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Being prepared is your best defense when RACs request records

Complete documentation, a rapid response plan are both necessary

Now that the permanent Recovery Audit Contractor (RAC) program has gone into high gear, hospitals can lessen their vulnerability to losing revenue if they know how to respond and what to expect, says **Deborah Hale**, CCS, president of Administrative Consultant Services LLC, a health care consulting firm based in Shawnee, OK.

The RAC process puts hospital billing and documentation under closer scrutiny than ever before, Hale adds.

"Now that the permanent RACs have begun their record requests, case managers should be more careful than ever before to make sure that the documentation in the medical record accurately reflects the services their patients receive and that it supports the medical necessity of inpatient admission," Hale says.

The RAC requests for records, which started as a trickle in many hospitals, are now coming fast and furiously, she adds.

The RACs have to get approval from the Centers for Medicare & Medicaid Services (CMS) before auditing for potential overpayments by demonstrating why the issue is worth examining, Hale says.

The permanent RACs have been approved by CMS to conduct validation reviews of almost every DRG and have been reviewing records for DRG validation since spring, Hale says.

The list of targeted medical necessity issues approved by CMS for RAC review continues to grow, she adds.

"Hospitals across the country are finding a wide variety of issues under review. There are a lot of commonalities among the regions in medical necessity issues they want to examine," she says.

She advises case managers and other hospital officials to scrutinize the issues that CMS approves for the RACs in each region of the country because there is bound to be a lot of overlap.

At Lutheran Medical Center in New York City, **Lori Dempsey**, vice

AHC Media LLC

president of financial compliance, is carefully monitoring the RACs in other regions to see where they are focusing.

For instance, in Region C, CMS has approved MS-DRG validation reviews that seem to correspond with similar DRG groups for which they are looking at medical necessity.

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Among the RAC targets across all regions are MS-DRG 313 (chest pain) and MS-DRG 312 (syncope), Hale says.

If a patient is admitted as an inpatient with DRG 313 or DRG 312, the auditors are zeroing in on medical necessity and addressing whether the documentation in the record supports the fact that the patient needed to be in the inpatient setting, she says.

"The belief is that patients who have these symptoms with no underlying cause documented in the medical record could be outpatients with observation services while they are being worked up to determine the cause," Hale says.

Since there is a significant difference in what Medicare pays for an observation stay versus an inpatient admission, the agency believes that the vast majority of patients with chest pain or syncope could be outpatients with observation services and could likely be discharged from observation, according to Hale.

In cases where patients have syncope or chest pain, case managers and coders should determine whether a physician knew or suspected a particular underlying cause and should make sure it is documented in the final progress note or discharge summary, Hale says.

"Making the documentation clearer with regard to physicians is likely to change the DRG and reduce the risk of an audit," she says.

Case managers should make sure that each medical record has a signed and dated admission order to avoid problems when the RAC auditors access the records, Hale says.

"The order has to be dated, timed, and signed legibly. The time and date of the order is the time and date of admission. This puts hospitals in a shaky position if they are using a case management protocol for admissions because the admission doesn't count until the physician has signed and dated the level of care order," she says.

CMS says case managers can help the physicians determine whether a patient is an inpatient, an outpatient, or an outpatient with observation services, Hale points out.

"But the physician has to make the final decision. The order has to have a physician signature," she adds.

Hospitals that use the case management protocol would be wise to look at their average length of stay in observation and make sure they aren't missing medically necessary inpatient admissions when the length of stay exceeds 24 hours even though

they do not strictly meet inpatient screening criteria, she advises.

Make sure the order accurately reflects the services that the patient actually received, adds **Brian Pisarsky**, RN, MHA, ACM, CPUR, director, case management services, DCH Regional Medical Center and Northport Medical Center, located in Tuscaloosa, AL.

"You blow the appeal upfront if you have an order that says 'observation,' and the case was billed as an inpatient admission. It doesn't matter if the patient meets medical necessity criteria, if the order says 'observation' and it was an inpatient stay, the hospital is going to lose," he says.

To prepare for the permanent RAC initiative, Lutheran Medical Center rolled out a documentation enhancement program in the fall of 2009.

"We used some of the lessons learned from the RAC demonstration project as a map for our clinical documentation team to use to address the opportunities going forward associated with the RAC demonstration project outcomes," Dempsey says.

For instance, where there is a debridement service, the clinical documentation specialists made sure the documentation includes the areas the RAC focused on during the demonstration project, namely the appropriate nomenclature, the size of the wound, and the type of instruments used to address the wound, Dempsey says.

The hospital participated in the RAC demonstration project and had about 18 months between the end of the demonstration project to the roll-out of the permanent RAC to get internal processes in place.

In early 2009, DCH Health System formed a RAC committee that included the CFO, physicians, financial representatives from the individual facilities, and representatives from medical records, case management, and compliance.

"We went to seminars to learn about the RACs, analyzed what happened in the RAC demonstration project, and sent our RAC coordinator for intensive training," Pisarsky says.

The team alerted each department in the hospital as to what the RACs were looking for in the demonstration project, developed audit processes for each department, and asked for monthly reports.

For instance, since the RAC demonstration project targeted medical necessity for one-day and two-day stays, the hospital system reviewed a percentage of its one- and two-day stays to verify that the order for inpatient status was on the chart; that medical necessity criteria were applied; that the coding and documentation were accurate; and that in cases where there was a question, the chart was reviewed by the physician advisor.

"This gave us an idea of where we stand and enabled us to develop action plans to make improvements in what we were doing," Pisarsky says.

Hospitals must have a team of internal experts to prepare for the RACs and deal with requests, Dempsey says.

Lutheran Medical Center's interdisciplinary RAC committee includes representatives of departments that naturally tie into the RACs, including compliance, patient accounts, medical records, appeals management, case management, and the director of clinical documentation, Dempsey says.

The committee operates under a charter that outlines roles and responsibilities of each team member.

"The people on the RAC committee are senior staff in each department and have the ability to make changes in real-time if necessary based on RAC requests and outcomes," Dempsey says.

Dempsey cautions people working with RAC requests to immediately assess what resources are

The Power of 'Because'

The clinical documentation staff and the case managers at Lutheran Medical Center in New York City have hit on a one-word solution to the challenge of getting physicians to fully document in the medical record.

That word is "because," according to **Lori Dempsey**, vice president of financial compliance.

"This simple word helps prompt the physician to add information to the medical record to support his or her clinical decision making. Using the word 'why' seems to be challenging. Instead, say, 'You did this because…' and ask the physician to write the 'because' in the medical record," she says.

"One simple word can open a floodgate of clinical decision-making to support the physician's action. It suits every situation — to admit or not to admit, to order a test or procedure, or to support their assessment and plan," she says. ■

needed to meet the request and not let individuals get overloaded.

"If the workload gets overwhelming, I want people to let me know immediately to avoid having details fall through the cracks and missing deadlines and opportunities," she says.

Develop a detailed process to ensure a timely response, Pisarsky suggests.

"One of the lessons learned from the RAC demonstration project is that hospitals need a designated place for requests to go. In some cases, the requests were sent all over the hospital. Hospitals in the demonstration project lost out on a lot of appeals because they couldn't respond in a timely manner," Pisarsky says.

DCH Health System established a post office box dedicated to the RAC reviews and made sure the RAC contractor had the appropriate address. The team designated a person to go to the post pffice box every day and hand-deliver the mail to the RAC coordinator.

The RAC coordinator enters the RAC request in the computer system and notifies the proper department by e-mail of the request. She tracks the RAC request throughout the entire RAC process, Pisarsky says.

"Depending on the RAC request and the issues, the RAC coordinator forwards the request to the individual department and continually follows up to ensure that the department responds by the deadline date," Pisarsky says.

After the permanent RAC contractor was decided for her region, Dempsey worked with health care trade organizations in New York to develop a RAC vendor communication contact list to ensure the prompt delivery of requests to the appropriate contact person.

"This is extremely important because the clock starts with the demand letter date. You don't want to waste time having a letter go through unnecessary channels until it gets to the right person. In preparation, we set up a special fax line strictly for the RAC letters," Dempsey says.

Despite her efforts, the first two RAC demand letters came by mail and the hospital lost seven calendars days before it got to Dempsey.

Hale advises hospitals to appeal all questionable denials from the RACs and keep appealing through the prescribed process.

'Keep appealing'

"On the DRG validation requests, so far, we've noticed that the RACs don't always get it right. Sometimes they approve things that should not have been approved and deny things that are supported by coding. This means the hospitals have to keep appealing," Hale says.

Medical necessity appeals may not be overturned until they get to the administrative law judge, she adds.

"Hospitals shouldn't get discouraged if they don't win on the first two levels of appeal," she says.

Hospitals should appeal anything they believe is incorrect, even if they get an overpayment, Hale adds.

"It may be tempting to let an overpayment go, but the ultimate goal is an accurate payment," she says.

If they get a denial and are appealing, hospitals need to make a decision whether to return the money or risk having to pay interest if they lose the appeal, Pisarsky points out.

Take advantage of the discussion period following the denials, Pisarsky advises.

"We've been successful in talking with our RAC to find out what additional information they need, sending it to them, and ending the denial right there," he adds.

DCH health system takes a proactive approach to the appeals process.

When the RAC requests a record to review it for medical necessity, the RAC coordinator alerts the individual case manager so he or she can review the case and determine why they made the decision that the patient met inpatient criteria.

"If we appeal, we already have information on why the decision to admit the patient was made," he says.

Lutheran Medical Center used an outside vendor to conduct appeals during the RAC demonstration.

"This vendor was able to get 97% of our appeals overturned, most of which were appealed at the administrative law judge level," Dempsey adds.

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PEPPER can help you focus on likely RAC targets

Identify areas where you need to improve

Analyze the data in your hospital's Program for Evaluating Payment Patterns Electronic Report (PEPPER) to identify areas where your hospital may be vulnerable to denials from the Recovery Audit Contractors (RACs), suggests **Deborah Hale**, CCS, president, Administrative Consultant Services LLC, a Shawnee, OK, health care consulting firm.

The report provides data on the Centers for Medicare & Medicaid Services (CMS) target areas where there are likely to be payment errors due to billing, MS-DRG coding, and/or admission necessity issues.

PEPPER is a spreadsheet that contains hospital-specific data for target areas, which include one-day stays, hospital readmissions, and DRGs that have historically been associated with Medicare payment errors. The data can help hospitals identify potential overpayments as well as potential underpayments.

"The PEPPER data alert hospitals to potential problems and should be used to determine the focus of internal audits or validation studies. It can help case managers identify areas where medical necessity of admissions is questionable, readmissions are too frequent, or where there is over-coding or under-coding," Hale says.

PEPPER previously was distributed to hospitals through the state's Quality Improvement Organization (QIO) as part of the Hospital Payment Monitoring Program. The report was not available for about a year. Beginning in early 2010, PEPPER is produced and distributed to hospitals by the TMF Health Quality Institute under a contract with CMS. The reports are available through My Quality Net for registered users.

CMS provides PEPPER to the fiscal intermediaries/Medicare administrative contractors (FI/MACs). The RACs have the ability to generate PEPPER data for individual hospitals.

The current PEPPER has 11 target areas, including five involving potential coding errors and six involving admission necessity areas.

The report shows the percentile in which your hospital falls in each target area and compares your rank to other acute care hospitals in your state, MAC jurisdiction, and for the nation, identifying areas that may be questionable in terms of medical necessity. The report includes data on both the high and low statistical outlier target areas for each measure.

The PEPPER data can help hospitals set priorities on how to focus their auditing and monitoring efforts, Hale says.

The first step case managers should take is to find out who in their hospital has access to the PEPPER data, such as the hospital's Quality Net Security administrator, usually the person who is involved in reporting of your hospital's quality data. Ask him or her to give you a passcode that will allow you access to the data.

Hospitals should use PEPPER to identify areas that look unusual compared to the rest of their state. Then take the data one step further and drill down to see if they represent a problem, Hale says.

When you get the report, look at where your hospital falls in terms of the 11 indicators. If your hospital falls in the 80th percentile or above or below the 20th percentile, you should look carefully at those categories to find out why, Hale advises.

Higher values may indicate questionable medical necessity or coding errors. If a hospital's scores are consistently low in the medical necessity measures, that may indicate over-utilization of observation services, she adds.

For instance, a high number of short stays may imply that the admission wasn't necessary and the patient should have been treated on an outpatient basis. If certain medical necessity measures fall in the 80th percentile or above or the 20th percentile or below, it could be an indication that your hospital isn't using observation status appropriately.

Look at which DRGs are generating the greatest number of one-day stays and why and determine whether you need to examine them further. Your data may reflect appropriate level of care determinations for your particular circumstances, Hale says.

For instance, if your hospital uses physician advisors appropriately, you are more likely to have a higher rate of one-day stays than a hospital that relies too heavily on screening criteria alone.

Look beyond the percentiles in which your hospital falls and examine the number of cases that fall into the outlier categories, Hale says.

"If there are just a few cases, that doesn't raise as much concern as something that involves a high volume of cases," she says.

If your hospital has more 30-day readmissions than the rest of the state, look at whether the patient was provided incomplete care during the first admission and readmission was needed to provide services that should have been provided during the first stay, Hale advises.

[For more information, see www.pepperresources.org.] ■

Model lets CMs concentrate on care coordination

CMs, SWs use sequential model for patient care

By developing a case management model that frees RN case managers to do what they do best — coordinate care — Fauquier Hospital in Warrenton, VA, has reduced its average length of stay without affecting the readmission rate.

"Our RN case managers pay close attention to ensuring the patients get appropriate care. Our length of stay is below or at the Medicare average for most MS-DRGs, and our overall readmission rate is well below 20%," says **Pat Gerbracht**, BSN, MA, CRA, director of case management and social work at the Planetree-designated patient-centered hospital. *(For details on the Planetree principles, see related article in* Critical Path Network*, page 186.)*

The hospital has three teams of case managers and social workers who are assigned by unit. One social worker supports two case managers. Case managers typically have 25 or fewer patients and review every patient in the hospital using InterQual criteria.

The social workers have a case load of 30 to 35 active cases.

"We use a sequential model for patient care. The RN case managers manage the case from admission until the patient is nearing discharge. They act as true medical case managers, constantly in contact with the physicians, maintaining intensity of service, monitoring quality measures, delays in service, or anything that wouldn't meet our standards of care," Gerbracht says.

When the patient begins to meet the discharge screen criteria, the case manager transfers the case to the social worker who puts the final touches on a personalized discharge plan.

The social workers and case managers meet every day to go over the census and touch base throughout the day. The RN case managers alert the social workers to anything that may affect the discharge plan.

In addition, the social workers conduct independent social work assessments on patients with 20-plus diagnoses that are likely to necessitate complex discharge planning, she says.

This model frees up the case managers for the degree of vigilance and interaction needed to ensure appropriate length of stays and reduce readmissions, Gerbracht says.

"The case managers are involved in managing every day of the stay, and this includes communication with the insurance companies. In practical reality, they're the only people on the team who have the information to do that part," she says.

The department has a clinical documentation specialist who serves as a resource to the case manager as well as handling documentation improvement and core measures validation.

In the past, case managers concentrated primarily on whether patients continued to meet inpatient criteria when they conducted a clinical review. Now, under the new model, they incorporate the discharge screen into their review along with severity of illness and intensity of service, says **Patsy Coffman**, RN, CPUR, CCM, case manager at the 97-bed hospital.

"The discharge screen shows us how patients are progressing. We could get so caught up in the intensity of service piece that we neglect the discharge screen. But that's just as important to move the patient forward. The discharge screen is the pivotal point for the case manager to get the social worker involved," Coffman adds.

When the patients begin to meet the discharge screen criteria, the social worker completes a discharge assessment and starts working with patients, family members, and the rest of the team to plan the discharge, she adds.

"Traditional thinking says that discharge planning starts on Day 1. We find that while that may be ideal, our patients and families are focused on medical concerns and not ready to talk about discharge planning at that time. Once the initial high-anxiety phase begins to wane, patients and families are ready and able to think about the next steps," Gerbracht explains.

Gerbracht credits constant surveillance from

(Continued on page 187)

CRITICAL PATH NETWORK™

Nurses, CMs focus on special needs of elderly

Hospital offers classes on geriatric nursing

As a case manager on the congestive heart failure unit at Danbury Hospital, **Karen Morgan**, RN, MSN, CCM, RN-BC, often manages the care of elderly patients.

When the hospital received a three-year federal grant to develop a family-centered geriatric nursing care curriculum, Morgan signed up, completed the course, and achieved her certification in geriatric care.

"If we understand the special needs of the elderly, we can help maintain them as the person they've always been; but we have to learn to approach them in a different way from the way we approach younger patients. This education helped me tailor case management to meet the needs of elderly patients and their families," she says.

The hospital applied for the grant to give its nurses and case managers the additional skills and competencies to care for its growing elderly population, says **Moreen Donahue**, DNP, RN, chief nursing office and senior vice president of patient care services at the 371-bed regional hospital, located in Danbury, CT.

Many nurses on the staff received their education before the nursing curriculum included geriatrics and caring for the elderly as a specific population. The course offered them an opportunity to increase their knowledge in caring for their older patients, she adds.

"Nurses and case managers need to understand the special needs of the elderly. Their eyesight may be failing, their hearing may be impaired, and their balance may be affected. Being away from the home setting is very disorienting. The needs of the elderly are very different from those of younger patients, even with the same diagnosis; the treatment process is different, and the discharge process also is very different," Donahue says.

In addition to providing education on geriatric care, the hospital also included educational sessions on providing culturally competent care and including the family in the care plan.

The cultural competency portion of the curriculum focuses on the knowledge and skills nurses should have to identify the needs and deliver care to patients who come from cultures that are different from their own.

"We looked at how cultural beliefs and traditions can affect the care of the patients, including how some cultures view illness, the importance of extended families in post-acute care, and times when patients may be hesitant to discuss their personal health with family members," she says.

An additional component alerted nurses to religious prohibitions and dietary restrictions that taking certain medications might violate. For instance, some insulin has a pork base, which may not be acceptable to people from cultures in which pork is prohibited.

As part of the grant, the hospital included the curriculum to prepare nurses and case managers to be able to take the gerontology nurse certification examination. A number of participants, including Morgan, have become board certified in geriatric nursing.

During the first year of the program, about 100 registered nurses and 50 nursing assistants from the Danbury Hospital and the Danbury Visiting Nurses Association were trained in culturally competent, family-centered geriatric care.

During the next two years, nurses and nursing assistants in the region will have access to the curriculum through a partnership with the

Connecticut Hospital Association and the National Institute of Family Centered Care.

The hospital tested the knowledge of the participating nurses and case managers before and after the classes.

"The results were overwhelmingly positive. We determined that after taking the course, the nurses have significantly increased their understanding and appreciation for the unique needs of older adults and the importance of their families to their continued care," Donahue says.

One reason case managers were encouraged to participate in the education is so they can understand the special discharge needs of this population, Donahue says.

"When the elderly have an acute event that results in a hospital admission, the next level of care may be very different from the level of care they were in prior to hospitalization," she adds.

As they develop a discharge plan for the elderly, case managers incorporate an understanding of all components and family capabilities necessary to complete the plan of care.

"Lengths of stay are getting shorter and shorter, which means case managers have to have the knowledge to assess the special needs of the elderly and to get a plan in place to address them in a short time. Case managers need expertise to plan for the appropriate level of care for these patients and to help the families make the best decisions," Donahue says.

Since receiving the training, the case managers are involving the family earlier in the hospital stay after getting permission from the patient to talk to the family member, she adds.

"They are becoming more flexible in how they work around the availability of the family and meeting the needs of the patient," she says.

The case managers make rounds on their elderly patients more frequently and try to see the patients when their family members can be there.

"Elderly patients often need assistance at home, at least in the beginning. The case managers provide the link to the necessary support in order to provide a safe environment after discharge," she says.

Now that the case managers understand the special needs of the elderly, they talk to the family about the importance of good lighting at home, picking up scatter rugs to prevent falls, and making sure that they are monitoring the patient's medication, Donahue says.

As part of its efforts to provide patient- and family-centered care for elderly patients, the hospital created a patient education department, which prepares discharge information in an easy-to-read and easy-to understand format.

"We include the basic targeted information patients need on one sheet front and back. The type is easy to read, and it's less confusing that handing out multiple booklets and sheets of paper," she says. ■

Listen to your elderly patients for plan of care

Keep in mind they need special considerations

As **Karen Morgan**, RN, MSN, CCM, RN-BC, makes rounds with the rest of the treatment team on Danbury Hospital's heart failure unit, she uses her knowledge as a certified gerontology nurse to point out the special considerations that the elderly patients on the unit may need.

"Patients need to feel like somebody is listening to them. These patients haven't always been 80 years old or older. If we pay attention to what they are saying, the input of elderly patients can be very valuable and can help with some of the issues in daily care," she says.

For instance, it can be helpful to ask patients how they have been transferring from the bed to a chair, rather than showing them how to do it.

"Interaction and inclusion is very important. Older patients can help us determine what will work best for them," she says.

Hospitals operate on a specific schedule, and it's often hard for the elderly to adjust, Morgan says.

"Doctors come in at certain times; meals are at a certain time; medications are at a certain time. We forget the fact that patients had a routine when they came into the hospital, and with the elderly, it's hard for them to adjust to changes," she says.

Younger people tend to speak up if they get hungry before their tray arrives, and they don't have a problem pushing the call button if they need something, she says.

"Many elderly patients feel like they don't have a choice. They have to go along with the routine and not bother the nurse. If they need to change position or something worries them about their medications, they are likely to wait until a nurse comes in before asking," she says.

It's important to round on patients frequently instead of waiting for them to voice their needs,

she says.

The treatment team may need to make special accommodations to ensure that they get adequate nutrition and calories.

"Elderly patients are not necessarily big eaters, but that doesn't mean they won't eat. Instead of just assuming the patient will not eat, I encourage the rest of the team to explore individual eating habits so we have insight that we can act upon," she says.

For instance, if someone cuts the crust off a sandwich and cuts it into squares, seniors may eat it. If they won't eat what's on their tray, offer a bowl of soup, she advises.

She often suggests putting nutritional supplements into a cup with a lid and straw so the patient doesn't have to struggle with spilling it.

Be alert for the effect of multiple medications on the elderly patient's system, she adds. For instance, watch out for a patient's reaction to sleep agents that may not adversely affect younger patients, she adds.

"Elderly patients are very sensitive to even the smallest doses of some medications. Medication adjustment is often a big issue. I have become much more aware of drug interactions and reactions in the elderly and carry a medication book with information on the drugs and recommended dosages so I can alert the physician if it appears one of my patients is having problems," she says.

For instance, one of her patients was taking several medications for heart failure and, while in the hospital, was started on a drug for an enlarged prostate.

"After a couple of days, he began to have symptoms of dementia and it got to the point that he needed a sitter. Before he was hospitalized, he had been a professional man with normal behavior according to his wife. It didn't add up," Morgan says.

When the team analyzed his medications, they determined that the prostate drug was the only one that was new. They took him off the drug and after three days, his behavior started to normalize, Morgan says. ■

With elders, be cautious with fluid resuscitation

Your patient could be harmed

Aggressive fluid resuscitation, which normally would be used in younger trauma patients, potentially could do serious harm to an elder patient, warns **Rhyan Weaver**, RN, BSN, CEN, clinical supervisor in the ED at St. Joseph's Hospital and Medical Center in Phoenix, AZ.

"This could cause new problems, such as pulmonary edema in the elder with a pre-existing condition such as congestive heart failure," she says.

Also, chronic diuretic therapy can cause chronically contracted vascular volume and low serum potassium, says Weaver. "Rapid crystalloid infusion in this population can potentially cause electrolyte imbalances," she adds.

Normally, fluid resuscitation prompts potassium to shift out of the cells to maintain a normal serum potassium, explains Weaver. "Elders with chronically low potassium levels may not have intracellular reserves to maintain normal serum levels, causing hypokalemia and lethal complications," she warns.

Assess frequently

Hypoperfusion can result in decreased oxygen transport and organ damage, notes Weaver. "So not addressing hypotension can also be fatal," she says. "Be aware of the unique needs of the elder. Complete frequent, thorough assessments to maintain the elder's delicate homeostatic state."

Fluid resuscitation has to be goal-directed to prevent over-resuscitation in the elderly population, says **Glenn Carlson**, MSN, ACNP-BC, CCRN, a clinical nurse specialist/acute care nurse practitioner at Bronson Methodist Hospital in Kalamazoo, MI. "Markers of resuscitation, such as lactate and/or tissue oxygenation, can be used to help direct efforts to avoid heart failure," he says.

Elevated levels of lactate are related to tissue hypoperfusion that might be the result of under resuscitation, explains Carlson. "Normalizing lactate levels early, within the first 24 hours, has shown to be beneficial," he says.

Steven Glow, MSN, FNP, RN, associate clinical professor at Montana State University College of Nursing in Missoula, notes that the evidence regarding fluid resuscitation in trauma is changing significantly.

The current trend is fluid resuscitation to only 80 mmhg systolic, or a mean arterial pressure of 60 to 65, until all significant bleeding sources have been identified and controlled, says Glow.

"We used to try and resuscitate trauma patients back to a 'normal' blood pressure like 120/80," he says. "Large volumes of fluid that raise blood pressure to 'normal' levels increase the risk of bleeding and death." ■

Planetree model focuses on entire person

Staff partner with patients to answer

In the Planetree model, staff don't treat patients like they'd want to be treated. Instead, they find out how the patient wants to be treated, says **Linda Sharkey**, RN, MSN, vice president of patient care services and chief nurse executive at Fauquier Hospital.

"The way we want to be treated and how a patient wants to be treated could be completely different. We provide an individual approach to our patients and try to find out early in the stay what is important to them," Sharkey says.

Fauquier Hospital, located in Warrenton, VA, is a Planetree-designated patient-centered hospital.

The staff at Fauquier look beyond the problems that are being treated in the hospital and try to help decrease the patient's anxiety by doing whatever they can to help the patient remain calm and relaxed, Sharkey says.

"We take care of the entire person and partner with the patient to resolve all their concerns so they can concentrate on healing," she says.

For instance, an elderly couple driving through the area from New York to Florida was involved in an automobile accident. The husband ended up in the intensive care unit. The wife suffered from dementia and couldn't stay in a motel alone.

"His biggest concern was her, and he was her biggest concern," says **Pat Gerbracht**, BSN, MA, CRA, director of case management and social work.

The hospital moved another bed into his intensive care room so the wife could be with her husband. The ICU nurses took care of her as if she were a patient, helping her shower every day, providing her meals, and sending her clothes to the laundry.

"We took care of the woman until her family could get here at no extra charge. We cared for her as if she was our family member instead of his," Gerbracht says.

In another instance, a man having outpatient surgery brought along his puppy, and his wife planned to stay in the car with the dog during surgery.

When the surgery was delayed, the nursing staff took a sandwich to the wife as well a bowl of water for the puppy.

The hospital encourages patients to have a care partner, a family member or someone else they trust, who can be present when the physician, the case manager, or the social worker talks with the patient.

"The care partner is another set of eyes and ears. When patients are sick and anxious, they may not remember everything they're told or remember what questions they wanted to ask. The care partner can remind them and can reinforce the treatment plan once the patient gets home," she says.

All of the rooms in the hospital are private, with in-room beds for overnight visitors. The hospital has open visiting hours, allowing loved ones to visit whenever they like. The hospital's open-chart policy encourages patients to understand and take part in their own care.

In addition to the traditional therapies, the hospital offers relaxation therapies such as massage and Reiki energy and visits by trained pet therapy dogs for patients who want them.

"I've seen the Reiki therapists take away patient pain by redirecting energy from them. We offer this to our infusion patients, especially those getting chemotherapy to help take the fear away. We're beginning to offer it in labor and delivery as well," Sharkey says.

Patients may order meals from a food service menu of the hospital's Bistro restaurant and have them delivered when they want them, on their own schedule.

The hospital's patient concierge takes care of any patients needs, including making hotel reservations for out-of town patients, arranging for hot cocoa and cookies or even a glass of sherry at bedtime, celebrating patient birthdays, and providing flowers in a bud vase to cheer patients.

A network of volunteer chaplains addresses the patients' spiritual needs and visit with patients who would like company.

The staff are expected to show people the way to their destination rather than pointing out the way. Each staff member also is responsible for what the hospital calls "service recovery." For instance, when a patient's appointment is mixed up and he or she has to return, the staff give the patient a gas card to compensate for the inconvenience.

"All the staff are responsible for making sure the patient has the kind of experience that shows that we appreciate the opportunity to care for the patient rather than thinking the patient is lucky that we're here for them," Sharkey says. ■

(Continued from page 182)

the RN case managers for the decrease in length of stay.

The key to success is getting everybody on the team involved in managing length of stay and efficient utilization of service, she adds.

"The case manager has to constantly be communicating with the rest of the team and checking in to make sure all the bases are covered and the patient is getting everything he or she needs in a timely manner," she says.

The case managers and social workers are located on the unit to which they are assigned and communicate throughout the day with the health care team, she says.

They make sure that all tests, procedures, and consults occur in a timely manner.

"As a Planetree facility, we look at stewardship of patient resources, hospital resources, and payer resources. We don't want a patient to wait over the weekend for a procedure that can be done on Saturday or on an outpatient basis," Coffman says.

The documentation specialist reviews cases for core measures and posts the Medicare length of stay on a white board where the entire team can see it.

For instance, if the patient has chronic obstructive pulmonary disease (COPD), she writes: "This person is here for COPD, DRG 191, which has an average length of stay of 4.8 days."

"It keeps the physicians aware of the time frame. Often we have physicians approach us and ask if we are within InterQual criteria. If a patient is in a gray area, we'll get the doctor to give us further background information to make the case," Coffman says.

When they assess the patients, the social worker-case management team tries to anticipate any problem that may arise after discharge, particularly for a diagnosis that is at high risk for readmission.

For instance, if patients are hospitalized with chronic obstructive pulmonary disease, the case managers go beyond the immediate post-acute period to develop a care plan for when the patient goes home.

They find out if the patients have everything they need to manage their disease. For instance, they ask patients if their nebulizer is working, if their oxygen tanks are full, if they have transportation to their next physician appointments. If not, the case manager will assist them in getting what is needed lined up.

Patients often put up roadblocks to discharge and the case managers work to overcome them, Coffman adds.

"They'll say that the clothes they came in with are dirty, and someone on the staff will take them home and wash them. We set up taxi rides to home or doctor's appointments and give patients vouchers to pay for transportation. Our purpose is to be caring but not create codependency," she says.

The hospital has set up a continuing care fund that case managers can access if patients can't afford their antibiotics or have other unfunded needs after discharge.

The hospital partners with local pharmacies and refers patients to those that offer prescriptions for $4. The case managers and social workers work with physicians to see if there is a generic version of a medication that will be less costly for the patient.

"We look at whether there is a support person in the home or if there is someone in the community who can help care for the patient. We work to develop a safety net to help the patients follow their treatment plan when they get home," she says.

For instance, if a Medicare patient with COPD or heart failure doesn't qualify for home health, the case manager refers him or her to the hospital's LIFE Center, which provides pulmonary and cardiovascular rehabilitation services. The LIFE Center includes a fitness center and offers monthly educational meetings with nutritionists, physicians, and other health care professionals.

The case manager is able to obtain a week's free pass to the LIFE Center for patients who need extra encouragement after discharge.

"We want everybody to go home with something — not just a doctor's appointment. If they don't meet home health or nursing home criteria, we try to connect them with a community service," Coffman says.

"Patients don't disappear from our radar when they walk out the door. We make post-discharge calls to patients and follow those at risk for readmission for 30 days after discharge," she adds.

The case managers analyze the data from their units to focus on high-volume DRGs that are beyond the Medicare average length of stay and those with high readmission rates, Gerbracht says.

"We are strong believers in the data-driven work approach. You have to know where the opportunities are in order to improve. Otherwise, the staff work in an unfocused, shotgun approach," she says.

The case managers break down their data to the individual physician level and have instituted a physician feedback program, reporting on the same top 10 DRGs with unusually long lengths of stay. They report back to the physicians monthly on their individual data compared to their peers.

"It's one of the best techniques we've have to modify physician practice," she says.

"Sometimes it is physician practice patterns that are the issue. Some physicians use a 'string of pearls' model and order one thing one day and another thing the next. The case managers work with the physicians to ensure that the patients have all the tests they need early in the stay so they can move to the next level of care in a timely manner," she adds.

The reorganization effort began in September 2009 and went live in January 2010.

The team of case managers and social workers first looked at the roles of everyone in the department, how they were spending their time, and identified the strengths and weaknesses in the department.

The team members created a list of all tasks from the point of admission to the point of discharge. The social workers and RNs met frequently — at the hospital, at their homes, in restaurants — and defined their own roles.

"Role definition was No. 1 on our list of concerns. We wanted to maximize the expertise of the various disciplines and let the RN case managers do what they do best and the social workers do what they do best," she says. ■

AMBULATORY CARE QUARTERLY

Where do EDs remain challenged?

EMRs do not guarantee accurate documentation

Every summer The Joint Commission issues a list of those standards hospitals find most difficult to comply with. Among those challenging standards are three that experts say most directly impact the ED:

- DC.02.03.01: The laboratory report is complete and is in the patient's clinical record.
- RC.01.01.01: The hospital maintains complete and accurate medical records for each patient.
- LS.02.01.20: The hospital maintains the integrity of the means of egress.

Compliance with the first two standards is made much easier if the ED is fortunate enough to have an electronic medical record, or EMR. "We have an EMR, and really and truly it solves a lot of problems," says **Darryl Williams**, RN, BSN, clinical manager of the ED at Barnes-Jewish Hospital in St. Louis, MO. "It has a direct interface with the lab. Their system talks with ours, and the results go directly into our system."

Results are flagged and posted to the record, Williams adds. "The icon turns red, yellow, and then green when it's posted," he notes. "For any critical results, they still call the doctor."

But having an EMR doesn't guarantee compliance, insists **James Augustine**, MD, FACEP, director of clinical operations at Emergency Medicine Physicians, an emergency physician partnership group in Canton, OH. "There is still an issue between the 'in' computer and guiding patient care with somebody knowing the results," Augustine says. "In the medical records for patients, it should be clear that somebody has reviewed the results and dealt with any discrepancies."

For example, he notes, when it comes to cultures, specimens are obtained in the ED, but the initial result might come back a day later. "The results can be sitting in the computer, but they do not do you any good unless a decision-maker acts on it," he says. Some computerized systems now have prompts to trigger the staff to review results of important lab work that comes back later, he says.

Diana S. Contino, RN, MBA, FAEN, senior manager of health care with Deloitte Consulting in Los Angeles, says, "The lack of compliance may be the result of policies not keeping up with technology or practice. If your organization uses an electronic system to review lab results, and staff go to this system rather than using printed copies, then define an 'active chart' as encompassing the electronic lab reports in the lab or results reporting system."

If a surveyor then pulled an active chart during a visit, the staff would be expected to describe this process and be knowledgeable of policy and procedures. "Organizations using

paper charts are expected to define time frames when a chart is complete," Contino says. "In these cases, the organization needs to ensure that all final printed results are filed in the paper record."

Amend your action plan

If your ED hasn't been able to achieve this standard, there are several items that should be in your action plan, says Contino.

"First, map out the steps of this process, and identify a streamlined approach that minimizes handoffs and multiple persons being responsible for similar actions," she recommends. "One process that has been successful for some organizations is to implement automated 'final results reporting.'"

You should generate "final summary" reports from the lab system at the time that the chart is considered closed, says Contino. "These reports could even be printed on a different color paper, creating a visual queue that all labs are final and ready to file," she suggests. The outcome in this case is "one" easily identifiable report to be filed, as opposed to staff looking for multiple individual sheets.

The third step "should be the implementation of an EMR, which ultimately enhances the process of integrating the results with the patients' record, improving compliance with the standard around 'filing a laboratory result in the medical record' as well as meeting many other regulatory standards," Contino says. *(Contino says clinicians should be involved in planning for all of these difficult standards, especially egress. See the story, page 190.)*

Augustine says, "If you do not have an EMR, then you have to have a very sophisticated process of getting lab tests back to the emergency physicians or a responsible nurse, and make sure the results are managed appropriately."

Williams says, "If you do not have an EMR, you either have to have a paper from the lab delivered to you when resulted, or you have to take a read back; the lab calls you, and you give it." This process can be complicated, he says, because many people "turn numbers around" even when they read them, and handwriting these results also can cause mistakes.

Williams adds that even with an EMR, it can take quite a while to attain compliance with the second standard. "We've been working with our EMR for seven years now and customizing it, but

CNE questions

21. The Recovery Audit Contractors have to get approval from the Centers for Medicare & Medicaid Services before auditing for overpayment by demonstrating why the issue is worth pursuing.
A. True
B. False

22. What percentage of denials was the Lutheran Medical Center able to get overturned before the administrative law judge level during the RAC demonstration projects?
A. 87%
B. 90%
C. 95%
D. 97%

23. How many target areas are in the current PEPPER?
A. 4
B. 8
C. 11
D. 15

24. What is a typical case load for case managers at Faquier Hospital?
A. 25 or fewer
B. 27
C. 30
D. 35

Answer key: 21. A; 22. D; 23. 11; 24. A.

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the this issue, you must complete the evaluation form provided issue and return it in the reply envelope provided to receive a credit letter. ■

it's just now achieved completeness," he says. Each consulting service that came down to see patients in the ED had its own consulting documentation sheet, Williams recalls.

"We eliminated that problem by creating templates in our system for them to use," he says. Another piece of paper "people chase all over the world" is the EKG, Williams says. "As soon as it is taken here, our secretary can scan it into the EMR, so our record is a complete record," he says. The accuracy of the system allows the EKGs to be read in a timely manner, including the signature of the physician who wrote the note, Williams says. ■

Involve clinicians in egress plans

There are any number of reasons why an ED and its hospital would have difficulty complying with The Joint Commission standard regarding egress, says **Diana S. Contino**, RN, MBA, FAEN, senior manager of health care with Deloitte Consulting in Los Angeles.

"These include space limitations for the volume of patients, an inability to efficiently manage patient flow, and selecting equipment without the input of clinicians or concern for regulatory standards," Contino says.

Involving clinicians who understand the standards in the selection of equipment improves the ability to incorporate equipment that is useful and efficient, she says. "It is the clinicians who understand the impact of three large vital-sign monitors on poles for 12 rooms. All three poles usually end up in the hallway," she notes. "One medication cart with one barcode reader for 12 rooms usually results in a cart remaining in the hallway."

The involvement of clinicians facilitates the selection of the ideal process/procedures and equipment to meet the egress standards, Contino says. "For example, many clinicians have encouraged the use of asset tracking systems," she says. "These systems create real-time visibility of all equipment or tagged assets, allowing staff to put them in storage areas to maintain egress, while enabling rapid location." Other clinicians have conducted Lean projects to document mounting vital sign and computer equipment in the rooms, which saves staff time and reduces loss — justifying the costs of the additional equipment, she says.

"The bottom line is that clinicians should be actively involved in the selection of equipment and processes to maintain egress, as well as the accountability to adhering to the standards," says Contino.

There are other approaches ED leaders can take to help improve egress, adds **James Augustine**, MD, FACEP, director of clinical operations at Emergency Medicine Physicians, an emergency physician partnership group in Canton, OH. "Many hospitals have come to use new storage systems that allow them to more efficiently store supplies for the ED and have more space available for large pieces of equipment like EKG machines and computers on wheels," he says.

When it comes to the boarding of patients, Augustine says, "Hallway egress is a common cause of problems. That requires us to more effectively predict our volumes and create care spaces so that patient management can occur in a room as opposed to a hallway." Part of that process involves efficient movement of admitted patients to the floors, he says.

Barnes-Jewish Hospital in St. Louis, MO, has created an 18-bed transition unit away from the ED that takes just ED patients waiting for admission, reports **Darryl Williams**, RN, BSN, clinical manager of the ED. "That has really helped us maintain integrity of egress," Williams says.

When it comes to compliance with all Joint Commission standards, Contino adds this reminder for ED managers: "There are many ways to achieve the standards. The Joint Commission doesn't tell you 'how' to do it, but they define 'what' you need to do." ■

Cell phone pix: A new diagnostic tool

Photos taken by patients help speed flow

Initial data on the use of cell phone photos of injuries, taken by the patients themselves in the ED at The George Washington University Hospital in Washington, DC, offers the promise that they might have the potential to speed treatment without sacrificing diagnostic accuracy.

The patients send their pictures to a secure e-mail account, where they can be downloaded by ED physicians. "You look at a patient who comes in with a slice injury, for example, and sometimes you're not sure if they need stitches or not," notes **Neil Sikka**, MD, an assistant

professor of medicine at the George Washington University School of Medicine and chief of the Section of Innovative Projects. "When the patients present, we enroll them in the study, they take a picture of their wound, fill out a questionnaire [which covers their history and symptoms], and the doctor will look at the pictures to see if in fact they need stitches."

A research assistant helps the patient with the consent process, as well as the questionnaire and a survey that asks their opinion of the process. "They also help them shoot the close-ups from one or two feet away," says Sikka, noting that up to four photos may be used to show different angles on the injury.

The study is "very focused," looking only at patients who come in with acute lacerations or soft tissue infections, he says.

Sikka says that thus far, he has data from 125 patients after several months. He is encouraged by the results. The accuracy rate for determining whether acute lacerations require stitches is in the "high 80% range," Sikka reports. In terms of whether, upon follow-up, patients are getting better or worse, the rates are similar to those of patients who did not participate in the program. "Where we are not as good is in determining management of soft tissue infection," says Sikka, adding that the accuracy rate there is in the upper 60s. "This is probably limited by the fact that we only have 2-D pictures, which can't tell depth or level of swelling," he says.

Sikka also believes the rate could be improved by asking better questions of the patient. "History is the majority of medicine," he says.

Leena Salazar, RN, BSN, director of emergency services, was quite interested in the study when Sikka began it. "From a nursing perspective, it seemed very worthwhile," she says. "Anything that can help to alleviate long waits in the ED and still get the same quality treatment patients expect is a definite plus." *(For more on the reaction of nurses and patients, see the story below.)* ■

Nurses, patients like new approach

Nurses and patients in the ED at The George Washington University Hospital in Washington, DC, have responded positively to a new study that allows patients to e-mail cell phone photos of their injuries to ED physicians prior to their treatment.

"Most of our nurses are of the techno-savvy generation, so anything that brings technology into patient care and attempts to streamline things, they are all for," says **Leena Salazar**, RN, BSN, director, emergency services "They're excited about the things that it can do, and if the study pans out — and I don't see why it wouldn't — it will help their triages to know what to expect, since the patients will already have sent the pictures to the physician."

As part of the study, surveys are given to all of the patients for their opinions on convenience, time saved, and improved communication with the provider. **Neil Sikka**, MD, an assistant professor of medicine at the George Washington University School of Medicine, whose researchers conducted the surveys, says, "They have indicated really good acceptance. People are open to it and interested in the use of technology."

Salazar predicts that in the future, this

CNE OBJECTIVES

After reading each issue of Hospital Case Management, the nurse will be able to do the following:

- identify the particular clinical, administrative or regulatory issues related to the profession of case management
- describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the health care industry at large
- discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.

COMING IN FUTURE MONTHS

- Proving the value of your case management initiatives
- Reaching beyond hospital walls to prevent readmissions
- Tips from your peers on managing denials
- How to determine and develop optimum case loads

approach "would definitely improve satisfaction" because it streamlines the treatment process. "Patients do not have to wait hours to be triaged, only to then go back to see a doctor and be told they do not need stitches," she explains. Initial patient survey comments indicate they agree this approach can save time while improving communications with the physician. ■

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