Newborn Hepatitis B Vaccine – Prior to Discharge

A survey conducted by the Center for Disease Control and Prevention (CDC) revealed that only 50 percent of newborns receive a dose of the hepatitis B (HepB) vaccine prior to discharge. The current recommendation for administering HepB is to give the first dose to medically stable infants weighing at least 2,000 grams (4 pounds 6.5 ounces) prior to hospital discharge.

When infants become infected with the HepB virus they have a 90 percent chance of becoming chronically infected, which can eventually lead to cirrhosis and liver cancer.

The CDC believes that delivery hospitals play a key role in the national strategy to prevent HepB transmission and recommends that hospitals have policies and procedures in place to ensure that HepB vaccination is administered to all newborns before they are discharged.

Many parents fear possible vaccine side effects and refuse the vaccine due to misguided and false information from family, friends and medically unsound Web sites. We encourage our network hospitals to be compliant with the Advisory Committee on Immunization Practices and CDC current recommendations. Providing education and discussion of the benefits of vaccinations can help allay parental fears about possible side effects and help increase the number of infants receiving the protection of the HepB virus vaccine in a timely manner.

Making Mammography Easier

Mammography is the only screening tool proven to reduce mortality from breast cancer in women over age 40. Yet, the National Cancer Institute has reported that only 66 percent of women age 40 and older get annual mammograms, which is three million less than just five years ago.

A randomized clinical trial published in the July 22, 2008, issue of Radiology demonstrated a significant reduction in breast discomfort during mammography with the topical application of a four percent anesthetic gel, which is available over the counter. Women who received either oral acetaminophen or ibuprofen prior to the mammogram experienced no significant difference in breast discomfort.

Study results indicated that the anesthetic gel had no effect on subsequent image quality.

Most women expect discomfort during mammogram, which is a common reason women avoid the procedure. Eighty-eight percent of the study’s participants indicated they would definitely repeat the mammogram the following year. Having some control over the expected discomfort may be just what women need to encourage annual screening. Your hospital and outpatient radiology departments may want to consider offering or planning for topical anesthetic gel application prior to mammography.
Combating Post-Discharge Noncompliance

Even with the most careful discharge planning, an alarming number of patients fail to obtain the recommended post-discharge follow-up visits and care after leaving the hospital. Noncompliance with post-discharge follow-up occurs for various reasons, and makes relapse and readmission more likely.

While no measure of discharge planning can guarantee 100-percent compliance, studies have shown that patients who have follow-up visits scheduled before leaving the hospital tend to complete these visits more often than those who are instructed to schedule the visit themselves.

We know that it is not possible for you to schedule visits for all discharged patients, but it is important for high-risk populations, such as patients hospitalized for mental illness. (We request that you make all efforts to schedule Medical Mutual patients for the first follow-up appointment within seven days of discharge before they leave the hospital). Patients hospitalized for pneumonia are another high-risk population that benefit from having a scheduled appointment for a follow-up chest X-ray within six to eight weeks of discharge to ensure resolution of the infiltrate. Many of these patients feel better long before the six- to eight-week time period and neglect to obtain this important X-ray.

Make sure your patients understand the importance of post-discharge follow-up, and schedule important follow-up visits for the patient when there is a high risk of noncompliance.

If you need assistance finding a network provider that can provide post-discharge care, please contact our Behavioral Health Case Management department at 800/258-3186.
Continuity of Care

Preventing Adverse Events after Discharge

Continuity of medical care following hospital discharge is critical, especially for older patients. A breakdown in the transition process can lead to gaps in care, worsening symptoms, readmissions and medical errors. Common issues that lead to adverse events post-hospitalization include:

- Confusion regarding medications schedule and self-care instructions
- Prescriptions are not filled
- Follow-up appointment is scheduled too late
- Untimely and inadequate communication between inpatient healthcare providers and the outpatient healthcare providers

Patient education is key

To promote a smooth transition, the patient and family caregiver need to understand the medication and self-care needs prior to the discharge date. To ensure the patient and/or family caregiver understand ask them to repeat in the home instructions. The patient education and discharge checklist should include the following:

Medication

- The name of each medication and why it is needed (pre and post-hospitalization)
- The dosing schedule for each medication
- What pre-hospital medications are to be continued
- Any changes in the dose or frequency of pre-hospital medication
- What new medication is being prescribed
- The possible medication side effects and who to contact if they occur
- Who will pick-up the patient’s medication
Self-care

- What symptoms may indicate a relapse
- Who to call if symptoms occur
- What lifestyle changes are needed (e.g., diet, tobacco use, physical activity)

Follow-up care

- What outpatient appointments are needed
- The name, address and phone number for each healthcare provider
- Available transportation for outpatient care

Foster communication between healthcare providers

Healthcare professionals providing follow-up care need timely and complete discharge information. Strategies to improve communication include:

- Confirming the PCP at the time of admission
- Involving all community healthcare providers when the discharge and transportation plans are executed
- Sending a comprehensive discharge summary, including a reconciled medication list, to appropriate providers via the preferred method (e.g., fax, mail, phone)
- Scheduling appointments for high-risk patients prior to discharge

Improvement in the discharge process can create a smooth and safe transition from hospital to home. For a complete guide, visit the Institute for Healthcare Improvement Web site at ihi.org.

Coding for Neonates

Coding newborns can be challenging, but there are a few quick steps that will simplify this process.

1. Code the birth of the infant as the principal diagnosis.
   - Assign a code from categories V30-V39 to indicate the type of birth.
     - A code from the V30-V39 range is not appropriate if the infant has been transferred from the birth hospital to your hospital or if the infant has been readmitted after discharge.

2. Code all clinically significant conditions as additional diagnoses. A condition is considered to be clinically significant if it requires any of the following:
   - Clinical evaluation
   - Therapeutic treatment
   - Diagnostic procedures
   - Extended length of stay in the acute care setting
   - Increased nursing care or monitoring
   - Has implications for future healthcare needs

Example:

Scenario: Baby Boy Reed was admitted to the neonatal intensive care unit (NICU) immediately after delivery. He is twin A; delivered at 30 weeks gestation via cesarean, and twin B is also a liveborn. Baby Boy Reed, twin A has a significant clinical issue of prematurity.

Coding Steps:
1. First, code the birth. The most appropriate principal diagnosis code is V31.01, which indicates a twin birth, both liveborn, and born in the hospital via c-section.
2. Secondary codes would be necessary for prematurity. Based on the available information, the most appropriate codes are 765.10 (other preterm infant, weight unspecified) and 765.25 (29-30 completed weeks of gestation).

Coding Chronic Obstructive Pulmonary Disease (COPD)

COPD develops when there is chronic obstruction to the airflow. Conditions comprising COPD include:
- Chronic Obstructive asthma (493.2x)
- Chronic Obstructive bronchitis (491.2x)
- Emphysema (492.8)
- Chronic Bronchitis with emphysema (491.20)
Correct coding of COPD depends on whether an acute condition is associated with it and on the accurate identification of the specific condition responsible for the airway obstruction. When the diagnosis is given as COPD only, coders should review the medical record for documentation of a more definitive diagnosis. If no definitive diagnosis is documented, COPD should be coded with 496: Chronic airway obstruction, not elsewhere classified.

Generally, COPD has two patterns of symptoms that occur; progressive worsening of underlying lung function (progressive dyspnea, fatigue and exercise intolerance) and intermittent exacerbations from upper respiratory or lung infections. These conditions are often concurrent. Treatment for COPD includes increased bronchodilators, antibiotics, IV corticosteroids and evacuation of secretions.

Since these same treatment modalities can be seen in other chronic conditions, such as bronchitis and asthma, accurate coding of COPD can be challenging.

<table>
<thead>
<tr>
<th>COPD Coding Examples:</th>
</tr>
</thead>
<tbody>
<tr>
<td>491.20 Chronic Bronchitis with COPD</td>
</tr>
<tr>
<td>491.21 Chronic bronchitis with acute exacerbation of COPD</td>
</tr>
<tr>
<td>491.22 Acute bronchitis with COPD with acute exacerbation</td>
</tr>
</tbody>
</table>

When coding COPD, it is important to review the index first and then verify in the Tabular list, which is in Volume 2. The tabular list will verify if your code selection is appropriate and correct.

Guidance for proper code selection may be found in the instructional notes listed under the different codes and subcategories of COPD.

Support is available
The American Hospital Association (AHA) Coding Clinic provides numerous coding guidelines/clarifications to help with accurately coding COPD.

The Uniform Hospital Discharge Data Set (UHDDS) is required for reporting Medicare and Medicaid patients in the inpatient acute care, short-term and long-term care hospitals.
It is a well-known fact that even brief physician advice to quit tobacco use increases the likelihood of a patient successfully quitting. However, studies have shown that advice from nurses and other healthcare providers also can have a positive impact and contribute to a higher success rate for quitting.

Every hospital healthcare team member should promote the benefits of quitting tobacco. The more patients hear the same message, the more likely they are to attempt to quit. Even hard core smokers who are frequently admitted may eventually get the message if they hear it often enough.

Our Company has developed several useful smoking cessation tools for healthcare providers. All of the tools are designed to help healthcare providers offer the necessary motivation and support in a minimal amount of time.

**Provider smoking cessation tools include:**

- Tobacco Dependence Clinical Practice Guidelines – evidence-based information concerning diagnosis and treatment
- Tobacco Dependent Chart Identification Stickers – to distinguish each patient who smokes
- Physician Pocket Guide – a quick reference for smoking cessation tips and resources
- Smoking Cessation Fact Sheets – patient handout
- Prescription Pad – patient handout

To obtain provider tools contact the Clinical Quality Improvement department at 800/586-4523.

*Remember – The entire healthcare team can make a difference!*
Influenza and pneumococcal infection cause disease in all age groups, but rates of serious morbidity and mortality are highest among persons 65 and older and persons of any age who have medical conditions that place them at high risk for complications.

The inpatient hospital setting and emergency department offers a unique opportunity to reach a segment of the population who may not seek consistent preventive care and who are not identified with a medical home (primary care practice). Optimizing contact with this patient population requires a strategic plan.

Standing orders have been shown to be the most consistently effective means for increasing vaccination rates in the adult population. The Independent Task Force on Community Preventive Services (communityguide.org) and Advisory Committee on Immunization Practices (cdc.gov/vaccines/recs/acip) recommend the use of standing orders based on strong evidence of effectiveness with adult populations. When standing orders for influenza and vaccination of persons 65 and older were implemented in a group of community hospitals, the vaccination rate improved to 40.3 percent compared to 9.6 percent using patient educational programs only.

Another effective intervention is utilization of chart reminders. These can be colorful stickers applied to the patient’s chart to alert the physician that the patient is due or overdue for an influenza or pneumococcal vaccination.

Take advantage of every patient contact to assess vaccination status. Consistent implementation of one or more intervention strategies can improve and maintain high levels of vaccination coverage and low rates of vaccine preventable diseases.
It remains a goal of the Company to ensure members receive high-quality, medically necessary healthcare. To further support this initiative, we are developing a corporate policy to address “Preventable Adverse Events,” which are defined as clearly identifiable errors in medical care that have preventable and serious consequence for patients\(^1\). While this definition could be applied in many clinical situations, a complete list is available from the National Quality Forum (qualityforum.org.)

“Preventable Adverse Events” often result in increased cost as well as serious injury or death to the beneficiary of such care. In 1999, the Institute of Medicine (IOM) estimated that as many as 98,000 deaths a year were attributable to medical errors. An additional IOM study included review of 18 types of medical events and concluded that medical errors may account for 2.4 million additional hospital bed days, $9.3 billion in excess medical charges (for all payers) and 32,600 deaths each year.

In response to this important quality concern, the Company is currently determining appropriate responses to known “Preventable Adverse Events” to address proper notification requirements and payment issues. Communication regarding the Company’s finalized response and action plan will be available in future publications.

\(^1\)National Quality Forum
The Ohio Immunization Partners for Healthy Adults (OIPHA), an Ohio KePRO partner, is offering a free, comprehensive packet of information to help you prepare for the upcoming influenza and pneumonia season.

The packet includes:

- Laminated pocket guide summarizing indications, precautions and dosing, plus “Talking Points with Patients”
- Screening questionnaires, standing orders and consent forms
- 2008 Vaccine Composition and Dosing Recommendations
- Vaccine Information Sheets (VIS) and other patient education
- Immunization coding and Medicare payment guidelines

To view the materials, visit: ohiokepro.com/OIPHA/resources.aspx. To order materials, contact Liz Simpson at 216/447-9604.
Electronic Certification for Behavioral Health Reviews

The Behavioral Health department will soon implement ReviewLink, a Web-based process for inpatient medical necessity review. The implementation is being targeted for first quarter of 2009. ReviewLink enables facilities to submit, via the Web, demographic and clinical review information in user-friendly, HIPAA-secure format.

This method eliminates the need for waiting on the phone and allows for around the clock ability to submit the certification information.

ReviewLink is in place and being utilized to submit a broad range of medical/surgical reviews so many contracting providers may already be familiar with utilizing the ReviewLink system. If you have questions about the ReviewLink system, contact Kristen Shordt at 419/473-7272.

In the near future you will be contacted or will receive information regarding security access, training and implementation.