

Implementation of a System Process to Improve Compliance with the NOTICE Act

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Abstract

Problem: The current practice at a large urban medical center did not include a standardized process for the use of the new Medicare Outpatient Observation Notification (MOON) form; patients were not being informed about the implications of the cost of care related to being placed in observation status (OBS). **Objective:** The aim of this scholarly project was to implement and evaluate a standardized process for implementing the Notice of Observation Treatment and Implication for Care Eligibility Act, or NOTICE Act including a policy and procedure (P&P) and a teaching plan to deliver the MOON form. **Design:** This quality improvement project evaluated the implementation of a standardized process including the use of a policy and procedure to formally direct how the MOON form was delivered at a large urban academic medical center. **Sample:** A convenience sample of 346 Medicare beneficiaries who arrived at the medical center through the emergency department and were placed in OBS during a four week data-collection period. **Methods:** The DNP Project Leader (PL) developed a P&P and used one-on-one sessions to train and evaluate each of the Clinical Resource Specialists (n=12) to deliver the MOON form to these patients. The PL collected data for four weeks using chart audits on the rates of completion for the MOON. Additional reports were generated to identify when the MOON was not delivered or not delivered within 36 hours, the time mandated by Medicare. **Results:** There were 346 Medicare beneficiaries placed in OBS during the four weeks; 43 patients were changed to inpatient status or discharged before 24 hours, leaving 303 patients placed in OBS. Of those, 253 (83.5%) had a completed MOON form documented, 241 (95.6%) of which were delivered to the patient before 36 hours. Fifty (16.5%) patients did not receive a MOON form. **Implications:** Putting a standardized P&P into use could facilitate the standardization of the teaching of all providers and can help to ensure compliance with the NOTICE Act. It is anticipated that if providers are taught the standard and its implications for

both the patient and the organization, providers will be better prepared to communicate this information to the patients in a consistent manner.

Implementation of a System Process to Improve Compliance with the NOTICE Act

Patients who present to an emergency department can be treated and released, admitted as an inpatient or placed in observation status (OBS). This designation process has caused confusion with some of the more vulnerable patient populations, such as Medicare beneficiaries, because patients in OBS have been frequently placed in the same area of the hospital as inpatients, where they spent the night and received similar nursing care (Kaiser Family Foundation, 2016). Patients placed in OBS received outpatient services reimbursed under Medicare Part B. However, patients who required a higher level of care were admitted as inpatients and covered by Medicare Part A benefits (Centers for Medicaid and Medicare Services [CMS], 2016c). This distinction between what is paid for by Medicare Part A and Medicare Part B and the information provided to the patient about these costs contribute to confusion and rising concern from patient advocacy groups (Medicare Payment Advisory Commission [MEDPAC], 2015).

The main difference between the two payment sources is that Medicare Part A pays for an inpatient admission with a single fixed deductible cost to the patient. The cost to the patient for observation services covered by Medicare Part B is a sum of several deductibles of outpatient and physician services. One example of the increased cost of observation status versus the inpatient cost in an Illinois hospital was \$2,166 plus the cost of medications and \$1,260, respectively (IllinoisHealthMatters.org, 2016). Additionally, routine outpatient medications that the patient took daily at home were not covered under Medicare Part B, so these costs were likely incurred as out-of-pocket expenses while the patient is in observation status.

It is essential to note that Medicare Part B does not pay for a skilled nursing facility, or SNF. In order for a Medicare beneficiary to be eligible for reimbursement of SNF cost, they must spend a qualifying three midnights as an inpatient, and that is paid for by Medicare Part A

benefits. The cost of a SNF stay for a patient not covered by Medicare Part A may be staggering. According to Genworth Financial (2015), estimates of the typical SNF cost in the Mid-Atlantic US area averaged \$300 per day. In contrast, a Medicare beneficiary who is discharged to SNF after an eligible inpatient stay pays nothing for the first 20 days. Therefore, the cost of continued health care services are also affected because these patients placed in OBS are not eligible for reimbursement of any skilled nursing facility (SNF) charges after discharge from the hospital (CMS, 2016c; Kaiser Family Foundation, 2016).

According to the Kaiser Family Foundation, almost 1.9 million Medicare beneficiaries were placed in OBS nationwide in 2014, which was double the number similarly placed in 2006. Since OBS is not covered by Medicare Part A, the sheer number of Medicare beneficiaries affected over the past 10 years has brought this issue to the forefront, predominantly because patients reported they had not been informed of being placed in OBS. Patients and families were surprised, if not outraged, when they received a bill in the mail for their hospital stay (Society of Hospital Medicine, 2014). The use of dedicated medical observation units continues to increase across the US, and it has been reported that the costs of observation care remain less than inpatient costs of care, which makes them effective financial tools for hospitals (Abbass et al., 2015).

The lobbying effort by patient advocacy groups about the increased cost burden associated with OBS led to town hall meetings, Congressional Listening Sessions, and a class action suit co-counselled by the Center for Medicare Advocacy (Center for Medicare Advocacy, 2016). These efforts led to a change in federal legislation, and in August 2015 the Notice of Observation Treatment and Implication for Care Eligibility Act, or NOTICE Act, was passed (MEDPAC, 2015). This law enabled Medicare to require each hospital to give each individual

who qualifies for Medicare benefits and who is placed in observation status for more than 24 hours written and oral notification no later than 36 hours after initiating services (NOTICE Act, 2016). The written form, called the Medicare Outpatient Observation Notice or “MOON”, (CMS, 2016d) must include implications of cost and subsequent coverage eligibility for SNF care (CMS, 2016b). The expectation of legislators is that if institutions adhere to this law, patients and providers will engage in meaningful conversations regarding health care costs and reimbursement implications. Subsequently, there was a delay in the implementation date of the NOTICE Act, to March 8, 2017 (CMS, 2016a).

The current practice at this large urban academic medical center did not include a standardized process for the use of the new MOON form; Medicare beneficiaries were not being informed about the implications of cost related to being placed in OBS. The only existing process was for the clinical resource specialist (CRS) team to notify the patient that he or she had been placed in OBS. Patients signed a courtesy letter, called an ‘OBS letter’, that stated they had been notified of their observation status. However, not all patients received this OBS letter for any number of logistical reasons such as the patient was in a diagnostic test; was discharged before the CRS arrived, or another medical reason. According to MEDPAC (2015), these patients were also at risk for increases in their financial liability should they be transferred to a rehabilitation center from OBS, which may affect their future ability to seek or access care.

The purpose of this scholarly project is the implementation and evaluation of a standardized process to formally direct how the MOON is delivered to the patient, signed, and documented at a large academic medical center in order to meet the mandate of the NOTICE Act. Putting a standardized process into use facilitates the teaching of all providers and can help to ensure compliance with the NOTICE Act which will promote consistency and reflect best

practices (Long, Burkett, & McGee, 2009). The potential significance of this project was the expectation of increased knowledge of the patients, compliance with the federal law, and improved communication amongst the different levels of providers. An economic outcome can be measured by a cost benefit analysis: The cost of regulatory compliance using a standardized process versus the status quo (no process). This includes training, the staff, time, and administrative costs to follow the policy and procedure to deliver the MOON. Additionally, an anticipated outcome was to improve the rates of completion of the MOON and the hope that this meaningful information would lead to an improvement in patient education outcomes.

Theoretical Framework

Donabedian's (1988) model has been used to examine healthcare services and evaluate the quality of health care. Donabedian (1988) distinguishes in the model the importance of identifying key aspects of structure and process that drive an organization in its quest for improved outcomes. Each component-structure, process, and outcomes-is independently important yet directly linked to the other, and each must be systematically addressed. It is this relationship of the triad of the concepts of structure, process, and outcomes that makes it an appropriate framework in health care systems, especially as it can be used to guide improvements of health care outcomes (Richards, Qu, Shewchuk, & Chen, 2010). The propositions of these concepts are explicitly related such that the structure and process can be measured and manipulated and this in turn can produce improved outcomes.

Specifically, incorporating Donabedian's model to address this clinical practice problem seemed reasonable as the proposed solution was identified, and involved implementation of a standardized process such as the P&P, and delivery of provider and patient education related to the NOTICE Act. In identifying the concepts within this model as they may apply to this

problem, the structure was represented by the hospital, personnel, existing culture, policies and procedures. The staff training, the development of a standardized process, and most importantly the buy in from the stakeholders and leadership were crucial to ensure that there were resources available to implement this new process. This process consisted of having the providers implement the proper notification (teaching) to the patient to include the cost implications of observation status, as well as the communication and interactions among all parties involved. The intended outcomes were increased rates of completion of the MOON and the expectation that this meaningful information would lead to an improvement in patient education outcomes. This simple model, involving those clearly defined concepts, was used to inform, guide, and implement a clinical practice solution.

Literature Review and Synthesis

The NOTICE Act is a new federal legislation. As such, this writer was unable to find any published accounts of how hospitals are implementing the notification and documentation of the MOON to their patients placed in OBS. In one article that targeted health care organizations, specifically the compliance issues required of the NOTICE Act, Brown (2017) stressed the importance of preparation to operationalize this new process by collaborating with the utilization management department to check on any policies and forms that will need to be revised or developed. There is evidence of the importance of P&P in nursing practice and how a standardized process improves outcomes of care in similar clinical settings. This key link between putting standardized care processes in place to improve care outcomes was the focus of this literature review. The review began broadly with the evidence supporting the utility of P&P in health care and the value of integrating evidence into nursing policy. This discussion followed with a review of several studies that implemented a standardized process, such as a P&P, to

address a practice issue, improve compliance, and improve patient outcomes. This evidence supported and informed what was proposed in this scholarly project. An expert opinion, a descriptive report of a practice change, one quality improvement project, and two quasi-experimental research studies were reviewed for their outcomes and recommendations to address standardizing a process with development and implementation of a policy and procedure (See appendix A).

Randolph (2006), an instructor of occupational health nursing, provided an expert opinion on the development and implementation of P&P in occupational health to guide the practice of the nurse to affect standards related to health and safety. Among the uses of P&Ps the author discussed the importance of the process of developing policy to meet gaps in practice or to meet a government standard such as a Medicare reimbursement regulation, as in this writer's scholarly project. The author identified the utility of policy development such that a P&P serves as the foundation of an institution's practice, and how these processes are effective in supporting resource management and collaboration, which can be generalizable to any health care system. Additionally, the author provided an example of a P&P template as well as the detailed steps to developing a system based P&P. Finally, the author promotes a collaborative based approach with members of the occupational health staff and members of the health team. Team members can collectively engage in broader, creative thinking, and write effective P&Ps.

In the descriptive report of a practice change at a large academic medical center, the value of incorporating evidence of safety into existing nursing policies and procedures was discussed by Long, Burkett, and McGee (2009). An interdisciplinary team including advance practice nurses, a medical librarian, senior nursing leadership, legal services, nurses, and members of their Policy and Procedure Committee was charged to incorporate evidence into 32

existing nursing P&Ps. In six months they developed a template for the policy revision, identified a system and framework for change, completed the revisions of the 32 nursing P&Ps, and rolled out an educational plan for the dissemination of the revised P&Ps in their medical center. The authors concluded that the development of this process of integrating evidence into the nursing policies supported the mission of the organization and improved the consistency in the practice of the point of care nurses. The strength of this report of a performance improvement process was the successful use of a team, their development of a template for the policy and the system wide education plan roll out.

In the next example, implementation of a standardized process was used to address a compliance issue related to the reporting of two Core Measures, which are requirements of CMS for reimbursement. This quality improvement project by Kwan, Daniels, Ryan, and Fields (2015) was prompted by chart audits that reported unacceptably low rates of compliance with venous thromboembolism (VTE) prophylaxis and hospital based inpatient psychiatric services (HBIPS) Core Measures. At a large regional health care system hospital, a team of clinical nurse specialists and nurses developed and implemented a standardized process including a nursing education tool and a documentation component to address this clinical issue and improve adherence rates to those selected Core Measures of all patients in selected units. After implementation of this standardized practice, compliance with VTE prophylaxis and HBIPS Core Measures improved from 66.7% to 90% at four months, and from 8.3% to 97.2% at six months, respectively. The limitation of this study was the team described by the authors included only nurses and clinical nurse specialists. However, the strengths were that the results demonstrated that the use of a standardized process was successful in improving a Medicare compliance issue and the education tool they developed could be used throughout the system.

Furthermore, the authors use a quality improvement framework integrating the Toyota production system's 4 rules and Lean Six Sigma Methodology, an audit and feedback model similar to Donabedian's model.

The highest level of evidence reviewed comes from two quasi-experimental pre- and post-intervention studies, the first of which is by Cook, Thompson, Suri, and Prinsen (2014). This research team posited that it was the variations in health care of their cardiac surgical service in a large academic medical center that were a source of high cost and reduced quality. These variations in clinical care negatively affected their reporting of Surgical Care Improvement Project (SCIP) quality metrics. Compliance with SCIP is closely associated with decreased incidence of catheter associated urinary tract infections, which affects Medicare reimbursement. The purpose of their study was to improve the quality of care by decreasing the duration of indwelling urinary catheter use with the implementation of a standardized care model. This standardized care model included education of staff and an electronic prompt in the electronic medical record (EMR) to flag items needing attention from the care team as a reminder system. Following the implementation of this standardized care model, the duration time of indwelling urinary catheters was dramatically reduced, and subsequent compliance with SCIP quality metrics was significantly improved. This study provided strong evidence that implementing a process was effective in improving the compliance among hospital workers with a Medicare reimbursement issue. Additionally, a strength was the development of a reminder tool to be used in the EMR to reinforce the expected behavior: removal of the indwelling urinary catheter. The limitations are that the authors did not include the details to put this standardized process in place. Also, there was no mention of the composition of the research team, but it was

noted that a multidisciplinary care team of nurses, nurse practitioners, physicians, and physician assistants implemented the standardized care model.

The last piece of evidence included in this review comes from another quasi-experimental pre-post intervention study by Fus, Kimm, Haw, Trohman, and Stephan (2007). The purpose of their study was to improve compliance to the evidence based guidelines related to anticoagulation practice in an electrophysiology (EP) lab of a large academic medical center by the implementation of a written policy. These guidelines reflect strong evidence that risks of stroke are reduced when therapeutic anticoagulation occurs prior to cardioversion of atrial fibrillation. The authors found that variances in practice affected the compliance to these guidelines. This retrospective study involved a team approach of the nurse leader and the medical director to develop a policy and disseminate it to all providers using the EP lab. Following the implementation of the written policy, the rates of noncompliance to the anticoagulation guidelines at one year decreased significantly ($p=.03$). The strengths of this study were the use of a policy and a multidisciplinary proactive team approach to improve rates of compliance.

In summary, there was evidence that development and implementation of evidence based policies and procedures could be used to address compliance issues, specifically those that affect reimbursement with Medicare, (Cook, 2014; Kwan, 2015) such as the implementation of the NOTICE Act. An outcome following development and adherence of a policy in two studies would be decreased care costs (Cook, 2014; Kwan, 2015). It was hoped that the integration of evidence into P&Ps could lead to future implications such as research into outcomes related to length of stay and nurse work flow (Long, 2009).

Based on the review of these articles, there was valuable information to support the evidence for the implementation of a P&P to address this paper's stated practice problem. There were similar components associated with the development of a P&P throughout this literature review. Several of the authors discussed the education component that was disseminated along with the P&P implementation in order to address any knowledge gaps and provide consistent training (Fus, 2007; Long, 2009; Cook, 2014; Kwan, 2015). The use of a collaborative team or multidisciplinary approach is a well-known strategy to implement change (Weiss & Tappen, 2015). This type of team approach was an advantage when used to develop a policy or a standardized process and was promoted by all of the authors (Randolph, 2006; Fus, 2007; Long, 2009; Cook, 2014; Kwan, 2015). Finally, several of the reviewed articles included discussions by the authors of the development and use of a policy template or a reminder tool for the staff involved (Randolph, 2009; Long, 2009; Cook, 2014). In conclusion, there was strong evidence across the literature review of the association between implementing a policy and realizing improved outcomes (Randolph, 2006; Fus, 2007; Long, 2009; Cook, 2014; Kwan, 2015). It was the hope of this writer that incorporating the components of a collaborative approach to implementing a P&P, along with an appropriate staff education plan with durable resources, would result in a consistent process of meaningful information to the patients. This would also result in improved completion rates of the MOON and lead to improved patient education outcomes. For the evidence review rating and grading table refer to the Appendix A.

Protection of Human Subjects

Prior to implementation of the project, a query was submitted and approved by the University of Maryland Baltimore Institutional Review Board for a Non Human Subjects Research determination (Appendix G). A proposal was submitted and approved by the

Institutional Review Board of the medical center at which the project was implemented.

Additional measures to protect any health information are that data were reported as aggregate only. No identifying data for either employees or patients was collected and all data was stored on a password protected computer.

Methods

Design, Setting, and Sample

This was a prospective quality improvement project to evaluate the implementation of a standardized process including the use of a P&P to formally direct how the MOON was delivered to patients, signed, and documented at a large urban academic medical center in the mid-Atlantic region of the United States. A convenience sample of Medicare beneficiaries who arrived at the medical center through the ED and were placed in OBS during a 32-day period was selected. The sample size was 346. Inclusion criteria included patients who were classified as observation during their entire encounter at the medical center. Exclusion criteria include patients who were reclassified as inpatients prior to being discharged or those patients who left against medical advice. This project was originally intended to be a pre/post intervention study to evaluate the effect of a standardized process on a required practice change. However, as CMS delayed the actual implementation date of the NOTICE act, it became clear there would not be any “pre intervention” data to collect. CMS eventually set the date for implementation of the NOTICE Act at March 8, 2017, which coincided with the start date of the DNP project intervention.

Procedure

Staff training. The DNP Project Leader (PL) identified and accessed the stakeholders in the department that included the Director and two nurse managers. The PL developed the training materials during two strategic meetings with the stakeholders. The PL is a long time employee of the medical center and this relationship facilitated access to institutional electronic resources, physical access to the ED and all the patient units. The project began with training the members of the CRS team who had been charged by the medical center with getting the MOON delivered to all patients receiving Medicare benefits as per the NOTICE Act mandate (CMS, 2016e). The training of the CRS team (n=12) occurred over the first two weeks of the project. The training took one hour per session, and was delivered in groups of two learners over six sessions. The content included the background on the NOTICE Act, a review of CMS documents, the organizational P&P to deliver the MOON, instructions for the MOON form from CMS, the documentation process in the EMR, in Allscripts, the software platform that connects directly to Medicare, and a review of pertinent regulatory standards.

Training occurred in a classroom setting and consisted of an active learning format including a brief lecture on the formal content and a simulation by the PL demonstrating the delivery of the MOON to a patient using the script. There was an opportunity for each CRS to practice the scripted process with the PL in the simulation environment using role play and then practice the documentation of the MOON in Allscripts. There was a script developed from a similar template for the CRS team to use to deliver the MOON. Finally, the PL observed each CRS deliver the MOON to a patient in the clinical setting, and provided feedback and reinforcement as needed. During the training, each CRS received a copy of the CMS publications “Instructions CMS 10611,” “Supporting Statement for the Medicare Outpatient Observation Notice CMS-10611,” (CMS, 2016f), a copy of the P&P (Appendix B), a script to deliver the

MOON (Appendix C), a one page handout summary of the training (Appendix D), and “MOON”/Form AMC02762”(Appendix H). Additionally, documentation samples were provided to each CRS for them to use to provide consistency in the EMR (appendix F). A laminated job guide with the script on one side and the brief step-by-step process for delivering the MOON was also provided to each CRS.

Implementation. Within 2 weeks of the training, the CRS team implemented the new scripted delivery of the MOON to the patients, the signing of the MOON and the documentation process in the EMR. The PL evaluated each of the CRS team on seven different days over six weeks of project implementation. The PL routinely monitored the process of the delivery of the MOON by the CRS team in both the ED and other areas in the medical center by observing the CRS-patient encounters, attending the morning CRS huddles, and providing support as needed over the six weeks. The PL provided hands on support on ten different days, which amounted to around 40 hours, and was available by email for questions the entire project.

Data Collection

The nurse managers provided orientation and access to Allscripts to the PL. The PL collaborated with the informatics worker in the department to identify the data fields in the EMR for the reports which would provide the CRS team with the information to deliver the MOON: time/date placed in OBS and verification of Medicare B beneficiary. The PL collected data daily over a six week period on the rates of completion for the MOON by daily chart audits for the previous day. Out of these six weeks, a 32 day sample was selected (n=346 patients). There are two clinical outcomes that will be measured. The medical center wants to make sure the MOON is delivered to each Medicare beneficiary placed in OBS and Medicare states the MOON must be delivered in a timely manner, before 36 hours since they were placed in OBS. The primary

clinical outcome is the MOON completion rate. The conceptual definition of a completed MOON is the delivery of the MOON form to the patient by the CRS. This includes the verbal notification, signing the form, and documentation in the EHR, in Allscripts. The operational definition of the MOON completion rate is “the number of MOONs completed/total number of MOONs that need to be completed.” The secondary outcome is the MOON timely documentation rate and the conceptual definition of this is the number of hours from when the patient is placed in OBS and the CRS documents the delivery of the MOON in Allscripts. The operational definition of the MOON timely documentation rate is “the number of MOONs documented within 36 hours/ total number of MOONs that need to be completed.” The documentation process for the CRS team was revised during the fifth week after reviewing feedback from the CRS team and the PL. This revision allowed for more accurate documentation and allowed for the data to be collected and audited easier. Reports were generated by the department twice each day at 0800 and 1400 to identify the names of patients who were placed in OBS. These reports were used as task lists to guide the workflow in the department. The data was collected on the MOON Collection Tool and entered into a Microsoft Excel spreadsheet for further data analysis (Appendix E).

Data Analysis

Data on the number of Medicare beneficiaries placed in OBS, the time they were placed in OBS, the time the MOON was delivered, and the completion rates for the MOON forms was calculated over 32 days, (n=346). Descriptive statistics (including mean, median) were calculated to discuss the completion rates of the MOON.

Results

There were 346 Medicare beneficiaries placed in OBS during the 32 days of the data collection period; 43 were switched to inpatient status or discharged before 24 hours, leaving 303 patients placed in OBS, eligible to receive a MOON. Of those, 253 (83.5%) had a completed MOON documented in the EMR, in Allscripts. There was one patient outlier who was in the hospital months prior to the implementation of the NOTICE Act. There were 241 (79.5%) MOON forms delivered before 36 hours, which met the Medicare mandate of the MOON must be delivered before the patient has been in OBS more than 36 hours. The average time between a patient being placed in OBS and having the MOON delivered was 17.1 hours; the median time was 15.7 hours. The longest duration between when a patient was placed in OBS and the MOON was delivered to them was 66.7 hours; the shortest time was 1.1 hours.

There were 50 (16.5%) patients who did not receive a MOON form. Of those, nine patients received courtesy OBS letters (incorrectly), and 13 charts were documented as initially “attempted” to deliver but included no documented successful follow-up.

Discussion

The utilization of a standardized process to implement the NOTICE Act at this large urban academic medical center was successful, based on achievement of the proposed outcome measures. The medical center leadership wants to make sure the MOON is delivered to each Medicare beneficiary placed in OBS so that the patient will be informed of the cost implications and so that the medical center can be eligible to receive the maximum reimbursement for those services. Medicare states the MOON must be delivered in a timely manner, within 36 hours of being placed in OBS. The MOON completion rate was greater than 83% in the first four weeks of implementation. Of those MOONs that were delivered, over 95% were delivered in a timely

manner. Medicare has not identified a benchmark for compliance and there was no specific benchmark established by this medical center in terms of the completion rate of the MOON at the onset. The leadership and compliance office will no doubt be tasked to integrate this new Medicare mandate into an effective compliance program, however identifying a target is beyond the scope of this project. It is reasonable to suggest that the medical center will use aggregate completion rates for measures of organizational readiness and evaluate individual CRS workers by auditing their completion rates.

The published literature indicates a collaborative approach is an effective driver to ensure the success of a practice change, and that notion was demonstrated in this project. This writer systematically identified and met with all stakeholders, including leaders from nursing, medicine, utilization management, and other essential staff. Tailoring the interventions to meet the specific practice requirements are critical (Wensing, Bosch, & Grol, 2013). The P&P, training materials, and resources were developed with collaboration from the Director and nurse managers in the department, and were based on existing templates in the department, which provided strong leverage. The long term relationship the PL has with this medical center including familiarity of the staff, the access to electronic and physical resources, and access to such a deep field of stakeholders is a significant facilitator for the success of this project.

The medical center had targeted the CRS team to deliver the MOON. These workers are administrative employees with no specific teaching skill requirements. The laminated job guide was developed by this writer in order to provide something immediate and durable for the CRS team to use until they became more comfortable and proficient with their new teaching role. The informatics liaison with the department was consulted to develop a report to drive the task list

based on data fields found in the EMR. It took a few iterations before the report efficiently and accurately displayed the data that was necessary for the CRS team to deliver the MOON forms.

One- on-one training sessions for the targeted CRS team utilized direct observation and audit/feedback as teaching strategies. In order to meet the medical center's departmental training criteria, each training session was evaluated by a post test (collaboratively written but not formally validated). The post test questions addressed the compliance aspects of the MOON such as the cost implications, time frame to deliver the MOON, and where the CRS might obtain resources. Each CRS underwent a direct observation evaluation at the bedside by the PL. The PL solicited verbal and written feedback after each training session. The results from the evaluations indicated that the training materials were useful, the format was conducive to learning, and the workers felt that the training gave them information to allow them to perform their job effectively. Monitoring the knowledge translation was an ongoing process, which involved regular contact with the Director and the nurse managers to review the reports and the evolving data collection. There was follow up with the CRS team, as well as biweekly department meetings. There was a final review training at the end of the six weeks to reinforce any subsequent changes in practice, such as the change in documentation process, a review of the reports, and the process for the weekends.

Donebedian's theory of Structure/Process/Outcome turned out to be a valuable framework as it helped guide the project forward and provided a way to address the problems and changes along the way. This quality improvement project involved many revisions along the way. The original MOON form that was printed and distributed by the medical center required a change in text and in form: the carbon copy did not work and that required the patient to sign it in three different places. Subsequently, CMS created a standard electronic version. The

workflow of the CRS team involved multiple tasks, not just delivering the MOON. During the implementation, there were occurrences of CRS workers not using the specific reports, which resulted in missed patients. This prompted a review of the function of each report with the CRS team. There was an issue with CRS follow up over the weekend, resulting in patients being missed. This led to the creation of a master list on Fridays with the status of each patient clarified for the weekend staff. The documentation in Allscripts was revised to include a pull down menu to distinguish: “UR-MOON Letter Delivered” or “UR-MOON letter attempted, but not delivered.” This was to promote the accountability of the CRS team and provide a solution to deliver the MOON to every patient.

Limitations

The main limitation of this project was the fact that the patients placed in OBS in this medical center were in beds located all over the hospital and they were not in one dedicated observation unit. This dispersion of patients placed in OBS made some patients harder to reach and locate, and because of the nature of OBS, patients were frequently off the floor in a diagnostic area. This situation led to patients being missed because they were not available on the first attempt and the re-attempt was not made prior to their discharge.

Translation Plan

The mandate for demonstrating compliance with the NOTICE Act is the driver of the practice change. The utilization of a standardized process with a P&P that is in alignment with the medical center’s operation and the spirit values will be a valuable and durable resource. The P&P is housed in the department and the MOON form is available on the CMS website, as well as the local EMR. The medical institution will continue to institute this procedure for delivering the MOON form. The training that was received by the original team will be integrated into the

orientation for those future workers who will become part of the CRS team and who will share this responsibility.

The medical center's support of new staff, an innovative new director, and the culture of evidence based practice throughout the medical center will assist in sustaining the knowledge translation. Making everyone in the team share the responsibility lessens the burden that would be placed in only one or a few individuals. This standardized process does not impose a significant time or financial burden on the medical center. Because the project was successful, there are plans to disseminate the findings by presenting a poster at an upcoming Nurse Research event, and submitting it for publication to a journal, yet to be determined. The community stakeholders need to be aware that the medical center is meeting this Medicare law, and that information needs to be addressed in the bigger communication plan.

Implications for Clinical Practice

This quality improvement project involved the development of a P&P that will be integrated into the medical center's practice and this will support consistency for the workers and help to ensure compliance with the NOTICE Act. The resources that were generated for the training sessions can be revised and updated for subsequent use. This writer (the PL) provided training on the NOTICE Act and the MOON to the CRS team and other workers in the Utilization Management department and it would be very reasonable to extend this training to other providers at the medical center, such as nurses and hospitalists. Increasing the scope of this training could improve the knowledge about the cost implications of OBS to more providers, which could be passed on to the patients. In addition, the completion rates of the MOON can be used as an audit tool for the department or to evaluate the performance of individual workers.

Conclusion

The use of observation status for patients has far exceeded Medicare's original intention. As more and more patients are being placed in OBS, the cost of care is shifted to the patients. Medicare has mandated that hospitals inform patients about the cost implications of being placed in OBS or risk loss of reimbursement. A quality improvement project was designed by this DNP student to utilize a standardized process including a P&P and a formal teaching plan to implement the NOTICE Act at a large urban academic medical center. The collaborative multidisciplinary team approach that was employed led to the development of durable tools and resources, and an effective plan to deliver the MOON. The use of this standardized process provided a sound and successful translation strategy to promote compliance with a required practice change.

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Appendix A

Table A1. Evidence rating table

Author, year	Study objective/ intervention or exposures compared	Design	Sample (N)	Outcomes studied (how measured)	Results	*Level and Quality Rating
Randolph (2006)	The purpose of this descriptive journal article was to discuss the development and utility of policy and procedures for nurses in occupational health service.	Expert opinion	Not applied here	Policies and procedures can serve as a foundation for the occupational health service and guide the role of the nurse	Policies and procedures serve as the foundation of an institutions practice. They aid in controlling performance and increasing consistency as well as provide a framework for staff training. Example of policy template provided, promoted collaboration of a team. Fairly comprehensive literature review and consistent recommendations (B)	7B
Fus (2007)	The purpose of this study was to improve compliance of evidence based guidelines of pre-procedural anticoagulation with the use of a policy in an electrophysiology lab	Quasi-experimental pre-post intervention study (retrospective)	N=55 pre-policy; N=53 post policy and N=48 1 year later	Baseline data collection prior to policy of the numbers of procedures where the anticoagulation status of a patient prior to cardioversion of atrial fibrillation met the established guidelines. Post implementation of a written policy data collection (retrospective)	Team was a nurse director and Medical director, but implemented with a multidisciplinary staff. Thorough education of staff involved. Noncompliance with guidelines decreased from 27% to 4% post implementation and to 8% one year post implementation. None of the 20 patients who underwent cardioversion in the absence of recommended anticoagulation had embolic complications. Explicit inclusion and exclusion criteria, sufficient sample,	6B

					reasonably consistent results, fairly comprehensive literature review with reference to scientific evidence.	
Long (2009)	The purpose of this article was to describe and inform about the implementation of a process to incorporate evidence into 32 existing nursing policy and procedures. The goal was to improve provision of safe patient care.	Description of a process improvement	Not applied here	Policies and procedures provide guidance for the nurse. To further enhance the use of policy and procedure, integration of evidence into the policy and procedure provides documentation of best practice.	Development of an evidence based policy and procedure template; completion of 32 divisional nursing policy and procedures; development of a plan to educate the nurses on integration of evidence into the policy and procedures. Use of an interdisciplinary team. Fairly comprehensive literature review. Consistent recommendations (B)	6B/C
Kwan (2015)	The purpose of this study was to develop, implement and evaluate a standardized process which included an education component and a nursing documentation component to improve adherence rates with venous thromboembolism (VTE) prophylaxis and hospital based inpatient psychiatric services (HBIPS) Core Measures.	Quality improvement project	Not stated	Compliance with both VTE prophylaxis and HBIPS Core Measures was reviewed by an external reviewer and those statistics were generated weekly. The education plan compliance was reviewed monthly by the investigators. Additionally the investigators reviewed charts of three patients/unit/month.	Team was CNS/RN only. Thorough education roll out and tool developed. Quality improvement framework utilized. VTE prophylaxis of non ICU units compliance improved from 66.7% to 84.4% and then to 90% after 4 months. VTE prophylaxis compliance of ICU units improved from 83.3% to 100%. HBIPS compliance improved from 8.3% compliance before to 59.4%, and to 97.2% after six months. Developed a teaching tool, team was CNS/RN only. Comprehensive review of literature; identified a theoretical framework and implications for future study, inconsistent recommendations,	6C

					no sample size, +reference to scientific evidence. (C)	
Author, year	Study objective/ intervention or exposures compared	Design	Sample (N)	Outcomes studied (how measured)	Results	*Level and Quality Rating
Cook (2014)	The purpose of this study was to improve the quality of care with indwelling urinary catheter use with the implementation of a standardized process or care model which included education of staff, an order set for the electronic health record and a reminder system, in the Surgical Care Service. The goal was to decrease the hours a patient had a catheter and improve compliance Surgical Care Improvement Project (SCIP) quality metrics	Quasi-experimental pre- post-intervention study	Randomly selected cardiac surgery patients from a random number generator. N= 86 baseline (prior to intervention) , and N= 187 post intervention.	Baseline data collection measuring urinary catheter removal time and subsequent dissemination of education and launch of the order set and reminder system. Post intervention data collection at initiation, 1 month,3 months,6 months, and 9 months after education.	Research team not described, but care team was designated as multidisciplinary. Included an education component and development of a reminder tool for the electronic medical record for the involved staff. The baseline mean time of urinary bladder catheter duration was 60 hours. Following implementation of the standardized care model, the mean duration time was reduced to 49.5 hours; and by 9 months, it was reduced further to 43.5 hours. Compliance with SCIP improved significantly. Insufficient sample, yes control, definitive conclusions consistent recommendations; comprehensive literature review with reference to scientific evidence.	6C

*Rating based on Melnyk & Fineout-Overholt (2011). Quality rating based on Newhouse (2006).

Table A2. Evidence review appraisal for quality (Strengths and Weaknesses Table) for quantitative research studies

Author, year	Study objective/intervention or exposures compared	Strengths	Weaknesses	Quality Rating
Randolph, (2006)	Expert opinion discussing the development and utility of policy and procedures for nurses in occupational health service.	Clearly defines the concepts used in developing policy and procedures in an occupational health service. Concepts are clearly discussed to be applicable to other organizations or services. (high generalizability). Clearly presents content in text and in integrated tables and figures. Discusses use of collaboration. Develops a policy template and detailed steps of policy development and implementation	Sample policy could have been generated.	B
Fus, (2007)	The purpose of this study was to improve compliance of evidence based guidelines of pre-procedural anticoagulation with the use of a policy in an electrophysiology lab	Study process clearly articulated. Quasi-Experimental pre- and post-implementation design. Results graphic is easy to understand. Policy developed by a nurse/physician team Extensive review of literature with references to scientific evidence	There is an inconsistent reporting of the results through the body of the paper. Small sample size, but comparable pre-post intervention.	C
Long, (2009)	Descriptive journal article discussing the implementation of a process to incorporate evidence into 32 existing nursing policy and procedures. The goal was to improve provision of safe patient care.	Use of instruments with established reliability and validity (levels of evidence, grading of evidence) including the actual tools. Study process clearly articulated. Clear description of the multidisciplinary team, staff involved, and roles of the members. Example of the template that was developed to keep a record of the policy and procedures completed. Example of the integrated table with evidence summary for 1 Policy and procedure/PICO. Appropriate stakeholders were involved in the development of the recommendations of the template/tool.	For completeness, the list of all 32 policy and procedures could have been included, including the PICO questions. This would have increased the strength of the evidence that was generated by this institution’s process. Incidentally, even though the review of literature included some older sources, this seems to be consistent with the existing literature.	B/C

Author, year	Study objective/intervention or exposures compared	Strengths	Weaknesses	Quality Rating
Kwan, (2015)	The purpose of this QI project was to develop, implement and evaluate a standardized process which included an education component and a nursing documentation component to improve adherence rates with venous thromboembolism (VTE) prophylaxis and hospital based inpatient psychiatric services (HBIPS) Core Measures.	<p>Authors developed an education tool to use for the staff that included the process and the knowledge needed to share with the nursing staff.</p> <p>Methodology was clearly described and defined.</p> <p>Study process was clearly stated.</p> <p>Appropriate stakeholders were involved in the development of recommendations, but the team was only CNS/RN.</p> <p>Discussed the framework which is the use of Lean Six Sigma and their process followed that model.</p> <p>Study groups were clearly defined. Recommendations were made for future use of the education component.</p>	<p>There is an inconsistent reporting of the results through the body of the paper.</p> <p>No sample size is documented.</p> <p>There is no tabulation of results, however, they are integrated in the text.</p>	C
Cook, (2014)	The purpose of this study was to improve the quality of care with indwelling urinary catheter use with the implementation of a standardized process or care model which included education of staff, an order set for the electronic health record and a reminder system, in the Surgical	<p>Quasi-Experimental pre- and post-implementation design and random assignment of subjects.</p> <p>Clear description of inclusion and exclusion criteria.</p> <p>Tables and text clearly integrated throughout the article.</p> <p>Study protocol clearly articulated.</p> <p>Results graphic is easy to understand.</p> <p>Clear definition of the variables.</p> <p>Study limitations were addressed.</p> <p>Research team not described, but care team was multidisciplinary. Education of staff on the standardized practice model. Development and use of a reminder tool in the electronic medical record.</p>	<p>Small sample size-which was addressed by the authors.</p> <p>Patient population was only from cardiac surgery; however, it is not unreasonable to believe this is generalizable to another patient population in a hospital, or another surgery service.</p>	B/C

	Care Service. The goal was to decrease the hours a patient had a catheter.			
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Appendix B

Medicare Outpatient Observation Notice (MOON)

I. PURPOSE:

This complies with the Centers for Medicare and Medicaid Services (CMS) regulatory requirement for the Notice of Observation Treatment and Implication for Care Eligibility Act, or NOTICE Act. CMS requires all hospitals to give each individual who qualifies for Medicare benefits and is placed in observation status for more than 24 hours adequate written and oral notification of their designation including implications of cost and subsequent coverage eligibility for SNF and document receipt of the notification with a signed form within 36 hours after beginning to receive such services (NOTICE Act, 2016). This form is called the Medicare Outpatient Observation Notice (MOON).

II. SCOPE:

The Clinical Resource Specialists (CRS) team has been designated by the hospital to deliver the MOON.

III. DEFINITION:

Medicare Outpatient Observation Notice (MOON): The MOON will serve as the standardized notice used to notify persons entitled to Medicare benefits under Title XVIII of the NOTICE Act, who receive more than 24 hours of observation services, that their hospital stay is outpatient and not inpatient; and the implications of being an outpatient. The MOON contains all of the informational elements listed above as required by statute. (CMS, 2016a)

Observation Status: Observation services are hospital outpatient services given to help the physician decide if the patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the emergency department (ED) or another area of the hospital. (CMS, 2016b)

Medicare Part B: Part B covers outpatient hospital and physician services. Generally, this means patients pay a copayment for each individual outpatient hospital service. This amount may vary by service. Note: The copayment for a single outpatient hospital service cannot be more than the inpatient hospital deductible. However, the patient's total copayment for all outpatient services may be more than the inpatient hospital deductible. The patient will pay 20% of the Medicare-approved amount after paying the Part B deductible. Generally, prescription and over-the-counter drugs taken in an outpatient setting (like an ED), sometimes called "self-administered drugs," aren't covered by Part B. (Medicare.gov, nd)

Representative: A representative is defined broadly to include individuals authorized to act on behalf of the beneficiary; someone acting responsibly on behalf of an incapacitated or incompetent beneficiary; or someone requested by the beneficiary to act as his or her agent.

IV. POLICY:

Hospitals must deliver the MOON to provide written and oral notification to individuals receiving observation services as outpatients for more than 24 hours. The written notice must be delivered no later than 36 hours after observation services are initiated, must include the reason the individual is receiving observation services, and must explain the implications of receiving outpatient observation services, such as cost sharing, and post-hospitalization eligibility for Medicare coverage of skilled nursing facility services. The hospital must obtain the signature of the individual or an individual acting on behalf

of the patient. Hospitals must deliver a hard copy of the MOON to beneficiaries and enrollees. Hospitals must retain a copy of the signed MOON and may store the MOON electronically if electronic medical records are maintained. If a hospital elects to issue an MOON that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper rather than electronic issuance if that is what the beneficiary prefers. Regardless of whether a paper or electronic version is issued, and whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the signed MOON. In cases where the beneficiary has a representative who is not physically present, hospitals are permitted to give the MOON by telephone as long as a hard copy is delivered to the representative.

V. PROCEDURE:

Patients that present to the ED of this hospital are evaluated by the physician care team. A patient can be placed in observation status during the time the care team is deciding whether the patient needs to be admitted to the hospital as an inpatient or discharged home. Observation services can be given in the ED or another area of the hospital, depending on the availability of a bed. Twice daily, at 0800 and at 1400, the Utilization-Clinical Resource Management Department generates a real time report which includes a list of the patients that have been placed in observation status at the hospital. These reports are used by the CRS team to distribute the work load. The CRS will meet each patient placed in observation status, deliver the MOON, which includes an oral explanation, and get the form signed. This encounter can take place while the patients are in the ED or in another area of the hospital. The encounter is then documented by the CRS in the electronic medical record through Allscripts, the health connection platform with CMS.

A. Initial attempt

Hospitals must deliver the MOON to provide written and oral notification to individuals receiving observation services as outpatients for more than 24 hours, however the notice may be provided before 24 hours. The written notice must be delivered no later than 36 hours after observation services are initiated. The hospital must obtain the signature of the individual or an individual acting on behalf of the patient. Hospitals must deliver a hard copy of the MOON to beneficiaries and enrollees. In cases where the beneficiary has a representative who is not physically present, hospitals are permitted to give the notice by telephone as long as a hard copy is delivered to the representative. Have the patient or representative place the date and time that he or she signed the notice.

B. Follow-up Attempt

The follow-up attempt(s) must be provided to the patient as soon as possible prior to the 36 hours or until the patient is discharged from the hospital or reclassified to an inpatient.

C. Beneficiary Refusal to Sign

If the beneficiary refuses to sign the notice, the hospital should note the refusal and the date of refusal on page 2 of the MOON, as indicated.

D. MOON Delivery to Beneficiary Representatives

When a beneficiary is unable to understand the notice, the hospital may have the beneficiary's representative receive and sign the notice in accordance with state or other applicable law. If the hospital is unable to personally deliver a MOON to a representative, then the hospitals are permitted to give the notice by telephone as long as a hard copy is delivered to the representative. The delivery of the initial MOON or any follow up attempt should be in person. Have the representative place the date and time that he or she signed the notice.

E. Medical Record Documentation

Hospitals should place a copy of the MOON in the patient's medical record. Hospitals must document timely delivery of the MOON in the patient's electronic medical record in Allscripts. The hospital should also document any attempted contact with beneficiary representatives, including telephone calls, messages and subsequent certified mail in Allscripts.

F. Copies

MOON form: 2 copies: 1) signed original for patient; 2) hospital copy.

References (For this P&P)

Centers for Medicaid and Medicare Services. (2016a). Details for title: CMS-10611. Retrieved from

[https://www.cms.gov/Regulations-and-](https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10611.html)

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[bill/876?q={%22search%22%3A\[%22NOTICE+Act%22\]}&resultIndex=4](https://www.congress.gov/bill/114th-congress/house-bill/876?q={%22search%22%3A[%22NOTICE+Act%22]}&resultIndex=4)

Appendix C

Medicare Outpatient Observation Notice Form (MOON)

MOON form Script

Hi my name is []; I work in Clinical Resource Management and I am here to present you with the new form called the MOON- Medicare Outpatient Observation Notification form.

Your physician has placed you in observation status. Medicare wants you to be aware of the costs associated with observation status.

- *Medicare Part B covers your outpatient and observation services. You might get a bill because the copays are different when you are in observation status. In order for you to know the exact cost, you need to reach out to your insurance company.*
- *Medicare Part B does not pay for your regular routine medications, so you will get a bill for some of the medications the nurses administer to you.*
- *Also, in observation status, Medicare Part B does not pay for skilled nursing facility care at rehab or a nursing home. If the plan is for you to go to a facility, you will have to pay for that out of pocket.*

So, we both sign this MOON form saying that I told you about observation status and you understand what it means. I give you the original and the other goes in your chart and it proves that we actually met and talked.

Take this and read it over. If you have any questions, I will have the social worker/case manager/discharge planner come talk with you.

Appendix D

Training Outline for Clinical Resource Management Specialists

Learning Objectives

At the end of the training the learner will:

- 1) Discuss the background of the Notice of Observation Treatment and Implication for Care Eligibility Act /NOTICE Act
- 2) Identify the policy and procedure to deliver the Medicare Outpatient Observation Notice/MOON and document the intervention in the electronic medical record (EMR) in Allscripts
- 3) Describe patient interactions that align with regulatory standards and the hospital's infection prevention policies
- 4) Demonstrate the delivery of the MOON as directed by the policy and procedure (P&P) and instructions by Centers for Medicaid and Medicare Services (CMS)

Content:

- 1) Background of the NOTICE Act
- 2) Review CMS documents
- 3) Review the P&P and script
- 4) Review regulatory standards

Classroom simulation:

- 1) Preparing for the patient encounter
 - a. Occupational Safety and Health Administration (OSHA)
 - b. Health Insurance Portability and Accountability Act (HIPAA)
 - c. The Joint Commission/ National Patient Safety Goals (TJC/NPSG)
- 2) Scripted delivery of the MOON: oral explanation and written record
 - a. Standard
 - b. Non-English speaking
 - c. Medically or cognitively unable
- 3) Documentation of the intervention in the EMR in Allscripts
 - a. Completion of the MOON to patient/representative
 - b. Unsuccessful completion/ missed attempt/refusal
- 4) Return demonstration and role play
- 5) Clinical observation of the delivery of the MOON
 - a. Feedback and reinforcement

Handouts:

1. "Instructions CMS 10611," "Supporting Statement for the Medicare Outpatient Observation Notice CMS-10611," and "MOON Form AMC 02762"
2. Policy and Procedure
3. Script for delivering the MOON

Appendix E
Documentation

Documenting as an intervention in Allscripts

The MOON should be delivered within 36 hours to all Medicare beneficiaries being placed in observation status. We have identified that the MOON should be delivered *on the first day of being placed in observation status. Please use the MOON reports that are sent out each day at 0800 and 1400 to identify those patients.* After the MOON is signed, documentation must be entered in Allscripts to verify the information has been conveyed to the patient to fulfill Medicare's requirement as it relates to the NOTICE Act. This intervention will have a time/date stamp. MedStar requests the standard use of consistent verbiage for compliance.

- a. The MOON form was delivered successfully. Use '*UR-MOON Letter Delivered*' in the intervention drop down. No need to provide any documentation/text in the intervention area. Your documentation goes in a time stamped **progress note**.

Progress note should read:

“The MOON form was delivered and signed by [patient/designated caregiver/caregiver/family/friend]. Original left with patient, copy placed on the chart.”

Or

“Patient is medically unable to sign the MOON form. The designated caregiver was [at the bedside/in the room/contacted by telephone]. The MOON form was signed/mailed to [name; provide telephone number and name of person spoken to and address]. Original is left with patient (or mailed) and copy is put on chart.”

- b. The delivery of the MOON was attempted but not successfully completed. Use '*UR-MOON letter attempted, but not delivered*' in the intervention drop down. No need to provide any documentation/text in the intervention area. Your documentation goes in a time stamped **progress note**.

Progress note should read:

“Unable to deliver the MOON form due to...[patient is out of room/at a test/medically unable; patient refused/ designated care giver caregiver/family/friend refusal]. Will return later.” or “...Task designated to CRS (name) or Case manager (name).”

Include a statement of any attempted contact –initial and follow up-with patient representatives/family designated caregivers including telephone calls and subsequent certified

mail. Each CRS is accountable for their task list from the daily reports. Please provide at least one follow-up attempt, and document as such. Include the plan to hand off the task to someone else. *UR-MOON letter attempted, but not delivered* indicates there is still work to do.

- c. If patient/designated caregiver caregiver/family/friend refuses to sign, note this refusal on the MOON, leave original with patient and place copy on chart.
Progress note should read:

“The MOON form was provided. Patient/designated caregiver/ caregiver/family/friend refused to sign. Refusal noted, original given to patient/designated caregiver /caregiver/family/friend and copy placed on chart.”

Appendix F

Not Human Subjects Research (NHSR) Confirmed

To: Robin Flanary
Link: [HP-00072887](#)

Description:

An IRB Analyst has reviewed the information provided and has determined that the project meets the definition of *Not Human Subjects Research* (NHSR). IRB oversight is not required and no further actions are required.

Submission Title: Implementation of a Process

POC: Susan Bindon

Please contact the HRPO at 410-706-5037 or HRPO@umaryland.edu if you have any questions.

Warning: This is a private message intended specifically for the above named receiver. If you are not the named receiver, or believe that you may have received this email in error, please forward it to cicero-help@som.umaryland.edu.

University of Maryland, Baltimore

Template:HP_NHSR Confirmed

Appendix H

MEDICARE OUTPATIENT OBSERVATION NOTICE (MOON)

On _____ at _____, you began receiving observation service at A Large Urban Medical Center
DATE (MM/DD/YR) TIME

You are a hospital outpatient receiving observations services, also called an observation stay. You are not an inpatient.

Observation services:

- Are given to help your doctor decide if you need to be admitted as an inpatient or discharged;
- Are given in the emergency department or another area of the hospital;
- Usually last 48 hours or less.

How being an outpatient affects what you may have to pay: Being a hospital outpatient affects the amount you may have to pay for your time in the hospital and may affect coverage of services after you leave the hospital.

Medicare Part B covers outpatient hospital services, including observation services when they are medically necessary. Generally, if you have Medicare Part B, you may pay:

- A copayment for each individual outpatient hospital service that you get
- 20 percent of Medicare-approved amount for most doctor services, after the Part B deductible

Part B copayments may vary by type of service. In most cases, your copayment for a single outpatient hospital service won't be more than your inpatient hospital deductible. However, your total copayment for all outpatient services may be more than the inpatient hospital deductible.

If you're enrolled in a Medicare Advantage plan (like an HMO or PPO) or other Medicare health plan (Part C), your costs and coverage are determined by your plan. Check with your plan about coverage for outpatient observation services.

If you are a Qualified Medicare Beneficiary through your state Medicaid program you cannot be billed for Part A or Part B deductibles, coinsurances, and copayments.

Your costs for medications:

Generally, prescription and over-the-counter drugs, including "self-administered drugs," given to you by the hospital in an outpatient setting (like an emergency department) aren't covered by Part B. "Self-administered drugs" are drugs you would normally take on your own. For safety reasons, many hospitals don't allow patients to take medications brought from home. If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs in certain circumstances. You will likely need to pay out-of-pocket for these drugs and submit a claim to your drug plan for a refund. Contact your drug plan for more information.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, if inpatient hospital services become necessary for you and the hospital admits you as an inpatient based on a doctor's order, generally Medicare Part A will cover inpatient services. Generally, you will pay a one-time deductible for all of your inpatient hospital services when you are an inpatient. You may have to pay 20 percent of the Medicare approved amount for doctor services after paying the Part B deductible.

Print Patient Name

Patient Signature

Date (MM/DD/YR)

Print MWHC Name/Title

Signature

Date (MM/DD/YR)

MEDICARE OUTPATIENT OBSERVATION NOTICE (MOON)

How observation service may affect coverage and payment of your care after you leave the hospital: If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you have a prior qualifying inpatient hospital stay. A qualifying inpatient hospital stay means you've been a hospital inpatient (you are admitted to the hospital as an inpatient after your doctor writes an inpatient admission order) for a medically necessary stay of at least 3 days in a row (not counting your discharge day) within a short time before you enter a SNF.

If you have a Medicaid, Medicare Advantage or other health plan, Medicaid or the plan may have different rules about qualifying for SNF services after you leave the hospital. Check with Medicaid or your plan.

Additional Information:

If you have any questions about your observation services, please ask the hospital staff member providing this notice or the doctor providing your hospital care. You can also speak with someone from the hospital's Clinical Resource Management or discharge planning department. In addition, you can call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

If you have a complaint about the quality of care you are getting during your outpatient stay, you may contact the Quality Improvement Organization (QIO) for this hospital.

QIO Name: XXXX Beneficiary Help Line QIO Phone Number: 1-844-XXXXXXX

If you have a Medicare Advantage or other health plan, you can make your complaint about quality of care by filing a grievance with your plan. Review your plan materials or contact your plan for information on how to file a grievance. You can also make a complaint about quality of care to the QIO listed above.

Please sign and date here to show you received this notice and understand what it says.

Print/ Signature of Patient or Representative	Date/Time
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