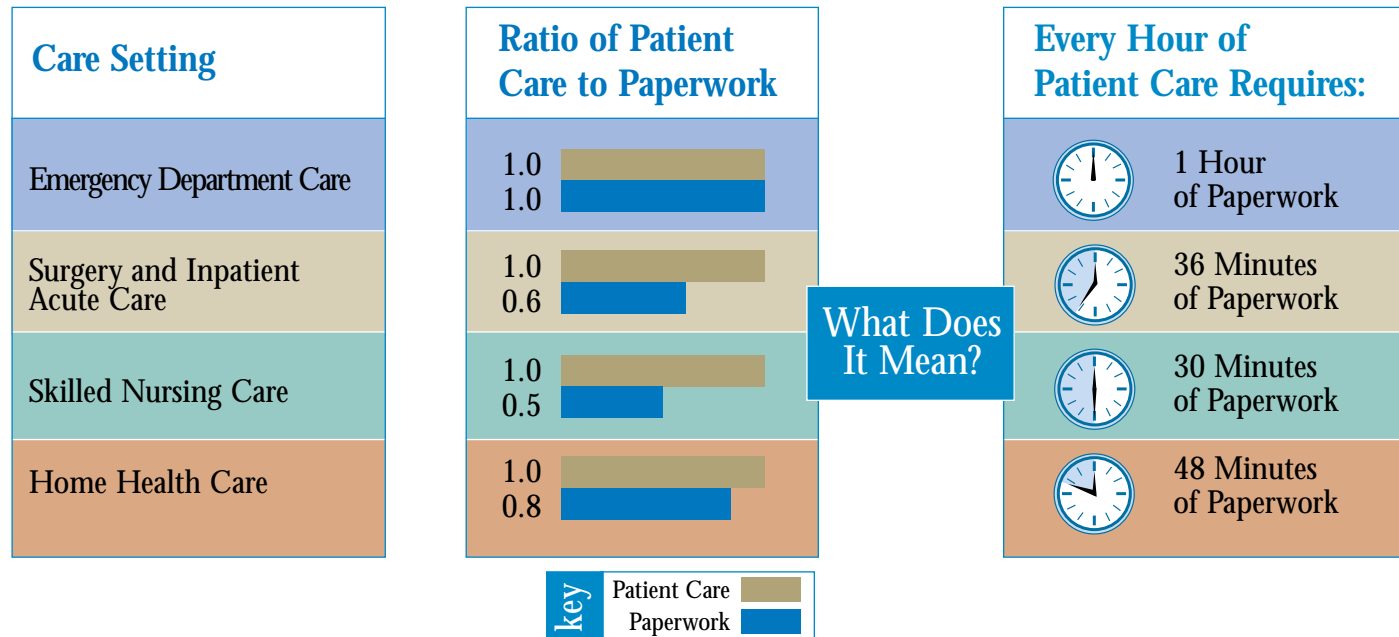
But how much time does a physician spend on paperwork and regulatory compliance, beyond writing diagnoses, medical orders and prescriptions? Or a nurse, a physical therapist, or any of the other professionals caring for the ill and injured?

Because hospitals, health systems and their caregivers are increasingly frustrated with regulatory red tape, the American Hospital Association (AHA) asked PricewaterhouseCoopers (PwC) to survey hospitals and assess the significance of the paperwork burden. The study illustrates a typical episode of care—an elderly woman who falls and fractures her hip—and the resulting patient care—and paperwork—which ensues (see appendix for details).

The results? For the various stages of care of a typical patient, paperwork adds at least 30 minutes to every hour of patient care provided and, in some settings, **adds an hour of paperwork to every hour of patient care**. The burden is simply too heavy—at the expense of patient care.

Paperwork can add an hour to every hour of patient care.

Study Results: The Paperwork Burden *fig. 1*



Source: PricewaterhouseCoopers survey of hospitals and health systems (see appendix for more information).

A Precious Resource: People

In an era of serious health care worker shortages, particularly when nurses, pharmacists and medical technicians are needed, we must use our caregivers' time as efficiently as possible. When less time is devoted to bedside care and more time is spent on regulatory paperwork and compliance, recruiting and retaining experienced, caring professionals—much less attracting future health care workers—becomes difficult.

Simply Wasteful Paperwork

Complete records and documentation are necessary for patient safety and quality care. They promote coordination, continuity and consistent quality improvement. But complying with the numerous regulations issued by local, state and federal regulatory agencies should not dominate our health care workers' day. Although some of this paperwork is directly associated with clinical care, there has been a significant increase in paperwork needed to document regulatory compliance. This administrative burden, driven by complex rules and regulations, shifts the focus from patient care to paperwork. In fact, some of these paperwork requirements make little or no sense.

Some paperwork makes sense, but did you know...

- A Medicare patient arriving at the emergency department is required to review and sign eight different forms—just for Medicare alone.
- Each time a physician orders a test or a procedure, the physician documents the order in the patient's record. But the government requires additional documentation to prove the necessity for the test or procedure. Although the physician made a clinical judgment, the decision-making process—which resulted in the medical order—must be documented using an established diagnosis assignment process mandated by the government.
- Hospital staff must complete a 30-item Medicare Secondary Payer questionnaire every time a Medicare patient comes to the hospital—whether for inpatient or outpatient care. The purpose? Make sure the elderly Medicare beneficiary still has no employer-sponsored insurance, or other coverage, that should be the primary payer.



- Because of the complexity and continuous changes in Medicare program requirements, medical records must be reviewed by at least four people to ensure compliance.
- OASIS, the Medicare patient assessment tool used in home health agencies, asks more than 60 questions that the Health Care Financing Administration (HCFA) does not use for calculating payment. Staff must complete the OASIS form an average of two to three times per 60-day episode of care.
- According to the General Accounting Office, OASIS requires 40 additional minutes of a nurse's time to complete the initial assessment. Additional staff time is required for supervisory review and data entry.
- The Minimum Data Set (MDS), the patient assessment tool used in skilled nursing facilities, requires almost 200 questions that HCFA does not use for calculating payment.
- Most skilled nursing facilities must designate one full-time employee to coordinate the collection and entry of MDS-required data.
- Each time a patient is discharged, even if only from the acute unit of the hospital to the on-site skilled nursing unit, multiple care providers must write a discharge plan for the patient. This documentation, as long as 30 pages, applies to all patients, regardless of the complexity of care received within the hospital or required post-hospital setting.
- Many forms, such as the "Activities of Daily Living," must be completed daily by clinical staff to submit to the government to justify the care provided to skilled nursing facility patients.

These are a few examples from a long list of how regulations pile on additional paperwork and documentation. Too often, these rules are implemented with no consideration for increased paperwork. The Appendix further illustrates the burdensome effect regulatory compliance and documentation has on paperwork.



There has been a significant increase in paperwork needed to document regulatory compliance.

The Ripple Effect

The PwC survey obtained information from hospitals about the patient care and paperwork time directly associated with a specific episode of care. It did not include what occurs when a new or revised rule, regulation or guideline is issued. Each new requirement—affecting either patient care and/or paperwork—demands a growing number of compliance and implementation activities by hospital personnel.

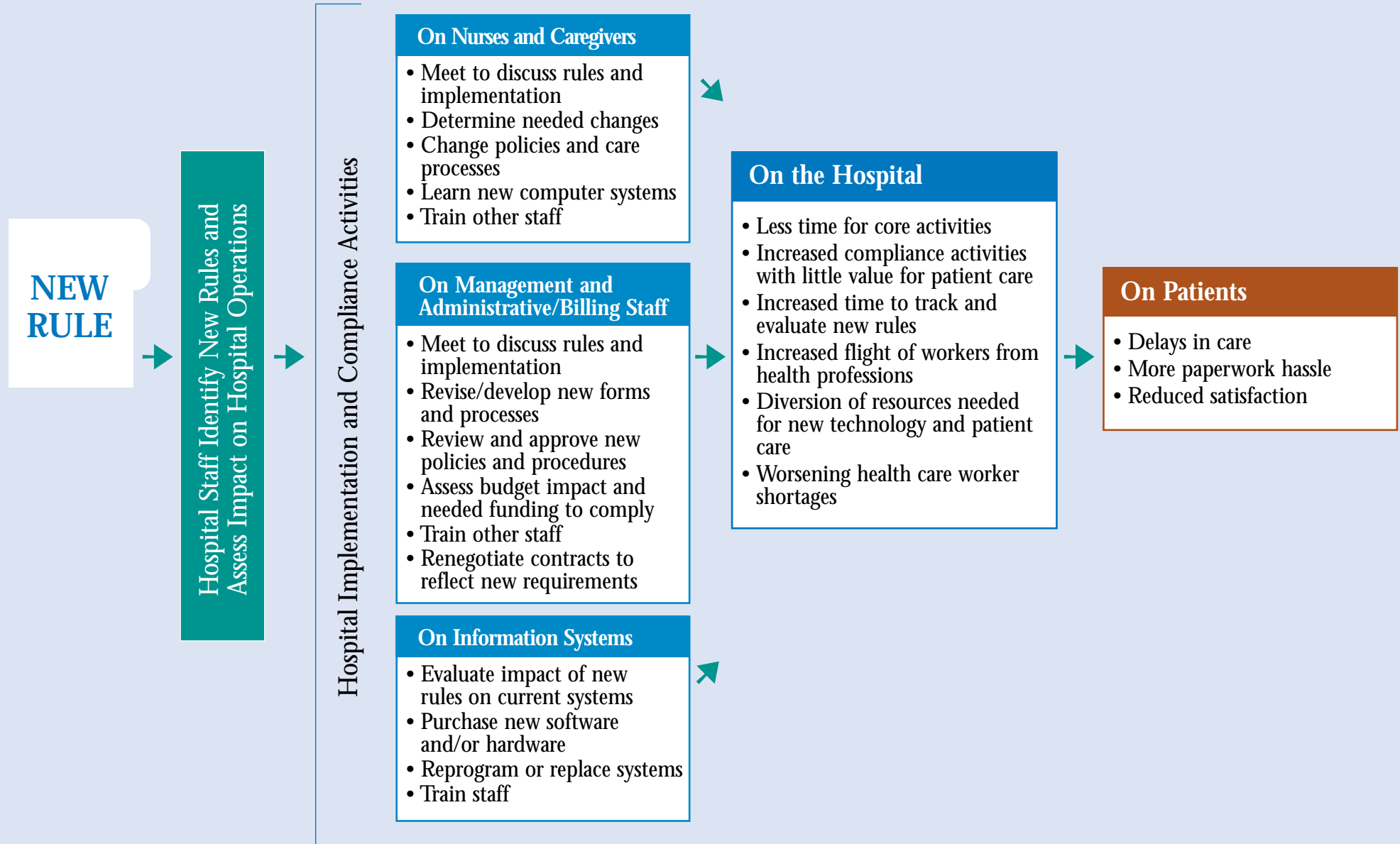
Each new regulation requires that a health care entity learn about the rule; conduct an analysis to determine how it changes current procedures; obtain approval for revised operating policies and systems; train staff; revise vendor contracts, if necessary; and establish methods for compliance documentation.



Figure 2 illustrates many of the activities needed to implement a regulatory change. Virtually every activity in a hospital is connected to another. Implementing and complying with just one regulation can cause a ripple effect, affecting operations and the care process throughout the hospital.

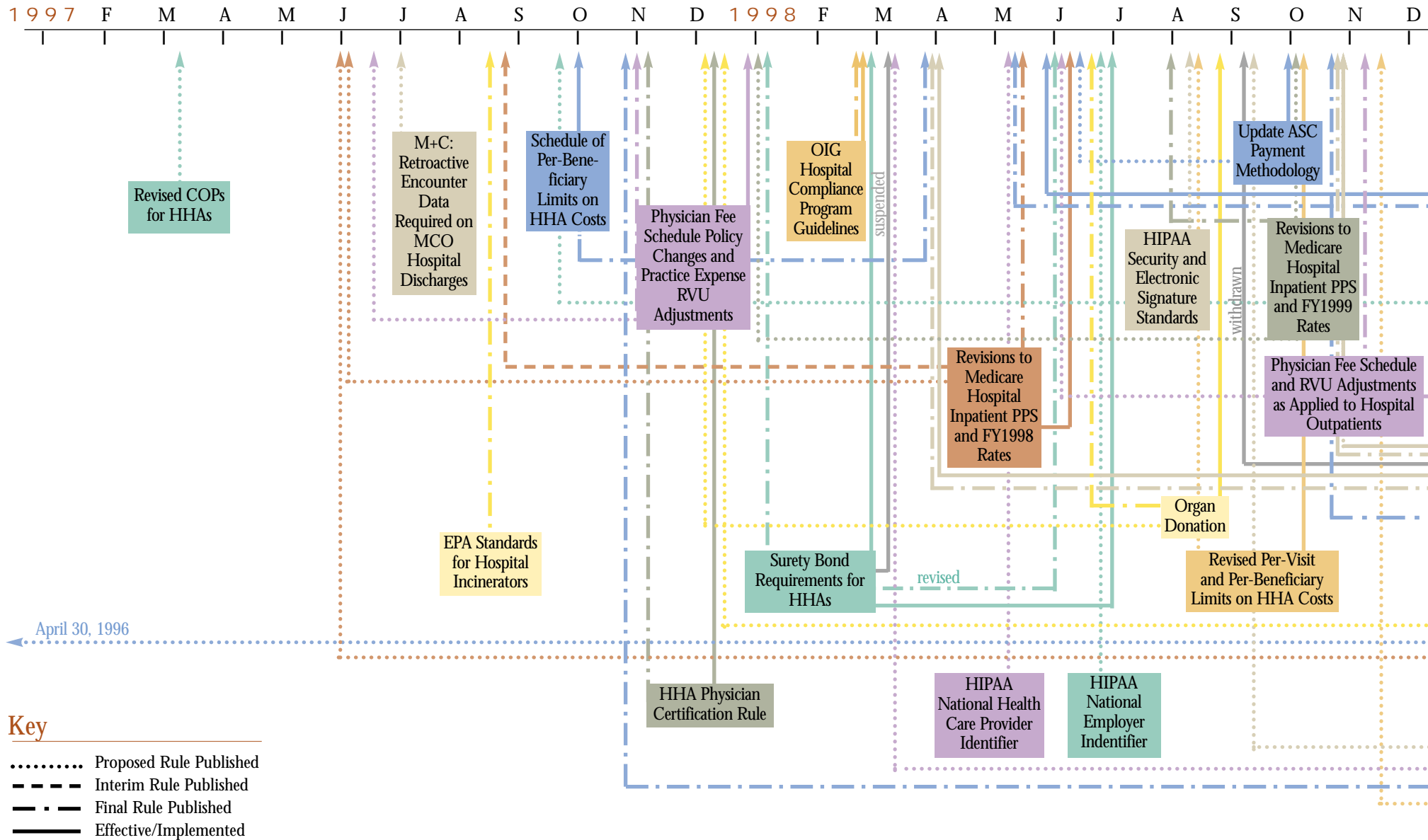
Just one regulation can cause a ripple effect.

One Rule, Many Changes—Many Rules, Countless Changes *fig. 2*



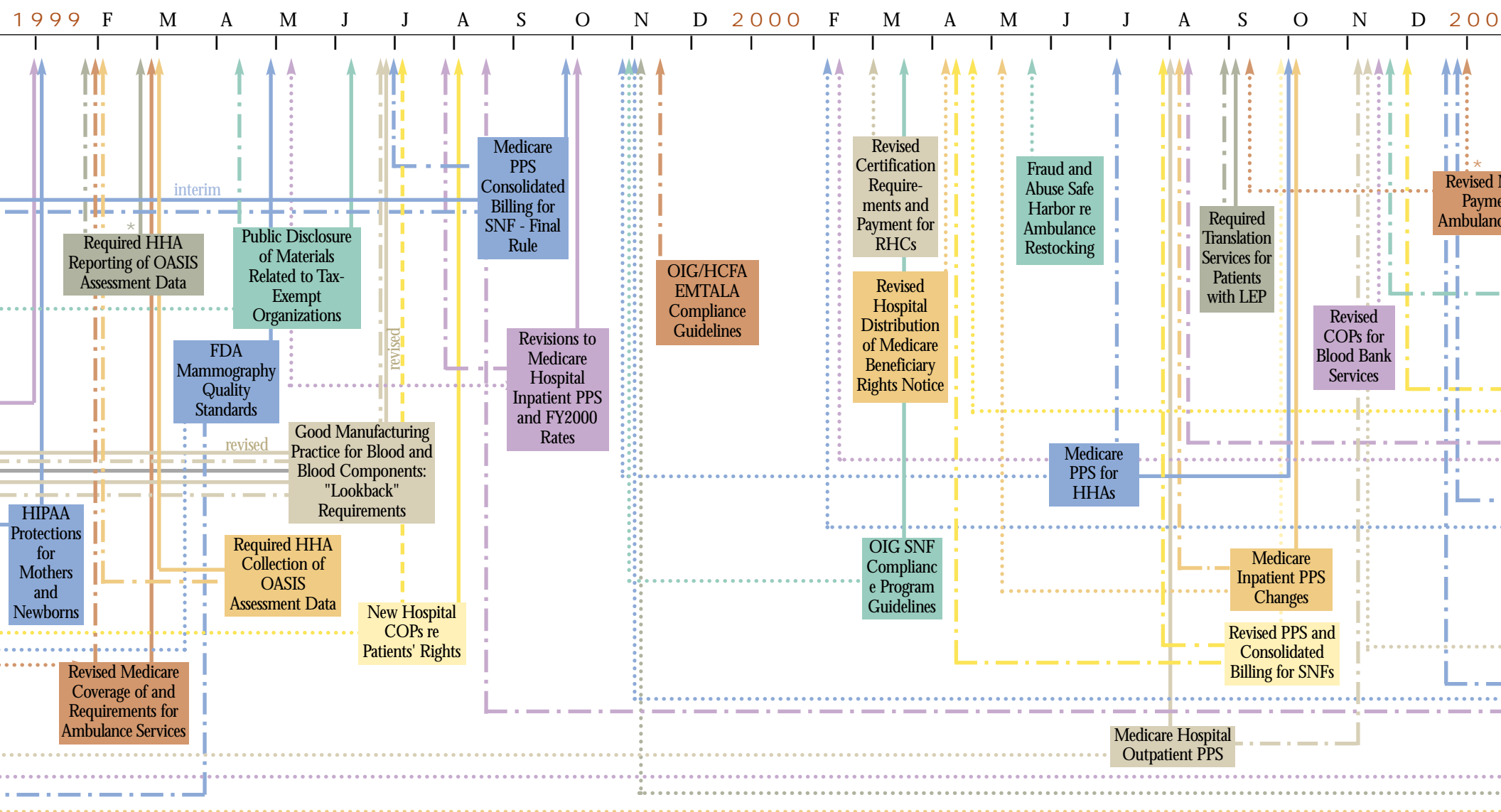
Added government regulation imposes unfunded costs on hospitals.

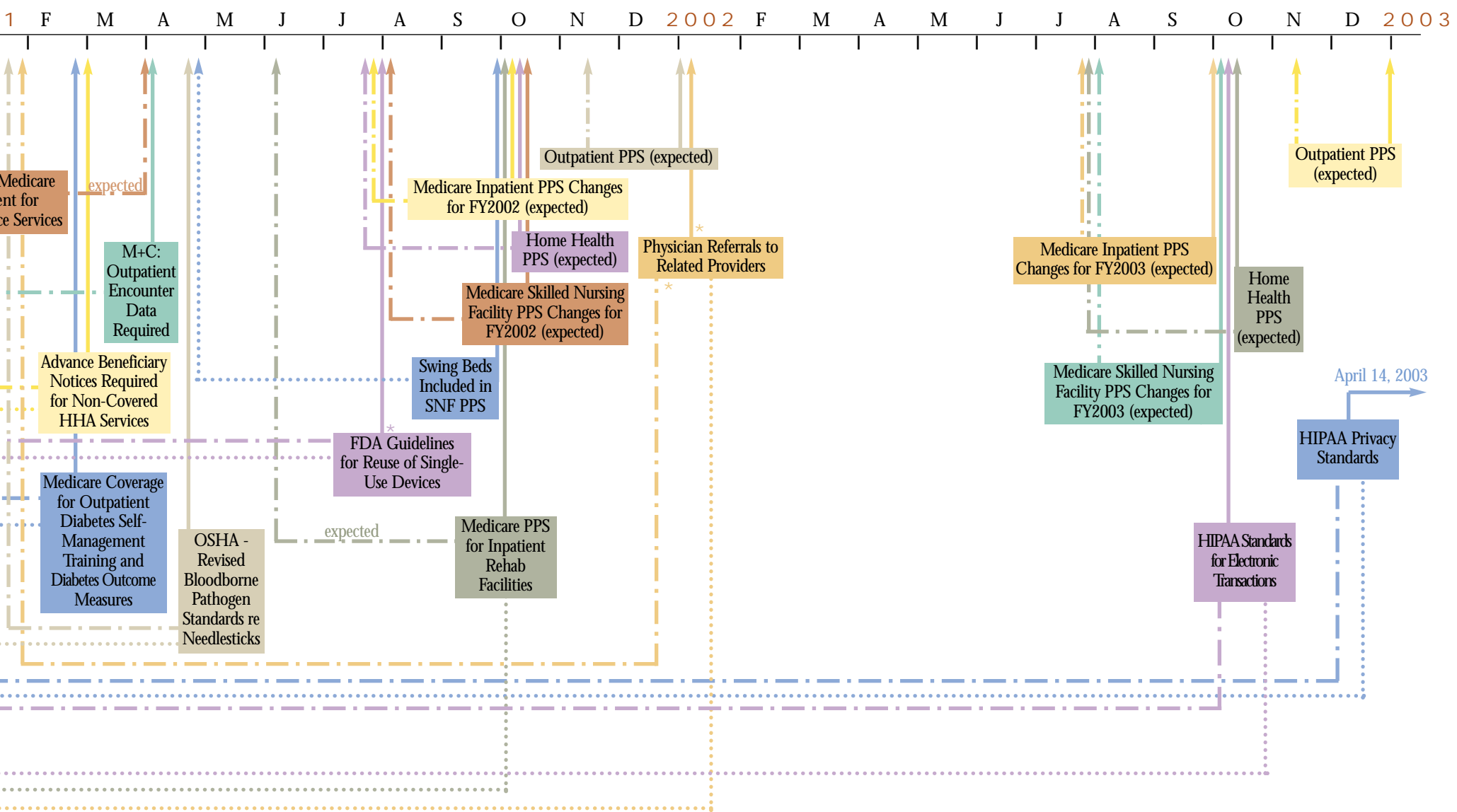
Health Care Regulation Timeline – 1997 to 2002:



* This regulation includes alternate effective dates for some sections of the rule.

A Period of Rapid, Massive Change for Hospitals





What's the Count?

Multiply what a hospital has to do to implement a new rule by the number of new or revised rules affecting health care and it begins to paint a picture of the time and dollars devoted to compliance with new regulations. After reviewing almost 100 new or revised requirements issued by federal agencies since 1997, the AHA selected 57 of the most significant to create the Health Care Regulation Timeline. While it illustrates only a portion of the rules issued, the pace of change is clear. Also, consider that just three provisions in one of those rule—the privacy provisions in the Health Insurance Portability and Accountability Act (HIPAA)—are estimated to cost hospitals \$22 billion over five years. The Health Care Regulation Timeline demonstrates why hospitals are saying, "Enough is enough."

A Dictionary of Terms

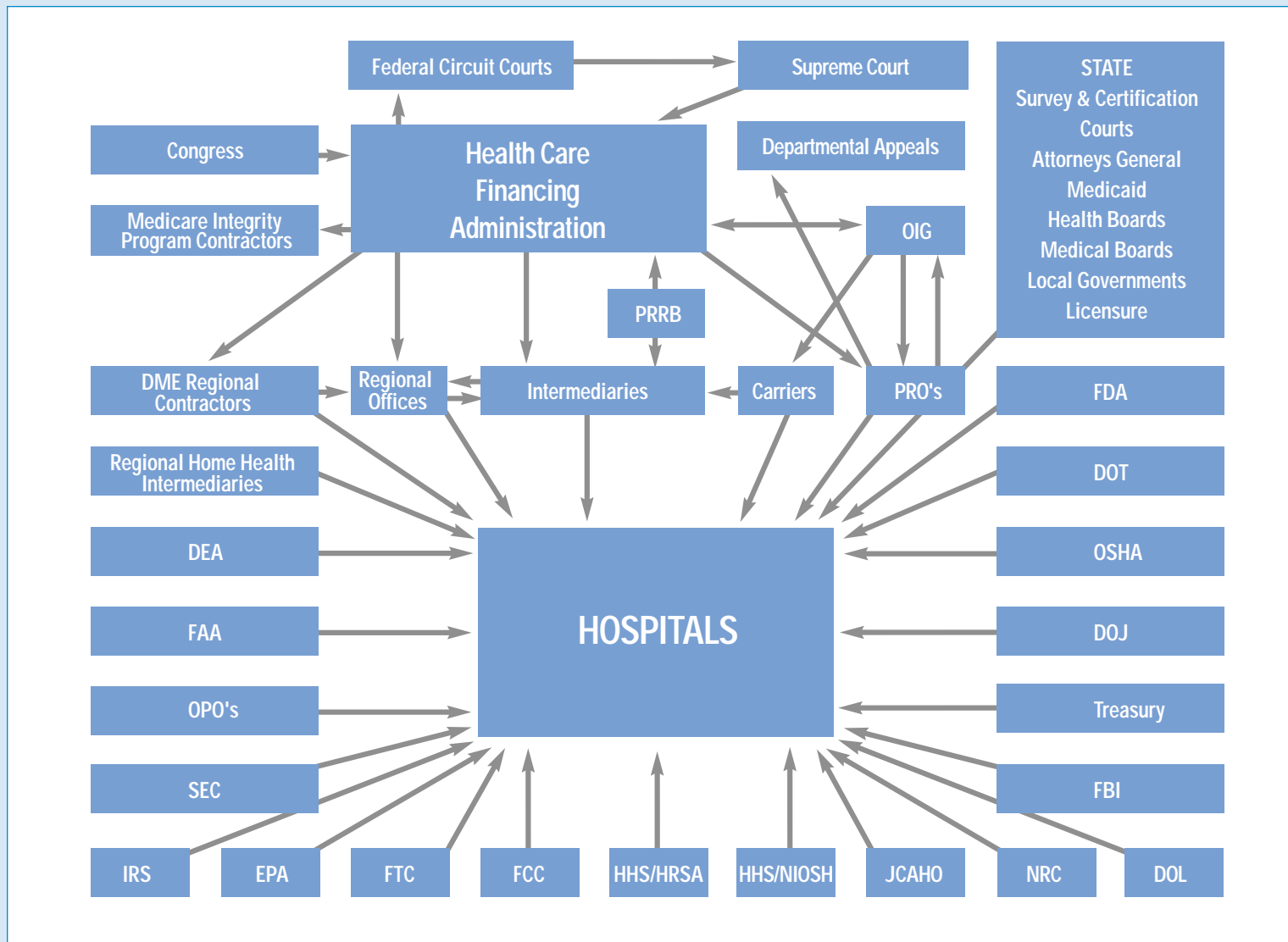
Acronym	Full Name
SNF	Skilled Nursing Facility
PPS	Prospective Payment System
COPs	Conditions of Participation
EMTALA	Emergency Medical Treatment and Labor Act
HIPAA	Health Insurance Portability and Accountability Act
HHA	Home Health Agency
ASC	Ambulatory Surgery Center
RVU	Relative Value Unit
LEP	Limited English Proficiency
MCO	Managed Care Organizations
M+C	Medicare+Choice

Who's on First?

But this is only federal-level regulation. Hospitals also are regulated by local and state agencies, as well as other private accrediting organizations. Figure 3 shows how many agencies are involved in regulating hospitals—almost 30 at the federal level alone. Almost no coordination exists among various federal agencies or between similar agencies at local and state levels, and private-sector accreditation. Even within the Department of Health and Human Services (HHS)—the major federal regulator of hospitals—there is little coordination among its different divisions. HCFA, for example, has trouble coordinating its Medicare and Medicaid rules and instructions—more than 130,000 pages. (That's three times the size of the Internal Revenue Service Code and its federal tax regulations.)



Government Regulation of Health Care Today: Complex, Cumbersome and Confusing *fig. 3*



Overdue: Regulatory Reform and Relief

The AHA, its member hospitals and health systems, and the millions who work within these facilities urge the Administration and Congress to work together to ease the regulatory burden confronting health care providers. A necessary first step is to create a more common sense approach to developing and issuing future regulations. Equally critical, though, is the need to quickly provide relief from the most burdensome, inefficient or ineffective regulations—those that take away from critical time spent with patients.

What We Need

Improve the regulatory process:

- **Enable providers to challenge questionable policy actions in court.** Unlike other federal agencies, Medicare program policy decisions made by the Secretary of HHS are insulated from judicial review. Health care providers are required to exhaust all administrative processes and remedies before they can file suit against HHS. However, there is no such process to exhaust on questions about whether the Secretary has exceeded his authority or failed in his duty. This effectively means that providers can bring a suit only if they violate Medicare requirements so significantly that they are thrown out of the Medicare program. HHS policy decisions should be subject to the same level of judicial review as other federal regulatory agencies.
- **Coordinate the orderly release of federal regulations to allow for more seamless compliance.** Government agencies with jurisdiction over hospitals need to release regulations in a coordinated manner so that implementation does not overwhelm hospital personnel and systems. That means establishing a point of accountability to coordinate regulatory activity across major federal agencies, as well as within HHS. As the predominant federal regulator of hospitals, HHS should periodically evaluate its overall federal regulatory framework applied to health care providers for clarity and expected behavior from providers.

- **Include the cost of implementing significant regulations into Medicare payment updates.** Currently, the initial cost of implementing significant new regulations is not captured by Medicare prospective payment rate updates. Like new technology and productivity improvements, these costs should be required to be taken into account by the Medicare Payment Advisory Commission (MedPAC) when it makes its annual rate update recommendations to Congress.
- **Provide interpretive and advisory guidance on Medicare payment requirements.** Medicare requirements for provider participation and payment are increasingly voluminous and complex, making compliance difficult, while penalties for compliance failures are increasingly severe. HCFA should establish query mechanisms for individual providers and their associations on the appropriate interpretation or application of Medicare rules in specific situations. HCFA's responses should be timely and readily available to others in an easily accessible format (such as an indexed file on the Internet).
- **Seek greater provider input on new rules and regulations.** Federal regulators need to become more acquainted with real world hospital operating environments so that practical implementation issues can be minimized before a regulation goes into place. Agencies should conduct outreach efforts to obtain early input from the health care field, including publishing notices of intent; making relevant databases, cost estimates, assumptions, and methodologies publicly available early on; holding field hearings; and conducting site visits.
- **Enhance the communication of regulatory requirements to health care providers.** Providers are finding it difficult to monitor, identify, absorb and comply with Medicare requirements because of the complexity of the program, the pace of change in requirements, and the numerous ways that HCFA issues policy and administrative requirements. HCFA should more actively communicate these changes and use contemporary technologies to provide free and easy access to a well-organized database of all requirements issued through any means.

- **Enact the Regulatory Fair Warning Act.** Introduced and approved by the House Judiciary Subcommittee on Commercial and Administrative Law in 2000 by Rep. George Gekas (R-PA), the measure would ensure that federal rules are issued and available in a timely manner, and in terms understandable to both the regulated entities and the regulators. Most importantly, it would prevent federal agencies from penalizing businesses or entities for alleged violations if the rule was not published in a public document, the agency did not give fair warning that a type of conduct was prohibited or required, or the agency already had given specific guidance that contradicted an inspector's claim that the regulation had been violated.
- **Restrict use of interim final rules.** HHS has increasingly issued new rules as interim final rules; that is, issued and implemented before the agency takes public comment. To reduce the disadvantages of this approach – which negates the public comment process – HHS should be required to issue final rules within a year after the interim final rules so that public comments are taken into account on a timely basis.

Provide relief from specific regulations:

- **Revise the HIPAA privacy regulation and offer grants to help hospitals with the huge costs of complying with the HIPAA rules.** These rules are so complex and prescriptive that they are unworkable and excessively costly, creating serious financial and administrative burdens.
- **Streamline the Medicare cost report.** The Secretary should evaluate and overhaul the cost report, reducing its size and complexity to reflect Medicare payment based on prospectively set rates, not cost-based reimbursement, and modifying or eliminating the arcane Medicare-specific cost accounting principles.
- **Prohibit the denial of payment by fiscal intermediaries for emergency services provided to Medicare beneficiaries that are required under the Emergency Treatment and Active Labor Act (EMTALA).** Fiscal intermediaries often deny emergency department services, applying local medical review policies based on diagnoses determined after screening (including tests) and

stabilization. First, Medicare coverage decisions regarding emergency services should consider a beneficiary's presenting condition, based on the prudent layperson standard. Second, hospitals cannot deny or delay treatment to assess or resolve any financial or coverage issues and cannot bill a beneficiary, even if use of the emergency room was inappropriate. It's simple—if hospitals must provide services to beneficiaries, then Medicare should pay.

- **Limit the collection and reporting of post-acute patient assessment data to useful information.** HHS requires the use of several patient assessment tools – OASIS for home health services and MDS for skilled nursing facilities – and is planning to adopt other instruments for other settings. Recognizing the need for greater consistency and standardization, Congress last year asked the Secretary to study the development of a common patient assessment instrument and report back in five years. In the meantime, though, providers need immediate relief from the excessive burdens and often irrelevant information requirements imposed by these assessment tools, and HHS needs to follow a rigorous process for changing or adopting new requirements.
- **Improve Medicare fiscal intermediary (FI) and carrier customer service performance.** Communication and interaction between FIs/carriers and providers/practitioners is critical to a successfully administered program. Give FIs and carriers specific customer service performance objectives, and allow providers and practitioners to participate in performance evaluations. Enhance accountability by making FI and carrier performance evaluations public.
- **Revise the Medicare Secondary Payer Provision.** Stop the burdensome requirement that hospitals complete a 30-item questionnaire for each inpatient and outpatient visit, just to ensure that an employed beneficiary doesn't have employer-sponsored coverage that should be the primary payer. Collecting this information once every 60 days would suffice.

Appendix: PricewaterhouseCoopers Methodology and Results

Background

PricewaterhouseCoopers (PwC) was commissioned by the AHA to ask some of America's hospitals about their patient care and paperwork experience. The survey methodology and results are summarized in the following pages.

Survey Methodology

The goal was to determine from hospitals the amount of time spent on patient care and paperwork for a typical episode of care. The study had four phases:

1) Outline a Typical Episode of Care

PwC developed a “typical” patient encounter to illustrate both the care delivered and paperwork directly associated with a complete episode of care (see box on opposite page describing the hypothetical patient, “Ida Smith”). A summary of key clinical events (patient care) and corresponding administrative activities (paperwork) associated with the encounter was developed (see pages 22 to 29). The hypothetical, yet typical, episode of care included Ida Smith accessing many health care services: emergency department care, surgery and acute inpatient care, skilled nursing care and home health care.

There was no attempt to capture a variety of other administrative and paperwork activities not directly involved in an episode of care. Hospital staff often spend time on administrative and paperwork activities, such as those associated with implementing new regulations or regulatory requirements (e.g. preparation of compliance reports, working with surveyors, responding to data requests, etc.).

IDA SMITH'S EPISODE OF CARE

Ida Smith is an 80-year old Medicare beneficiary with chronic obstructive pulmonary disease. She has been steadfast in living alone since the death of her husband two years ago. While visiting her daughter, Ida tripped and fell at the bottom of the stairs, experienced searing pain and was rushed by her family to the Emergency Department at Community Medical Center (CMC).

The nurses and doctors in the Emergency Department quickly tended to Ida's intense pain and diagnosed the cause: a right hip fracture. But this was just the start of the care that would be provided by the clinicians and staff of CMC. Ida was then immediately admitted as an Acute Care inpatient in preparation for hip reconstruction surgery the

following morning. After her surgery, Ida received three days of specialized post-operative acute care in the hospital's Orthopedic Unit. As her condition stabilized and improved, Ida's attending physician was able to transfer her care to CMC's Skilled Nursing Care Unit for two weeks of monitoring, further recovery and rehabilitation. Ida was happy that her doctor then discharged her back to her own home in the care of her family. Given her pulmonary condition and the lingering effects of her hip injury, Ida needed continuing professional care that her family could not provide. Once again, Ida's medical care needs were served, for the next 60 days, by nurses and other clinical specialists from CMC's Home Care Division. She is now fully recovered and busy enjoying time with friends and family.

2) Create a Survey Instrument

PwC, with the collaboration of AHA and three hospitals, developed the detailed survey instrument. Contributors included physicians, nurses and other clinicians, and health care personnel with administrative and operational experience in areas such as: medical records, coding, compliance and patient financial services (billing, collections, registration) as well as in all settings of "Ida Smith's" care. The illustrative care episode developed resulted in a 31-page questionnaire, detailing each patient care activity, as well as each paperwork activity. This was necessary to clearly and completely identify the key elements directly associated with this episode of care. The questionnaire was segmented into the four settings of "Ida Smith's" care: emergency department care, surgery and acute inpatient care, skilled nursing care and home health care. Pages 22 through 29 summarize the patient care and paperwork associated with "Ida Smith's" episode of care.

Survey Hospitals

Twenty-five hospitals, representing large healthcare systems, rural hospitals, urban hospitals and academic medical centers, were asked to complete the detailed questionnaire. Of these 25 facilities, 19 responded. This provided a cross-section of hospitals; it is not a statistically valid sample.

Each organization received the questionnaire and instructions. In general, the organizations selected an individual responsible for obtaining sound responses to the survey representing what actually happens given the typical episode of care presented. Hospitals were asked to obtain and provide their best estimates of minutes required for each defined patient care and paperwork task by obtaining the input of the hospital's knowledgeable clinicians and administrators.

The AHA and PwC would like to thank the following hospitals that volunteered to share their experiences and generously spend the time required to complete the survey.

Charles Cole Memorial
(Pennsylvania)

East Liverpool City Hospital
(Ohio)

Eastern Health System—
Medical Center East (Alabama)

HCA Healthcare Co.—Hendersonville
Medical Center (Tennessee)

Huron Valley-Sinai Hospital (Michigan)

Mayo Foundation—Saint Mary's Hospital
(Minnesota)

Mayo Regional Hospital (Maine)

Methodist Hospitals (Indiana)

Montclair Baptist Medical Center—Baptist
Health System (Alabama)

Wake Forest University—Baptist Medical
Center (North Carolina)

Northwestern Memorial Hospital (Illinois)

Scottsdale Healthcare Shea (Arizona)

Shands HealthCare (Florida)

St. Cloud Hospital (Minnesota)

St. John's Mercy Health Care (Missouri)

St. John's Medical Center, Inc. (Oklahoma)

St. Luke's Regional Medical Center (Idaho)

Sunnyside Community Hospital (Washington)

University of Pittsburgh Medical Center
(Pennsylvania)

3) Tabulate Results

Below is a summary of the number of organizations that were able to complete surveys and submit the results to PwC for tabulation:

Survey Section

Care Setting	# of respondents
Emergency Department Care	19
Surgery and Acute Inpatient Care	19
Skilled Nursing Care	15
Home Health Care	14

Results

The summary of the number of patient care and paperwork minutes reported by the hospitals for each setting within “Ida Smith’s” episode of care were converted to ratios and averaged for all respondents. The resulting ratios, shown below, present the proportion of paperwork time for each unit (e.g. hour) of patient care time.

Care Setting	Ratio of Patient Care to Paperwork Time
Emergency Department Care	1 to 1
Surgery and Acute Inpatient Care	1 to 0.6
Skilled Nursing Care	1 to 0.5
Home Health Care	1 to 0.8

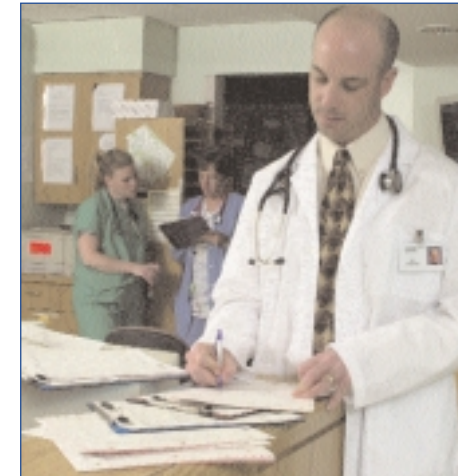
Emergency Department Care

- When Ida arrived at the Emergency Department (ED), she was greeted by a Triage Nurse who assessed her injury, evaluated her pain level and checked her blood pressure and pulse.
- After Ida's intake evaluation by the Triage Nurse, she was placed on a stretcher and taken to the treatment area of the ED where she was evaluated for an emergency condition by the ED Resident Physician.
- Nurses constantly monitored Ida's vital signs and gave her pain medication as needed, while she waited to be evaluated by the ED Physician.
- The ED Physician performed a medical evaluation, ordered blood tests and X-rays.
- The tests were completed and the results were sent to the ED Physician, who diagnosed her hip fracture and determined further examination by an Orthopedic Surgeon was necessary. The Orthopedic Surgeon on-call for the ED was consulted by the ED Physician to evaluate and assess Ida's condition.
- The Orthopedic Surgeon evaluated Ida, reviewed her test results, confirmed the diagnosis of her condition and determined that she needed surgery to repair her hip fracture.
- After the Orthopedic Surgeon discussed the diagnosis with Ida and her family members, she was admitted to Community Medical Center's (CMC) Medical/Surgical Orthopedic Unit for surgery.
- Ida was taken from the ED to her assigned inpatient bed by a hospital Transporter.



Paperwork Generated from Emergency Department Care

- The Triage Nurse who performed initial care activities documented Ida's medical history, vital signs, the appearance of her injury, and mode of transportation to the ED in the Hospital's triage log.
- Following the Nurse's initial assessment, the ED Resident Physician then documented within the medical record the clinical judgement that Ida's injury should be considered an emergency condition, as required to comply with government regulations.
- After confirmation of the emergency condition, the Registration Clerk entered Ida's demographic information into the hospital's central log, as required by government regulation. The Clerk then documented Ida's insurance information, obtained the necessary waivers and created paperwork to track Ida's care. Ida signed several government-required forms including: conditions of admission, consent to treatment and Medicare Secondary Payer. The Clerk then explained the policies on patient rights, the hospital's privacy policy, and grievance procedures: all as required by government regulations. The Clerk also entered Ida's personal and insurance information into the hospital information system.
- The ED Nurses documented every detail of the care they provided, including periodic pain assessments, vital signs and treatments performed.
- The ED Physician and Orthopedic Surgeon documented in the medical record all of their clinical judgements and decision making according to the government's Evaluation and Management coding guidelines in order to justify to the government that the care was really needed, and to prove they were actually physically present when providing the care to Ida.
- The orders written by the Physicians were entered into the ordering system by the Clerk and routed to the appropriate testing departments. The departments prepared government-required paperwork to verify the tests were performed as ordered and were medically necessary. They then entered information into the billing system.
- The ED Physician documented that the ED "on-call specialty list" was used, and that the Orthopedic Surgeon responded in a timely manner, in order to demonstrate compliance with government regulations.
- The Orthopedic Surgeon prepared documentation to justify the decision to admit Ida for surgery.
- Ida met with a Case Manager who reviewed the government's Medicare requirements for hospitalization and what would, and would not be covered by Medicare.
- The Clerk entered the orders to admit Ida into the hospital's information system and updated the growing file of medical records for this episode of care.



Surgery and Acute Inpatient Care

- When Ida arrived at the Orthopedic Unit, an Orthopedic Care Nurse admitted her to a medical-surgical bed. The Nurse gave Ida her prescribed pain medication, checked her blood pressure and other vital signs and prepared her for surgery.
- During her first day in the Orthopedic Unit, Ida's Primary Care Physician (PCP) evaluated and managed her medical problems. Her Orthopedic Surgeon performed a history and physical examination and ordered additional tests prior to the surgery. Her Anesthesiologist explained the medications that would be administered during surgery and their side effects.
- Ida was taken to an Operating Room, prepared for surgery and the surgery began. The Anesthesiologist administered anesthesia, and the Orthopedic Surgeon, an Assistant Surgeon, and a team of Surgery Nurses and Operating Room Technicians performed the hip reconstruction. During surgery, Ida experienced some blood loss and received a blood transfusion.
- After the surgery was completed, the Anesthesiologist brought Ida into the recovery room for constant observation by the Recovery Room Nurses.
- Once Ida was awake and her vital signs stable, the Transporter brought her back to her patient room for continuation of care. Once back on the Orthopedic Care Unit, the Nurse checked Ida's vital signs, cared for her surgical area, administered medication ordered by the Surgeon and provided Ida with other care that she needed for the duration of her three-day stay in the acute care unit.
- During Ida's post-operative care, her PCP and Orthopedic Surgeon visited Ida daily to evaluate her progress, monitor her recovery and assess additional medication needs.
- After three days, the Orthopedic Surgeon and the PCP determined that Ida did not need such a high level of nursing care. Therefore, the PCP wrote an order to discharge her to a Skilled Nursing Facility (SNF) for an additional two weeks of monitoring and rehabilitation. CMC's SNF was selected by Ida and her family.
- A Discharge Team, which consisted of a Nurse, Case Manager, Physical Therapist (PT) and Occupational Therapist (OT), planned Ida's discharge to the SNF and developed a plan for her continued care needs at the facility.
- The Nurse prepared Ida for discharge by performing the required tests (such as TB) and reviewing the discharge instructions with Ida and her family. The Transporter then moved her to the SNF wing of the Hospital.



Paperwork Generated from Surgery and Acute Inpatient Care

- On Ida's admission to the Orthopedic Unit, the Hospital's Admitting Specialist explained the grievance, admitting and discharge processes to her and her family. The Unit Clerk entered the admission orders and demographic information into her medical record.
- The PCP and Orthopedic Surgeon documented the medical and surgical orders and their medical decision-making and clinical judgments in the medical record to justify the care provided.
- The Orthopedic Nurse documented Ida's vital signs and pain level, and completed required pre-operative paperwork. A Nutritionist documented Ida's dietary evaluation.
- The Laboratory processed the blood-work and completed the necessary documentation of the tests. The lab results were sent to the Orthopedic Surgeon and a copy of the results placed in her medical record.
- After Ida arrived in the pre-operative area, the Surgical Nurse checked the pre-operative paperwork, validated that Ida signed the surgical consent form, and verified that all of the consent forms and Ida's history and physical were present in the medical record. The Operating Room staff documented the instrument sterilization procedures, instrument count and supplies available for surgery.
- Extensive documentation of the operative procedures performed was completed by all of the caregivers, including blood administration paperwork. The Orthopedic Surgeon wrote a report about the surgery and documented post-operative orders for Ida. The Surgical Nurse inventoried and verified the surgical instruments and supplies used. The Anesthesiologist documented the anesthesia and medications that were administered, as well as Ida's response to the medications. The Recovery Nurse documented Ida's recovery progress. A Clerk in the Surgery Department gathered all of the documentation and entered the information into the Hospital's information system.
- During daily follow-up visits, the Orthopedic Surgeon and PCP documented their clinical judgments and decisions in the progress notes.
- The PCP, Orthopedic Surgeon and the Hospital's Discharge Team documented their discharge plans.
- Once the PCP wrote the SNF admission order, the Case Manager discussed SNF options with Ida and her daughter, and a selection was made. The Case Manager completed a required Medicare eligibility form to verify that Ida qualified for skilled care and arranged for transportation to the SNF.
- Charge tickets were prepared by the Hospital's Staff and Physicians to support all the care provided, and resources consumed, in Ida's acute care and surgery. These were entered into the Hospital's billing system by a Clerk. Ida's medical records were sent to the Health Information Management Department for "coding," a complex system as required by the government. Due to the complexity of this system, and the resulting potential for inadvertent errors and government charges of non-compliance, multiple layers of supervisory review were required. The bills were generated and reviewed for accuracy, completeness and compliance with relevant Medicare rules, then submitted to the government's Fiscal Intermediaries for payment. Routine follow-up to collect the bill was performed by the Patient Accounting Staff.



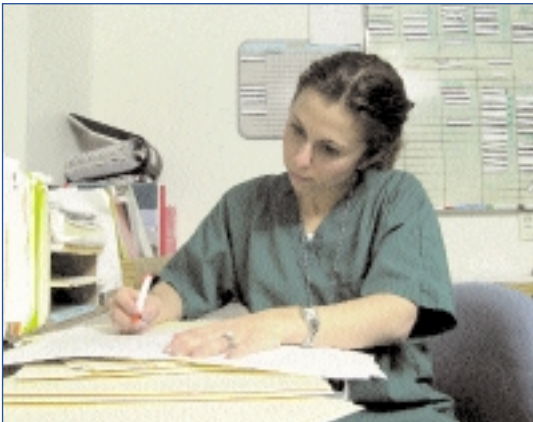
Skilled Nursing Facility Care

- Accompanied by her daughter, Ida arrived at the special Skilled Nursing Facility unit at CMC and was transferred from the transport stretcher to a bed in her assigned room.
- When Ida was situated in her room, a Nurse evaluated her, obtaining her vital signs, height and weight, checking her skin for signs of irritation, and determining whether Ida could be at risk to fall if she was left unattended.
- A Dietician then met with Ida to develop a meal plan and a Social Worker discussed resources Ida may need after discharge from the SNF. Later that day, the PT and OT performed their initial evaluations to determine the necessary therapy. The Nurse, Social Worker, and Therapists worked together with Ida to develop a plan of care and set goals for Ida during her stay in the SNF.
- Ida's PCP visited her within the first three days of her arrival into the SNF, and then as needed, to evaluate her condition and determine if any changes in her medical care were necessary. The Orthopedic Surgeon also checked Ida's surgical incision and removed her stitches before her release from the SNF. Ida's Physicians wrote orders for her care and made notes in the medical record to document their on-going review of her care.
- The Nurses visited Ida multiple times per day, checking her incision, changing her surgical dressing, monitoring her vital signs, and assisting her with activities of daily living such as bathing and grooming.
- The Therapists worked with Ida daily to enable her to be more independent. The PT trained Ida to get in and out of bed and chairs, and how to use a walker. The PT also initiated an exercise program. The OT worked with Ida on how to dress and bathe herself given her limitations.
- The Nurse, Social Worker, Therapists, Physician, Ida and her family discussed Ida's progress. The clinicians evaluated whether Ida had met her goals and should be sent home.
- Ida's caregivers determined that she was ready to be sent home after a two-week SNF stay, but required continued professional care that her family could not provide.
- The PCP made a judgment to discharge Ida to her home in the care of her family, supported by professional home health care services. The Social Worker assisted Ida and her family with the selection of a Home Health Agency.
- After Ida's discharge, her family picked her up from the SNF and took her home.



Paperwork Generated from Skilled Nursing Facility Care

- Once Ida's was referred to the SNF, the SNF Intake Coordinator completed the necessary pre-admission forms, obtained copies of Ida's hospital medical record, checked for bed availability, and verified Ida's insurance benefits and eligibility for skilled nursing care in accordance with Medicare rules. The Intake Coordinator registered Ida, collected additional information and created her SNF medical record.
- The SNF Staff discussed, with Ida and her daughter, the policies mandated by government regulators, including privacy, patient's rights, the grievance process, resuscitation status and advanced directives. Ida signed the conditions of admission and authorization for treatment, as required by government regulations, and the Clerk arranged a visit by her PCP.
- The plans of care developed by the Nurse, Social Worker, and Therapists (the Care Team) were collected and combined into one plan of care which guided Ida's care and established goals and projected outcomes.
- The Minimum Data Set (MDS) coordinator completed the MDS form (a government requirement) and the Resident Assessment Protocols form (another government requirement) in conjunction with the Care Team, verified its accuracy, and transmitted the documents to the State Department of Health and HCFA, as required by government rules. Based on the MDS "scores," Ida was designated with a Resource Utilization Groups (RUG) assignment (a complex system mandated by the government) which determines the amount Medicare pays for Ida's care.
- The PCP completed the government-required Medicare certification forms to document the clinical judgments and to justify, for purposes of regulatory compliance, Ida's need for daily skilled care. He followed government-prescribed documentation guidelines to validate the nature and extent of their medical decision-making.
- The Nursing Staff regularly completed the Activities of Daily Living forms required by the government, and wrote notes in the medical record that detailed Ida's on-going care and progress to her goals. The Therapists documented each treatment and her tolerance of the treatments.
- The Nursing Staff monitored Ida for a significant change in condition that would require the completion of an additional MDS, which may result in a different RUG assignment, as specified in government regulations.



- The Unit Clerk validated that the amount of therapy time provided to Ida to ensure regulatory compliance, and sent that information to the billing department.
- On the 14th day of Ida's SNF stay, the Care Team documented that Ida met the goals of her plan of care and was ready to be discharged to her home with the support of professional home health care.
- Ida's PCP wrote a discharge plan regarding the judgments for discharge and documented in the medical record Ida's need for home care.
- The clinical care team documented the discharge plan they had developed. Then, the Social Worker, Ida and her family reviewed Home Health Agency (HHA) options. Ida chose an agency best suited for her needs—one that was affiliated with CMC.

Home Health Care

- Soon after Ida returned home, the HHA Nurse visited Ida to evaluate her safety and health care needs. The Nurse completed a physical assessment, reviewed Ida's ability to care for herself, and began working with Ida on her activities for daily living. After the visit, the HHA Nurse contacted Ida's PCP to obtain medical orders to implement Ida's care plan.
- The HHA Nurse regularly visited Ida, evaluated Ida's vital signs and healing of her wound, and changed her dressings. Ida was doing well, so the nurse turned over the care management to a PT.
- The PT initiated Ida's home exercise program and taught her how to get in and out of bed and properly use her walker.
- During a PT visit, Ida had a flair-up of an old lung problem. This recurrence made it necessary for the HHA Nurse to reassess Ida's condition. The HHA Nurse notified the PCP who decided to change Ida's medications and begin home oxygen therapy.
- The Nurse arranged for the home oxygen equipment delivery from a Medical Equipment provider. The Medical Equipment provider trained Ida on how to use the oxygen equipment, and visited her several times over the course of her home health care.
- The OT also met with Ida several times to teach her how to dress herself, use a shower chair and complete household chores while using her walker.
- The Social Worker visited Ida and her daughter to educate them on the available community resources, including meal-on-wheels, financial assistance and transportation for doctors' appointments.
- The HHA Aide visited Ida several times a week to assist her with bathing, as well as follow up on her physical and occupational therapy exercise programs, until this was no longer necessary.
- After 60 days of home health care, the HHA Nurse, Ida and her daughter agreed that Ida had met the goals of her plan of care and was ready to be on her own. The Nurse contacted the Care Team and the PCP to discuss discharging Ida. The PCP agreed that it was appropriate to discontinue home care and each Care Team member developed discharge instructions for Ida and her daughter.
- The PCP reviewed the plan of care, which was developed by the Care Team and wrote notes and medical orders in the medical record that justified Ida's continued need for home health care, as required by the government.
- Ida was now able to resume her normal lifestyle, enjoying good health and time with her friends and family.



Paperwork Generated from Home Health Care

- Prior to Ida's first home health visit, the HHA Intake Clerk collected Ida's clinical information from the SNF, and entered her personal and medical information into the HHA's computer system. The Clerk then verified Ida's Medicare eligibility, in accordance with government regulations, and as required by government regulations, checked the "HIQH database" (Health Information Query for Home Health) in the Medicare Common Working file to verify that only one agency was providing HHA services.
- During the care planning stage, the HHA Nurse validated Ida's eligibility for home care based on Medicare regulations and verified the physician's orders.



- On the first home health visit, the Nurse reviewed with Ida a host of government-mandated forms and regulations, including advanced directives, Medicare Secondary Payer criteria, patient's rights and responsibilities and privacy rights. The Nurse then obtained her signature on the "consent to treat" and other authorization forms. The Nurse documented Ida's physical evaluation in the medical record, completed the HCFA 485 care plan form and completed the Outcome Assessment Instrument Set (OASIS) — all additional tasks and forms mandated by the government.
- A Clerk entered and electronically transmitted the OASIS to the State Department of Health (SDH), as required by government regulations. The Clerk received from SDH a Health Insurance Prospective Payment System code, a Home Health Resource Group classification, and a Matching Key which is used for Prospective Payment System billing — systems mandated by the government.
- The Billing Clerk was then able to file a Request for Anticipated Payment with the government's Medicare Carrier, the organization that pays claims.
- The Nurse obtained verbal orders from the PCP to implement the care plan and a Clerk sent Ida's written care plan and orders to the PCP for review and signature.
- The PCP signed and returned the care plan and the Clerk filed it in the medical record. To ensure regulatory compliance, the Clerk also notified the billing office that a signed care plan and medical orders were on file.
- Each time the Nurse, Therapists, Social Worker or Home Health Aide visited Ida, they documented their interventions in the medical record and coordinated Ida's care with each other, as mandated by the government.
- When Ida's lung problem recurred, the nurse completed another OASIS as required by government. The form was entered and electronically transmitted by the Clerk to the appropriate government authority.
- After 60 days of home health care, the Nurse, Therapists and PCP documented their judgments about Ida's discharge, and wrote discharge instructions and a discharge summary of the care they provided to Ida. The Nurse completed a discharge OASIS, as required by the government, and received verbal discharge orders from the PCP.
- The HHA Clerk transmitted the final OASIS to the SDH and obtained the PCP's signature for the discharge order, then filed it in Ida's medical record.
- The billing clerk filed the final claim with the government's Medicare carrier and tracked the collection of the bill.





AMERICAN HOSPITAL ASSOCIATION
One North Franklin
Chicago, Illinois 60606

WASHINGTON OFFICE:
Liberty Place
325 Seventh Street, NW
Washington, DC 20004-2802

www.aha.org