HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

AHC Media LLC

IN THIS ISSUE

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Does your documentation assurance program stop short?

Make sure the record is complete to accurately report mortality data

If your documentation assurance program focuses on reimbursement alone, you're not going far enough. With pay-for-performance initiatives on the rise and increasing mandates for public reporting of hospital data, it's critical that the medical record accurately reflect the severity of illness and the services provided to your patients.

Many times, documentation specialists do a great job of picking up the complications/comorbidities (CCs) and major complications/comorbidities (MCCs) but stop right there and miss the opportunity to add additional documentation, which will affect the drivers of acuity level and risk of mortality. **Bert Amison**, managing director of health care advisory services for KPMG LLP, who works with hospitals on documentation improvement projects, says he has found this to be true.

"So often, hospitals concentrate so much on reimbursement that they put other issues on the back burner. Many times, when we conduct an analysis of hospital documentation, we find little or no opportunity on the hospital reimbursement side, but there is a lot of opportunity on the risk-adjusted mortality side," Amison says.

The MS-DRG system is somewhat severity-adjusted, but it still doesn't give a comprehensive picture of how severely ill the patient is, adds **Tamara Hicks**, RN, BSN, CCS, manager of care coordination at North Carolina Baptist Hospital in Winston-Salem, NC.

This means it's no longer enough just to get the MS-DRG correct and ensure that your hospital is appropriately paid for the services it provides, she adds.

Often just one comorbid condition will put a patient into a higher-paying MS-DRG, but if the patient has multiple comorbidities, it can affect the hospital's severity of illness data, Hicks says.

"When we first started our documentation integrity program, we looked only at Medicare patients and their DRGs. When we got a

complication/comorbidity documented, we stopped because we had gotten the patient in the highest-paying DRG. But if there is a patient who is in the ICU for 50 days and we document only enough for the highest reimbursement, it skews our severity of illness and expected mortality data," she says.

When the administration asked for data that showed how sick the patients really are, the care coordination department evolved its documentation integrity process to ensure that the documentation gives a complete picture of the patients' condition and services received, Hicks says.

Draw complete picture

"It's important for the documentation to be complete. If a patient dies while in the hospital, we want our data to show that we expected it. We don't want the record to show that the patient had only a 10% chance of dying because the documentation was not complete," she says.

Web sites such as The Leapfrog Group and Health Grades include expected mortality and the mortality index in their hospital report cards, says, **Liz Youngblood**, RN, MBA, vice president, patient care support services at Baylor Health Care System in Dallas.

Documentation that accurately shows severity of illness and mortality data is more critical than ever because so many decisions are being made based on administrative data, she adds.

Patients are starting to shop for health care and may use public report cards in their decision-making process, Youngblood says.

"Consumers are becoming more savvy and more active in making decisions about their health care. They no longer rely solely on their physicians when it comes to choosing a hospital. They are looking on the internet and asking a lot of questions," she says.

The data also affect the hospital-specific assigned base rate with which Medicare reimbursement is calculated. Quality information that is based on administrative data also may be considered during the negotiation of managed care contracts, adds Youngblood.

Commercial insurers are focusing more and more on quality of care and are taking comparative data into account as they contract with providers, she says.

Managed care payers have claims data as well and can use the information to analyze hospital outcomes of care, Youngblood adds.

"Providers with more favorable outcomes may be considered the best choice for payer populations," she adds.

For instance, The Leapfrog Group's Hospital Rewards Program ranks hospitals in four tiers, based on quality measures and resources use, allowing commercial insurance and employer groups to use the information for pay-for-performance initiatives.

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Reporting accurate mortality data is important as Centers for Medicare & Medicaid Services moves toward value-based purchasing and begins to tie reimbursement to quality indicators, Amison points out.

"The trend is going in the direction of possibly tying more payments to hospitals who report more appropriately and more accurately," he adds.

Mortality reporting, severity of illness, and risk of mortality all are driven off of coding. This means the documentation in the medical record should be complete and accurate to fully reflect the patient's condition, Hicks says.

Documentation assurance makes sure you are paid appropriately for the care provided by ensuring that you have the documentation in place to support medical necessity. Additionally, other rules, such as whether a condition was present on admission, must be clearly documented to allow coders to appropriately code, Youngblood says.

"It's really about compliance — making sure that you have accurate coding, and that entails making sure you have the proper documentation in the medical record," Youngblood says.

Whether your department is starting a brand-new program or beefing up an existing program, you need to be able to demonstrate a business case for documentation assurance in order to sell it to management, Amison says.

Return on investment

"Return on investment for a documentation assurance program is very real, especially when Medicare and Medicaid are proactively looking to recoup funds through the Recovery Audit Contractor and Zoned Program Integrity initiative," Amison says.

"A proactive and robust documentation improvement program produces a financial return on investment, a compliance return on investment, and appropriate documentation of the severity level of patients," he says.

Start by pulling together a multidisciplinary team to evaluate what the program might look like, Amison suggests.

In addition to case management, the health information management director, the quality and/or compliance officer, the chief financial officer or a representative from finance, and the chief medical officer or the chief nursing officer or both should be on the team.

"The team should include representation from every department that has a stake in documentation assurance. If people are involved from the beginning in the evaluation process and the creation of the program, they're more likely to be involved and promote the program with their staffs when it is rolled out," Amison says.

The team should review the medical record and the coding to determine where the documentation deficits are and where there is room for improvement, Youngblood suggests.

Don't concentrate on every MS-DRG at once. Pick a few areas where you can make the biggest difference, she advises.

Don't assume that the areas other hospitals struggle with are the same areas where you should focus. All hospitals are different, Amison adds.

Amison strongly advises his clients to dedicate full-time staff to a documentation improvement program.

"The solution isn't just to put the documentation improvement process on the case managers' plate when they typically have more pressing things to do. If you take into account all of the benefits of a documentation assurance program and compare that to the salary for dedicated staff, it's a no-brainer," he says.

Before beginning the program, educate everyone who is going to be involved in the process.

Take a three-pronged approach to education, Amison suggests.

"You can't educate the documentation specialists and the coders and not the physicians," he adds.

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Education, auditing key to documentation programs

Multiple review levels assure records are accurate

Regular audits and continuing education are the keys to a successful documentation assurance program, says **Liz Youngblood**, RN, MBA, vice president, patient care support services at Baylor Health Care System in Dallas.

The Baylor system has developed multiple levels of review for its documentation assurance program. In addition, the care coordination and coding staff go through formal training to ensure the accuracy of the documentation in the medical record.

All hospitals in the Baylor system practice documentation assurance, and seven of those participate in a formal, structured program. These hospitals use different models depending on what is most effective at the individual hospital. The larger hospitals have dedicated DRG assurance nurses who work with the care coordinators on documentation assurance, adding an extra layer of expertise.

At smaller hospitals, the care coordinators are responsible for documentation assurance as part of their regular duties.

A robust auditing process is essential to make sure that your documentation and coding is up to date, Youngblood says.

The Baylor health system contracts with an external firm, which comes in quarterly and runs reports on the documentation integrity program as well as conducting an annual audit. Another external agency conducts a quarterly audit.

In addition, the hospital system's in-house coding auditors regularly review hospital medical records for coding accuracy. System-based coding auditors also audit the medical record for coding.

The coders and care coordination staff at each hospital get together regularly to review medical records that might be in question and decide if anything could have been done differently.

"We also have daily communication between the coding staff and the care coordination staff who help with ensuring that documentation is complete on the medical records," Youngblood says.

Internal, external reviews necessary

Youngblood suggests that hospitals put parameters in place to assure that they are monitoring their own documentation and coding integrity as well as consulting with someone outside the organization to audit the records on a regular basis.

For instance, if you are in a health system or partner with other hospitals, you could audit each other and exchange expertise, she suggests.

"Ideally, any review of documentation can be done internally but hospitals should also have an external review on a periodic basis. It doesn't have to be an expensive ordeal. You just need a different pair of eyes — some kind of outside objective review to make sure you don't perpetuate the same practices," Youngblood says.

If you're doing something that is not a best practice, you might not recognize it or pick up on it if you continue to review yourself, she points out.

If you choose to conduct your audit internally, make sure that whoever you choose to conduct your audit is looking at your documentation from a different angle, Youngblood suggests.

In addition, make sure that your documentation assurance and coding staff are educated regularly, as coding requirements change, she advises.

"The benefit of accurate coding is not necessarily tangible, but having fewer errors on the back end means that when an external agency reviews medical records, the hospital will have fewer errors that minimize the need to rebill," Youngblood adds.

At Baylor, the care coordinators receive formal training on documentation issues on an annual basis, in addition to attending regular educational sessions with the coding department.

In addition, the health care system has a coding educator who provides education for the staff at each hospital. The larger hospitals in the Baylor system have DRG assurance nurses who oversee the documentation integrity process and provide additional education.

"The education also extends to the medical staff at staff inservices and section meetings. The coders and care coordinators also provide just-in-time education to the physicians when they query them in person," Youngblood says. ■

Documentation specialists review 100% of admissions

Dedicated staff work separately from CMs

Tamara Hicks, RN, BSN, CCS, describes the work of the clinical documentation consultants as being like a detective who looks for clues and thinks ahead as to what the cause may be.

"When I conduct an initial review of the chart, I read it from the beginning, like a story — starting with the emergency department notes, through the history and physical — and start building a story from a clinical standpoint. I look at what is being described and try to determine what the documentation is not telling me," says Hicks, who is manager of care coordination at North Carolina Baptist Hospital.

For instance, if the chart indicates that the patient has an elevated potassium level, the nurse knows she needs to look for documentation of hyperkalemia.

"I'm trying to make sure that what appears to be going on from a clinical standpoint is clearly stated in the documentation," Hicks says.

Clinical documentation consultants

At North Carolina Baptist Hospital, a large teaching hospital in Winston-Salem, clinical documentation improvement is performed by BSN-prepared nurses with at least five years of clinical experience.

Called clinical documentation consultants, they review 100% of cases whether the patients are covered by Medicare, Medicaid, or commercial payers.

They review the charts of new patients within the first two business days after admission, then review them every two business days unless they have made a query to the physician and are waiting for a response or if the patient originally had no complication/comorbidity (CC) or major complication/comorbidity (MCC).

The clinical documentation consultants assign the working DRG.

"The nurses are not coding the record. They're only to say what the DRG appears to be and what are the opportunities," Hicks reports.

The care coordination department includes case managers as well as 11 clinical documentation consultants who are assigned by nursing unit.

"Clinical documentation improvement is not part of the case management role at all, and I have been very adamant to keep it separated. Case managers are already involved in utilization review, discharge planning, and throughput. Documentation improvement can't be a high priority for them," Hicks says.

Case managers and clinical documentation consultants both review the patient chart, but they're looking for different things, she asserts.

"The two groups work together, but it's a misnomer that case managers can perform documentation enhancement because they're in the record already. They're not looking for the same things. You have to wear two different hats to handle both roles, and we feel we get a lot more bang for the buck by having a dedicated clinical documentation staff," Hicks says.

The clinical documentation consultants undergo a homegrown training program that has its roots in a training video developed with the help of a consultant when the program started.

"Now that CMS no longer uses the DRG system for reimbursement, we have added to the program," Hicks says.

A supervisor works one on one with new staff members, going over the MS-DRG system and teaching them how to assign a working DRG. Then the new clinical documentation consultants shadow a peer to learn more about the system before going out on their own.

"It takes about five weeks to get a new clinical documentation specialist trained and about six months to a year for them to get proficient," Hicks explains.

Some of the nurses are specialized in a particular field and are assigned to that area of the hospital. For instance, the clinical documentation coordinator who works on the neurology and neurosurgery unit is familiar with what affects MS-DRGs and severity of illness in that population.

All of the nurses have a broad-based education in documentation that enables them to fill in for their peers on other units.

The clinical documentation coordinators make sure that the documentation is complete to demonstrate medical necessity, but they don't stop there.

"We look at the MS-DRG to see if there is potential for improvement. We need to document all the care the patient receives because it impacts our severity-of-illness data," Hicks says.

When the clinical documentation consultants have a question for a physician, they write it in the electronic medical record. They also use a computer-generated worksheet that does not go into the electronic medical record. If the physician doesn't answer the query in 24 hours, they follow up in person.

"One of the biggest challenges to this program is physician buy-in," Hicks says. About 80% of the physicians are totally cooperative, she adds.

The team educates the physicians on the importance of documentation one on one as well as in formal presentations at faculty and medical staff meetings and provides individual physicians with their query response rate.

The department tracks case mix index, revenue enhancement, CC and MCC capturing, queries and query response rate, and audits the query worksheets records for missed opportunities.

The supervisors compare the medical record with queries made by the clinical documentation consultants to make sure they are taking every opportunity to assure that the documentation is complete.

After the record is coded, the clinical documentation consultants review it a second time to see if they missed any opportunity to improve the documentation or if there is documentation that needs to be clarified.

Then either Hicks or a supervisor look at the record again to see if anything was missed.

"The goal is to make sure we are covering all the bases. The focus has shifted from just looking at the DRG to looking at severity of illness and the mortality index. Our goal is related to the hospital goal of keeping expected mortality up and the mortality index down," she says.

The hospital was undergoing an internal audit at the same time it found out the Recovery Audit Contractors were coming.

"What we learned was that even though the patient met medical criteria, the physician intent, such as admitting the patient for observation, wasn't always in the documentation. This wasn't something our utilization review nurses and case managers were focusing on. Now, when the case managers see this omission, they get it clarified or get the patient's status changed," Hicks says. ■

With hospital closed by flooding, CMs help out

Employees on payroll during renovation

Sharon Spencer, RN, was working around the house on a Saturday evening when she got word that Columbus (IN) Regional Hospital, where she is employed as a case manager, was being evacuated because of a flash flood.

"I knew there was going to be rain over the weekend, but the flood took everybody by surprise. I contacted my boss to see if I could help, but my access to the hospital was cut off by the flood," Spencer says.

Columbus Regional Hospital was damaged by record flooding and storms on June 7, 2008, when Haw Creek flooded 12 inches above the 500-year flood level. The hospital safely evacuated 157 patients within three hours, but the majority of the hospital remained closed until Oct. 27.

Following the flood, the hospital administration made the decision to continue paying all 1,800 employees while the flooded areas of the hospital were being restored and rebuilt, says **Jim Bickel**, CEO of the 225-bed regional hospital.

"While the hospital was closed, the hospital's people were open for business. Staff members assisted the community in a variety of projects. Not only was this the right thing to do for the hospital, it was the right thing to do for the community," he says.

Many of the case managers at the hospital were assigned to community agencies to put their skills to work helping people whose homes were destroyed by the flood find the resources they needed.

In the first days after the flood, **Kristie Leonard**, RN, a case manager at the hospital, was given a variety of assignments that ranged from assisting the public health department in giving members of the community tetanus shots and working at an urgent care center to cleaning hospital furniture that was damaged in the flood and sorting donated clothing items at a local charity's headquarters.

Eventually, Leonard was assigned full time to United Way to assist in community case management along with several of her peers from the hospital.

Spencer, who has asthma, was unable to do some of the work because of the mold and mildew that followed the flood. For her, the most frustrating part of the situation was waiting until she got an assignment.

"I felt very frustrated. I felt like I needed to be doing something," she recalls.

When Spencer attended one of the hospital's long-term recovery meetings, she and other case managers volunteered to help people who lost their homes find community resources.

"We felt like we had a lot of knowledge we could share and that this was where we could help the most," Spencer says.

Spencer and other case managers from the hospital set up the long-term assistance office at United Way, canvassed areas that had been hard-hit, and identified clients who needed help.

"None of us had any disaster training at all. We were all hospital-based case managers. We knew how to take the information we had and the needs to the clients and apply them to the practice of case management," she says.

The case managers began by going through the Yellow Pages and calling every business and individual that might be a good resource for their clients. The list ranged from contractors to electrician, plumbers, building supply companies, or wrecker services.

"We developed our own list for community

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CRITICAL PATH NETWORK™

Community network facilitates seamless transition of care

Hospital, nursing homes work together on transfer of patients

After Summa Health System began a series of initiatives to provide a seamless transition as patients move between levels of care, the rate of hospital readmissions within 31 days dropped from 26% to 24%.

"Avoiding readmission is a challenge for every care manager and discharge planner. We identified where the potential risk factors are and came up with strategies to manage them," says **Carolyn Holder**, MSN, GCNS-BC, manager of transitional care for senior services/post-acute for the integrated health care delivery system in Summit County, OH.

The challenge is compounded by the fact that today's hospitalized patients are older and far sicker than in the past and many have multiple chronic illnesses.

"We have an increasing number of patients who are aging with pre-existing functional impairments, as well as lack of caregiver and social support. In the past, patients were admitted with simple pneumonia or heart failure. Today, nothing is simple," Holder adds.

Today, a likely scenario would be a patient with pneumonia who is admitted for a two-day stay. The patient is elderly, living alone, and has functional problems and other comorbidities such as heart failure, lung disease, diabetes, or a complex medication regimen.

"We can't just look at medical conditions. We have to take into account all the risk factors that could prevent these patients from successfully managing their own care, preferably at home or in another level of care" Holder says.

Summa's post-discharge initiatives include collaborating with local skilled nursing facilities on communication issues as well as taking a proactive approach to discharge planning and patient and family education. **(For details on how the care coordinators and social workers collaborate to smooth the transition, see related article on p. 40.)**

"We knew we couldn't do this by ourselves. We have to reach out to the nursing homes and other community providers in order to provide a seamless transition between levels of care," Holder says.

One key factor in improving the transfer process was the development of the Care Coordination Network, a coalition of representatives from the hospital system and 28 nursing facilities in the community.

The goals of the Care Coordination Network are to reduce fragmentation of care, decrease hospital length of stay and unnecessary readmissions, and enhance quality and patient outcomes, Holder says.

Representatives from each of the nursing facilities work collaboratively with hospital staff to improve the way information is shared and ensure continuity of care as patients transition from one level of care to another.

"The network has been a real plus. We are looking at it from both sides when it comes to improving transfer of care between facilities. There would have been no way for us to change the process without knowing what the nursing facilities needed," she says.

The network team identified factors that impede smooth transition, including the time it takes to identify available beds at post-acute facilities and gaps in information the hospital provides to post-acute providers.

One of the first steps was to create a standardized nursing facility transfer form for orders and

information needed as patients are transferred from the acute care hospital to the nursing facility. Based on the success of this effort, Summa contributed to the development of a regional post-acute transfer form that is now used for transfers between hospitals and nursing facilities in a four-county area of northeast Ohio. The Akron Regional Hospital Association took a leadership role in the development of the regional transfer form.

"We also asked the nursing facilities to tell us what they need to make a decision on whether they could take the patient. This includes bed availability, patient needs, and other transitional issues," Holder says.

Using the information, Summa implemented an electronic referral process, using an electronic discharge planning product that has increased the timeliness and efficiency.

"As a result of this interaction, hospital staff were educated on what the nursing facilities need and why. Another positive effect of the interaction is the decrease in requests for chart forms to be faxed to the facilities. The network developed a core list of information needed, which decreased work time for the acute care staff," Holder says.

In the past, each nursing facility wanted different information, which meant the hospital staff had to copy as many as 30 or 40 different forms. The facilities got together and narrowed it down to about 14 areas of key information, she adds.

After creating the nursing facility transfer form for regional use, Akron Regional Hospital Association, in collaboration with Summa and the Care Coordination Network, developed a referral form for nursing facilities to use when they transfer patients to an emergency department.

"The communications process goes back and forth. They are telling us what they need from us, and we are telling them what we need from them," Holder says.

All of the nursing homes in the area use the transfer form to give the emergency department staff details on why the patients are coming in. The nursing homes also put a patient identification band on every patient transferred to the hospital or emergency department.

The post-acute care to emergency department/hospital transfer form provides information about the reason for the transfer and the baseline history and functional level of the patient.

The Care Coordination Network is working to review the quality of patient transfers and to identify factors that contribute to patients being admitted to the hospital within seven days.

"We're looking to see what we could have done differently and to develop initiatives to address them. We are seeing a trend for patients being admitted within seven days with symptoms of delirium," she says.

"Before we started this process, we had no way of knowing why they were coming back. We asked them to critique us and let us know how we could do a better job in providing information about the patient. It really helped us close the loop on what we needed to include when we transfer a patient," Holder says.

At the same time, the hospital system is able to communicate quality issues with nursing facilities, such as how a quick response for bed availability helps with hospital capacity. In turn, the hospital staff learned that when the patient is going to need a particular type of bed, such as for a bariatric care patient, the nursing home needs to know up front.

"They understand that we have to be able to move our patients when we're full. We have educated each other about what each of us needs to ensure a quality transfer," she says.

(For more information, contact: ***Carolyn Holder****, MSN, GCNS-BC, manager of transitional care for senior services/post-acute, Summa Healthcare, e-mail: holderc@summa-health.org.)* ■

Proactive approach speeds discharge

CMs identify self-care deficits, educate patients

When the clinical nurse specialists and case managers at Akron, OH-based Summa Health analyzed the reasons patients were being readmitted within 31 days, they determined that mobility issues, self-care deficits, pain control, and failure of discharge planning were key factors.

"We found that the No. 1 reason for readmissions was that the patients lacked the ability to take care of themselves. These patients were cycling in and out of the hospital and not getting better," says **Carolyn Holder**, MSN, GCNS-BC, manager of transitional care for senior services/post-acute for the integrated health care delivery system in Summit County, OH.

In the Summa system, patient care coordinators with an average caseload of 16-17 patients, moni-

tor and guide the plan of care and collaborate with social workers to coordinate the discharge plan.

Summa uses an initial nursing assessment form originally developed for its acute care for elders unit throughout the hospital. In addition to the current medical condition, the assessment form includes items on functionality, activities of daily living, cognition, depression, and a discharge planning screen to identify support at home prior to admission.

The emergency department starts the assessment form and shares any key information verbally with the unit team when the patient is admitted.

Most of the assessment takes place on the nursing unit.

"The patient care coordinators see their patients on Day 1 and start looking at their functionality, what they need to get back home, what are the barriers that may impede recovery or cause delays in stay. We try to gather as much information up front as possible when they are admitted so we can better plan the discharge and eliminate any roadblocks to a safe discharge," Holder says.

The care coordinators and social workers take the lead in making sure the patient moves through the continuum as quickly and safely as possible, interfacing with the family, the patient, and the physicians to make sure the plan of care is followed.

"We try from Day 1 to get a feel for what kind of care they will need after they leave the hospital. We ask for a physical therapy evaluation on Day 1 and talk extensively with the family to get details about the patient's functional level," Holder says.

Often, the team finds that the information gathered from the patient during the initial assessment isn't 100% accurate.

"Many times, the patient is too sick to give us a lot of details or doesn't want to tell us how many problems he or she has been having. We confer with the family and share the information with the physician," Holder says.

The patient care coordinators and social workers have collaborated on efforts to improve the process and worked to improve communication about what the patients and family members can expect at discharge and what they would need to be able to do at home.

The team is currently looking at the kind of instructions that patients and family members need in order to manage at home.

"We know that the discharge instructions must be in writing as well as verbal and that they must be reinforced throughout the stay," Holder says

The team uses an electronic post-acute referral process for nursing facility placement.

"As soon as we know a patient is going to need skilled care after discharge, we send out information to multiple facilities so that the families can begin to make choices early in the stay," she says.

An assessment nurse from Area Agency on Agency screens patients for eligibility for home health services provided by their PASSPORT program. PASSPORT is a Medicaid program designed to keep older adults at home instead of at a long-term care facility through a range of supportive services.

"The patient care coordinators ask for an assessment on every patient they think may be eligible so they can get long-term services in place as soon as possible," Holder says.

The Summa care coordinators also work with the PASSPORT care managers to ensure continuity of care for patients already active in the PASSPORT program. ■

Clinical documentation program keeps improving

DRG reimbursement increases more than 75%

In its second year, the clinical documentation program at Jupiter (FL) Medical Center was able to increase DRG reimbursement by 75% over the previous year.

The program generated an increase of $547,563 in fiscal year 2008 compared with the previous year, when the program increased DRG reimbursement by $313,441.

In addition to Medicare, several large commercial payers reimburse the medical center on a DRG basis.

"The whole secret to the success of our program is a close and collaborative relationship between the clinical documentation specialists and the coders, the physicians, and nurses. We recognize that they are the experts in coding and we let them know that we appreciate their knowledge and want to learn from them. We let them know that we are not trying to take their jobs but rather want to help them to have all the information they need at the point of coding," says **Cathy J. Hamilton**, RN, BA, MHS, CPHQ, CPUR, director of care management.

At Jupiter, clinical documentation improvement is the responsibility of two experienced RN case

managers who were trained to become clinical documentation specialists. They work closely with the coders and physicians.

"The relationships they already had with the physicians was definitely an advantage for them," Hamilton says.

The clinical documentation specialists review every DRG payer medical record to assure that the severity of illness and intensity of services being utilized are adequately documented and that present on admission conditions are specified. They also monitor the record for compliance with the Core Measures. **(For details on how the program works, see *Hospital Case Management*, January 2008.)**

Case managers at the 163-bed community hospital are unit-based and cover the emergency department and the intensive care unit as well as the medical, surgical, and telemetry units. A case manager is on duty in the emergency department from 11 a.m. to midnight.

Before the clinical documentation program began, the case management department started building the relationship with the hospital's coders, Hamilton says.

At the time, the coders were frustrated by difficulties in getting queries for additional information answered from physicians when they conducted their retrospective review of the patient record.

"The physicians felt that since the patient was gone and they had written the discharge summary, they were finished with the chart and had moved on. They rarely responded to the coders. In fact, their response rate was 0%. We got coder buy-in for the new program in part by helping coders on the back end by taking over the entire query process," Hamilton says.

Since the clinical documentation specialists query the physicians concurrently, the chart is almost always complete when it gets to the coders.

This makes it much easier for the coders to do their jobs and ensure that the bills get out in a timely manner, Hamilton says.

Now if the coders find something on the chart that doesn't appear to be present on admission or something that the clinical documentation specialists didn't pick up during their review, they write down the information they need and the clinical documentation specialists get the answers.

If the physician typically has patients in the hospital, the clinical documentation specialist asks the case manager on the unit to call her when the physician is on the unit and talks with him one on one.

Otherwise, she places a query on the medical record and faxes the query to the physician's office or calls the physician.

100% response rate

The clinical documentation specialists have achieved a 100% response rate on their queries from physicians.

They are assisted by the physician advisor to case management who calls the physicians if they don't respond.

"They know they're going to get a call if they don't respond. We make it clear that we aren't asking them to agree with the query. We just want them to answer the query and sign the document," Hamilton says.

The clinical documentation specialists and the coders meet monthly to share information and discuss what could be improved and any trends the coders see in documentation. In between meetings, the clinical documentation specialists frequently call on the coders with questions about documentation.

When Hamilton reports on the success of the clinical documentation program, she always gives the coders credit for their role in the process.

"We include them in any celebration we have and tell them how much we appreciate them," Hamilton says.

The case managers and clinical documentation specialists educate the physicians one on one about the importance of accurate and complete documentation. The department brings in a physician documentation specialist to present a continuing medical education program to the medical staff at least every other year.

"We tell them that if they aren't documenting severity of illness of their patients, they can't accurately support a higher billing code. We stress CMS and other third-party payers are developing physician profiles, and if the profile reflects that their patients have a low severity of illness but the cost of providing service to the patient is high, they will not be sought to be on the payer's physician panel," she says.

The case management staff point out to the physicians that CMS and other third-party payers are beginning to use utilization and quality information in physician contracting and institute pay-for-performance initiatives.

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(Continued from page 38)

resources and shared it with United Way's 211 national database for health and human services information," Spencer says.

In turn, the 211 database shared information on organizations and individuals who would provide free services for people in need.

"The case managers worked as a team with the volunteer action coordinator and the construction manager at United Way to help coordinate services for people," she says.

When she joined the other case managers at United Way, Leonard contacted people who were affected by the flood to assess their immediate needs. Some had lost their homes to the flood and were in hotels or temporary housing.

"Making sure people had a roof over their heads and food to eat was our first priority. As the weeks went on, we worked to help people get back into their homes, or if that wasn't possible, to find appropriate housing. We worked with FEMA to help people who had lost their homes find community resources and helped support them emotionally as well," she says.

Long-term recovery efforts

When funds became available, the case managers worked with the long-term recovery committee to get materials and supplies that people could use to repair their homes.

Many of the clients didn't have flood insurance, and the money they received from FEMA didn't cover all the damage, Spencer says.

"The area that was hit the worst was a neighborhood of rental houses for the working poor. Their rent was low, and many had lived there quite a while. Following the flood, they were faced with paying twice as much rent in an area where there was already a shortage of affordable housing," she says.

Renters received reimbursement from FEMA only for their possessions.

"Initially, we worked with the city government and the landlords to help find housing for these people," Spencer says.

Her case management background helped Leonard connect her clients with community agencies "but there were a lot of unknowns that we had to deal with on a day-to-day basis," she says.

"I was familiar with some of the community resources from my work with patients at the hospital who needed help with food or housing after discharge. It was nice to learn what other services are available," she says.

Now that she has returned to work at the hospital, Leonard anticipates putting her new knowledge to work.

"The work helped me understand what community resources are available and gave me a better understanding of what the patients I encounter may face in their lives, whether it's financial, physical, or emotional baggage," she says.

Leonard returned to work at Columbus Regional in October but in the new role of discharge utilization coordinator.

When the hospital flooded, the case management department was in the midst of a reorganization project and continued to work while the hospital was closed. A few weeks before the hospital reopened, Leonard and the other case management staff spent three weeks working with their new manager and new peers to identify what their new roles would be.

Spencer has continued working at United Way as the case management supervisor for the agency's long-term recovery efforts.

"I'm still a hospital employee. I'm working here because of a cooperative effort between the long-term recovery team and the hospital," she explains.

Spencer supervises 10 lay case managers who are volunteers and work part time and follows about 25 clients as well.

"We screen our clients for their needs and identify resources to help them. They may need something as small as drapes and blinds for their home or as big as having their entire home rebuilt," she says.

The experience has given Spencer knowledge that she and her fellow case managers can use as they struggle to find community resources for their patients.

"I'm going to be able to take back resources we've never thought about before, so it will be much easier to help patients find help they need. If we have patients who are having difficulty with rent, I'll know people on a first-name basis who can provide assistance," she says.

On June 7, the Columbus area received more than 10 inches of rain during the morning hours.

By late afternoon, water started flowing into the hospital parking lot and entered the basement.

The hospital basement where the laboratory, pharmacy, information services, and electrical/mechanical systems were housed was completely flooded and the first floor of the hospital had 6 to 8 inches of water. Total damage is estimated at

$210 million.

Hospital staff began the evacuation process around 6:30 p.m., transporting patients in wheelchairs and on stretchers, recalls **Tom Sonderman**, MD, chief medical officer.

"It took four to six people to carry the patients and others to hold flashlights and open doors. The patients were transferred to other facilities by ambulance and by school bus. By 9:30 p.m., all the patients and staff were safely out of the hospital," he says.

The hospital began offering outpatient services at locations across the community within the first week after the flood. A Carolinas MED-1 mobile emergency unit, based at Carolinas Medical Center in Charlotte, NC, relocated to Columbus and was open on the hospital campus by June 23. The hospital opened its interim emergency department within the hospital building on Aug. 1 and reopened the inpatient and surgical services inside the building on Oct. 27. ■

AMBULATORY CARE

QUARTERLY

Study: Telemedicine could reduce pediatric ED visits

Docs remain skeptical, say most visits are necessary

Telemedicine has long been recognized for improving access to care as well as access to specialist expertise, particularly in rural facilities. Now, in an unpublished study just completed in Rochester, NY, the lead author says it also can offer a possible solution to overcrowding when it comes to pediatric ED patients, many of whom, he asserts, easily could be treated by a primary care physician.

The report, which has not yet been published, analyzed data from 2006 and tracked all pediatric visits to the city's largest ED, at the University of Rochester Medical Center. The researchers then studied more than 6,000 telemedicine visits during the same period. The ED visits were categorized into ailments that always could be managed by telemedicine; those that were usually treated through telemedicine; and conditions that usually could not be treated with telemedicine. Results showed that nearly 30% of ED visits fell into the first category and could always be treated with telemedicine. If those problems had all been handled through telemedicine, the research concludes, Rochester would have had at least 12,000 fewer pediatric ED visits in 2006.

Many, if not most, pediatric-age ED visits are for nonemergency problems, says **Kenneth McConnochie**, MD, MPH, founder of Health-e-Access, the University of Rochester Medical Center telemedicine program that uses the Internet to connect pediatricians with sick children at inner-city child care centers. "There are a number of studies showing that between 25% and 75% of ED visits for kids are nonemergency visits," he notes. "If you accept that as a bad thing, it's a crazy use of resources."

EDs have to be prepared to manage the most severe illness and injury episodes, McConnochie says. "They are set up to manage that, and they do it very well," he says.

Subacute visits, he adds, take precious time away from the ED staff, McConnochie says. "The average time to treat a sore throat, ear infection, or pinkeye, is about 4.5 to six hours, according to what parents told us, and sometimes as long as 16 hours," he says. "We can do it in a telemedicine site in no time."

Drilling further down into his study's statistics, McConnochie says that for kids with telemedicine available in their day care center or elementary school, ED use dropped 22% based on a matched comparison of age, gender, socioeconomic status, and season of the year. "For every telemedicine child, they matched them month for month with children of the same age, gender, zip code, and so forth, who did not have access to telemedicine," he says. ED use was down 22%, McConnochie says. "That's good for payers, good for society, and ultimately good for the industry," he says.

But not everyone draws the same conclusions. "Telemedicine will do little to relieve pediatric ED overcrowding," claims **Gregory P. Conners**, MD, MPH, MBA, professor and interim chair, emergency medicine, University of Rochester Medical Center. "Telemedicine is most appropriate for minor visits, which we can usually manage in the ED fairly efficiently." Overcrowding comes from requiring EDs to manage inpatients or from receiving multiple simultaneously very

sick patients, he says.

Ironically, Conners has collaborated with McConnochie on earlier studies and believes in the ability of telemedicine to deliver quality care.

"We took kids who were sick and came for visits and examined them twice — once in person, and once by telemedicine," he recalls. "We found very good agreement between the in-person exam and the telemedicine; the care was just as good."[1,2]

But quality is not the issue in contention, Conners maintains. What he disputes is the fact that many pediatric ED visits are unnecessary "We in Rochester have great pediatric primary care, and yet we still get a certain number of children each day who come to the pediatric ED because of pinkeye or the equivalent, especially outside of the usual Monday-Friday daytime," he says. "As research in Rochester and other places has shown, if you ask parents why they brought the child to the ED, they often will tell you they were directed there, either by someone representing their primary care office — often a nurse or someone else in the office, sometimes following a written protocol — or a well-intentioned family member or neighbor."

Alternatively, he adds, parents often are unable to get to the doctor's office because there were no short-notice visits available, or they were at work or otherwise unable to get in during the limited hours offered by many primary care practices. **(For more on the potential benefits of telemedicine, see the story, below.)**

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Is telemedicine too limited for ED use?

Although a recent study at the University of Rochester (NY) seems to indicate that telemedicine could eliminate many pediatric ED visits, a pediatric ED physician with extensive experience with telemedicine believes that its applications are not broad enough to have a significant impact on ED overcrowding.

"Our group actually worked with telemedicine as far back as 10 years ago," says **Michael Gerardi**, MD, FAAP, FACEP, director of pediatric emergency medicine and an emergency physician at Morris-town (NJ) Memorial Hospital. "I think

CNE *questions*

9. When Bert Amison works with hospitals on documentation improvement, he often finds that hospitals are doing well in documenting for maximum reimbursement but they fall down when it comes to documenting for risk-adjusted mortality data.
A. True
B. False

10. Liz Youngblood, RN, MBA, suggests concentrating on every MS-DRG in reviewing medical records.
A. True
B. False

11. The clinical documentation consultants at North Carolina Baptist Hospital review the charts of patients with which payers?
A. Only Medicare
B. Medicare and Medicaid
C. Medicare and commercial payers
D. Medicare, Medicaid, and commercial payers

12. When flood waters swept through Columbus (IN) Regional Hospital, how many patients were evacuated within three hours?
A. 225
B. 136
C. 157
D. 208

Answer key: 9. A; 10. B; 11. D; 12. C.

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 **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

we are looking for a solution [to overcrowding], but this is not it."

While calling the Rochester research "a good, novel study," Gerardi adds that it paints a picture of parents of telemedicine patients as people who tend to use doctors more — "a bunch of 'nervous Nellies' who were coming to a doctor for none-mergency cases."

But many parents don't do that, he says. "They may think the patient really *does* have meningitis, or maybe they have abdominal pain, and you can't asses that with telemedicine," he notes.

Gerardi says he is doing more than just offering an opinion. "I *worked* telemedicine, and you certainly cannot diagnose otitis media unless the kid is really cooperative, and the only way to diagnose UTI [urinary tract infection] is to have a urine sample," he notes. Those diagnoses don't take a great deal of provider time, he adds, "but the kids need to be checked in person."

However, Gerardi says, he is not totally dismissing the potential use of telemedicine in regard to pediatric emergency medicine. "In the right hands of a big clinic like Kaiser [Permanente], which has lots of resources, you could pull some utility out of it," he notes. ■

Lawsuits may arise from ED 'boarding' practice

An emergency physician is managing an acute myocardial infarction, arranging for a patient transfer, sewing up a laceration, and putting in a chest tube, with 20 people still waiting to be seen in the waiting room. This is probably not the best person to provide routine inpatient care for multiple patients being held in the ED, says **William Sullivan**, DO, director of emergency services at St. Mary's Hospital in Streator, IL.

"Chances are that it's been a while since an emergency physician has ordered a colon preparation prior to a patient's colonoscopy or done an in-depth work-up to determine the cause of a patient's anemia," Sullivan says. "Those just aren't things we routinely do. Having admitting physicians handle admitted patients is better for patient care."

Holding admitted patients in EDs always was known to be bad for patient flow, but there is a growing body of research showing that it also harms patients.[1-4] There's no question that the risk of a poor outcome increases when patients board for long periods, particularly when those patients are critically ill, according to **Jesse M. Pines**, MD, MBA, MSCE, assistant professor of emergency medicine and epidemiology at the Hospital of the University of Pennsylvania in Philadelphia. "In many hospitals, it is the ED physicians and nurses caring for these boarders, so the risk falls squarely with them," Pines says. "It may be impossible to avoid getting roped into lawsuits if there is an error attributed to boarding."

When a bad outcome does occur, attorneys will scour the chart to see what happened while the patient was boarding. "This is especially true now that there is clear evidence that boarding is hurting people," he says.

ED leadership must be patient advocates, says **Robert Broida**, MD, FACEP, chief operating officer of Physicians Specialty Limited Risk Retention Group, the professional liability insurer for Canton, OH-based Emergency Medicine Physicians. His recommendations:

- Consistently and respectfully remind administration and medical staff leadership of the responsibility of the hospital, and ultimately the hospital board, to ensure reliable, quality care under its roof.
- Provide hospital leadership with the report on boarding from the American College of Emergency Physicians' (ACEP) Task Force, Emergency Department Crowding: High-Impact Solutions. *(Editor's note: To access the report, go to www.acep.org. Under "Practice Resources," click on "Practice Resources," and under "Issues by Category," click on "Boarding and Crowding." Scroll down to "2008 Boarding Task Force Report.")*
- Use examples, especially near-misses, from your own hospital to emphasize the risks involved.

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Crowding from boarding can harm patients

There is a significant amount of research that demonstrates ED crowding due to boarding is responsible for poor outcomes, says **Tom Scaletta**, MD, president of Emergency Excellence, a Chicago-based organization that improves patient care and efficiency in the ED while controlling costs. He also is medical director of a high-volume community hospital in a Chicago suburb.

Most lawsuits will involve delayed diagnoses in time-sensitive problems such as myocardial infarction, ischemic stroke, peripheral vascular disease/ischemia, intracranial bleeding, and hemorrhagic shock, Scaletta says.

In the event of a lawsuit, Scaletta recommends showing the jury a log of patients seen that day, with names redacted, and the number of ED physicians and midlevel providers that were working. "There are published statements published by professional societies that dictate reasonable staffing levels," he says. For instance, of the American Academy of Emergency Medicine says the rate of patient influx should not exceed 2.5 patients per physician per hour on average. *(Editor's note: To access this position statement, go to www.aaem.org. Click on "AAEM Position Statements," and scroll down to "Position Statement on Physician-to-Patient ED Staffing Ratios" and "Position Statement on Nurse-to-Patient ED Staffing Ratios.")*

Scaletta believes this is safely increased by 50% (to 3.75) when a physician works as a team with a midlevel provider. "Emergency physicians need to have due process so that they can speak up about problems like understaffing and not get fired, which has happened," he adds. Your documentation needs to be "factual and not accusatory," says Scaletta. "I also think emergency physicians need to be aware of the waiting room load and call in reinforcements when the number/acuity is high," he says. "Hospitals need to have a crowding action plan, akin to internal disaster activation."

For legal damages to result, a patient's long wait in an ED hallway has to be tied to some consequence, notes **Peter Viccellio**, MD, FACEP, vice chairman of the Department of Emergency Medicine at State University of New York at Stony Brook.

But what about the possibility of a jury being inflamed to hear that a patient was waiting for 20 hours in the hallway of an ED? "It should anger them, but the anger is misdirected. It's not the physician taking care of the patient, it's the fault of the system," he says. "But part of the problem is throwing our hands in the air and saying, 'We can't do any better,' which is not true. We really cannot accept this terrible care that is provided as part of the status quo."

If the ED is "filled to the gills" with patients, and you now have 20 additional patients to distribute, the logical answer is to put two of those patients on each unit. "But what's the current answer in many hospitals? To put all 20 in one place," says Viccellio.

He points to his own institution's practice, which sends the admitted patients to board on floor hallways when the ED is at full capacity. "It has dramatically enhanced the care of our patients. This is far more important than the consequence of that: decreasing our liability," says Viccellio. "And in

CNE objectives

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

- identify particular clinical, administrative, or regulatory issues related to the profession of case management;
- describe how those issues affect patients, case managers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■

COMING IN FUTURE MONTHS

- ■ How to get ready for an RAC audit
- ■ Tips for ensuring patients are admitted in the right status
- ■ Improving collaboration between case managers and social workers
- ■ Extending case management beyond the hospital walls

terms of putting patients on the floors, we have done an exhaustive search for patient safety issues, and we can't find any."

What most institutions are asking their EDs to do is care for all the patients who come in, and staffing for those patients, but in effect, saying, "By the way, you may have an extra 30 admitted patients that you have to care for,'" says Viccellio. "What we are asking of the inpatient units is that, during times of high capacity, a nursing unit that takes care of 30 patients will care for 31 or 32," he says. "Patients are much more comfortable upstairs than downstairs. And they don't stay in the hallway for long, because magically a bed opens up once they're up there."

Anyone on a jury has likely gone to an ED and waited for hours to be seen, notes Viccellio. "And to most of them, it's not apparent why," he says. "I think there is a very legitimate moral and legal question we need to ask: Does the fact that 'that's the way things are,' make them OK? I don't think you can fault somebody if it costs $100 million to do something. But if you can just change the way people work, at little to no cost, and it has a profound impact on the patient, why not do it?" ■