# HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

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## IN THIS ISSUE




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Executive Editor **Joy Dickinson**, Managing Editor **Felicia Willis**, Editor **Mary Booth Thomas**, and Consulting Editor **Toni Cesta**, PhD, RN, FAAN, consulting editor of *Hospital Case Management* and author of *Case Management Insider*, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. **Donna Zazworsky**, RN, MS, CCM, FAAN, serves as peer reviewer for *Case Management Insider*. She has no relevant financial disclosures.

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# Get documentation improvement in order or risk major trouble

*Making sure the DRG is correct isn't enough*

If you don't have a robust clinical documentation improvement program implemented by highly trained staff, your hospital might find itself in trouble in more ways than one.

"Clinical documentation improvement is important to ensure that the appropriate severity of illness is captured for public reporting purposes and hospital profiles, to ensure that the hospital receives the appropriate reimbursement from DRG-based payers, and to make sure that the hospital is in compliance when records are reviewed by the Medicare Recovery Audit Contractors [RACs]," says **Tamara A. Hicks**, RN, BSN, CCS, CCDS, ACM, manager care coordination, Wake Forest Baptist Medical Center, Winston-Salem, NC.

Clinical documentation requirements have expanded beyond the traditional boundaries of capturing the diagnosis and the correct DRG assignment. As healthcare reform rolls out and the Centers for Medicare and Medicaid Services (CMS) moves to value-based purchasing, it's going to be more important than ever for documentation to be accurate and complete, adds **Beverly Cunningham**, RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital, and partner and consultant in Case Management Concepts, a case management consulting firm based in Dallas.

### Beef up your documentation to prepare for the future

Hospital records and data are being scrutinized more as payers tighten reimbursement, and public reporting of hospital data increases. This means that documentation in the patient record must accurately and completely represent that patient's conditions and services received. In this issue, we'll take a look at why documentation is important, reveal problem areas where documentation may need improving, and offer suggestions for choosing and training staff. We'll look at how one hospital worked with a consultant to add clinical documentation staff and why pre-billing reviews of patients who die ensure that the mortality index is correct.

"All of our measures are being looked at through public reporting now, and pay-for-performance is coming soon. We're seeing a lot of external requirements for accountability from government, and private payers are following suit. When ICD-10 takes effect in October 2013, the use of the codes will have expanded specificity with more codes available for quality and public reporting purposes, and that means the documentation has to be correct," Cunningham says.

CMS began posting hospital data for eight hospital-acquired conditions on its Hospital Compare web site on April 6. The data shows the number of times the hospital-acquired conditions occurred per 1,000 discharges of Medicare fee-for-service patients in the period between October 2008 and June 2010. Hospital-acquired conditions listed include foreign objects retained after surgery, air embolism, blood incompatibility, pressure ulcer Stages III and IV, falls and trauma, vascular catheter-associated infection, catheter associated urinary tract infection, and manifestations of poor glycemic control.

"Clinical documentation indicates severity of illness, risk of mortality, and complication rates. It drives reimbursement by affecting the hospital's case mix index, hospital-acquired conditions, and value-based purchasing," Cunningham says. "Documentation establishes expectations for length of stay, for resource consumption, and for medical necessity, and serves as a source of information for data analysis for quality and financial outcomes."

Documentation improvement measures ensure that hospitals' publicly reported measures are accurate, enhances Medicare and state regulatory compliance, and improves the hospital and physician profiles by more accurately representing the patient population. "In addition, insurers are using publicly reported measures as a way to designate centers of excellence," Cunningham points out.

**Toni Cesta**, RN, PhD, FAAN, senior vice president of operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY, and partner in Case Management Concepts, says, "Hospitals need to be paid appropriately for the services they provide, and the only way to ensure that is to make sure the documentation accurately and completely represents the patient's condition and services received. But while reimbursement is very important, public reporting is what is driving the healthcare business today. If a patient is sick and requires services, the hospital will be reimbursed appropriately if it is documented." *(For a look at who should be doing documentation improvement, see related article on p. 85.)*

Cunningham says, "All of this makes it imperative for hospitals to have a comprehensive clinical documentation improvement program to ensure that the medical record accurately and completely reflects the patient's condition and services received."

**Doris Imperati**, MSN, MHSA, CCM, associate director of Chicago-based Navigant Consulting,

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has found that as she consults with hospitals about their clinical documentation program, "many hospitals have had clinical documentation programs, but they have faltered or stalled. Hospitals have got to stay on top of their clinical documentation improvement efforts and monitor the statistics each month, looking for opportunities for improvement. If the documentation isn't clear and complete, the hospital may get a denial or a reduced reimbursement and may end up with poor quality data on public reporting sites."

For example, if a patient is admitted with fever, respiratory distress, an increased white blood count, and is being treated with IV rocephin, the symptoms and treatment could be clinically indicative of pneumonia, bronchitis, a respiratory infection, or some other problem. If the physician documentation in the chart doesn't provide the exact diagnosis, the coder cannot assign an accurate diagnosis for that patient. "However, each of these conditions (pneumonia, bronchitis, respiratory infection) constitutes a different DRG with different reimbursement and length-of-stay ramifications. so it is critical for the clinical documentation specialist or coder to clarify documentation with the physician." says Imperati.

For example, if a patient's diagnosis is fever, the DRG guidelines call for a three-day stay. If it's pneumonia, the stay could be up to 5.3 days, or if the condition is defined as a respiratory infection, the length of stay could go up to 6.8 days. *(For more details on how the language used in the documentation can affect reimbursement, see related article on p. 84).*

Imperati says, "While most hospitals have focused their clinical documentation improvement efforts on Medicare patients, in today's healthcare environment, at a minimum they should expand the focus to Medicaid patients and those payers who reimburse by Medicare-Severity Diagnosis Related Groups [MS-DRGs]. Ideally, clinical documentation functions should encompass all payers, to improve the quality of documentation and accuracy of coding house-wide."

The responsibility for clinical documentation improvement isn't limited to just one department. Case management, health information management, quality, and compliance all have a hand in the process and should work together. *(For details on choosing your documentation improvement staff, see related story on p. 86).*

Cesta says, "A clinical documentation program should be approached as an organization-wide program, and not just the responsibility of case management and health information management. Everyone in the organization should understand that medical record compliance results in more accurate profiles for both physicians and hospitals, with more accurate portrayal of clinical complexity of patients as well as appropriate reimbursement for services provided."

Cunningham says, "All of the revenue cycle stakeholders need to understand documentation. These include case management, clinical documentation improvement, finance, health information management, coders, physicians, nursing, quality, the ancillary team, the Recover Audit Contractor [RAC] coordinator, and whoever is managing the National Coverage Decision (NCD) determination and Local Coverage Decision (LCD) determination."

Cesta suggests assembling a clinical documentation improvement team to identify trends and gaps in documentation and come up with improvement initiatives. She suggests that the team include representatives from case management, health information management, quality management, coding, and billing, along with an executive team champion, the chief financial officer, a physician champion, and a mid-level provider. The team should determine how the program will work, develop a timeline and a flow process and identify educational opportunities for all of the staff involved.

"To be successful, a clinical documentation improvement program needs an executive team champion and a physician champion who support the process along with appropriate staffing levels, and coordination and community among the documentation specialists and other departments such as quality management and health information management," Cesta says. "Develop a clear job descrip-


**EXECUTIVE SUMMARY**

Clinical documentation improvement is taking on a bigger importance as payers tighten reimbursement rules, public reporting of hospital data increases, and a variety of auditors are scrutinizing hospital records, making it imperative that the medical record accurately reflects the patient's condition and the services he or she received.

- Assemble a multidisciplinary team to create and monitor your documentation improvement program.
- Develop a training program for your documentation improvement staff.
- Encourage collaboration between the documentation staff and case management.
- Look for opportunities for improvement and track your outcomes.

tion for your clinical documentation improvement staff, along with policies, procedures, and work flow. It's a complicated job, and the staff interfaces with so many different departments. Don't just assume your staff will know how to do it."

The clinical documentation staff should meet frequently and regularly with the coding staff so the two can work as a team. "Collaboration, collaboration, collaboration is what makes a clinical documentation program work," Cesta says.

Cesta recommends cross-training staff to a minimum level in terms of what other departments are doing and looking for. For example, the clinical documentation improvement specialists might see a deficit in the documentation that could mean the severity of illness isn't accurately reflected in the record. They can work with the case managers to obtain the additional documentation.

"When the clinical documentation improvement specialist and the case manager work in complementary fashion, it results in better documentation which allows better reviews, better compliance, and fewer denials," Cesta says.

Develop a program tracking tool that's automated, if possible, and analyze your data on a monthly basis. Establish targets. When you don't hit them, drill down to determine the reason, Cesta suggests.

Outcomes measures should include the overall, medical, and surgical case mix index and the case mix index for service lines you are focusing on, Cesta says. Include the coverage rate for specified payer groups, the physician query rate including the response rate and agreement rate, the complication rate, changes in length of stay, and the ratio of major complication/comorbidity rates (CC and MCC) for specific DRGs.

The national standard is that clinical documentation specialists review about 15 to 20 charts per day, Cesta says. Use that as a benchmark to determine how productive your staff is. Make sure they are reviewing a combination of new admissions and re-reviews, Cesta suggests.

### SOURCES/RESOURCE

For more information on documentation, contact:


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• To order a webinar by Toni Cesta and Beverly Cunningham, **"A Case Manager's Relationship in Documentation Integrity"** produced by AHC Media, publisher of *Hospital Case Management*, log on to www.ahcmedia.com. Under "View by Specialty," click on "Case Management" ■

# Language is key in clinical documentation

*Sepsis by another name doesn't code the same*

When Stony Brook University Medical Center presented an educational program to its urology staff about the importance of using the correct terms in documentation, the physicians pointed out that in medical school, they learned to write "urosepsis" on the chart for patients who had developed sepsis from a severe urinary tract infection, according to **Catherine Morris**, RN, MS, CCM, CMAC, executive director of care management and clinical documentation improvement administrator at the 591-bed regional hospital in Stony Brook, NY.

However, if a physician writes "urosepsis" on the chart, it codes out to a urinary tract infection, which is not enough to meet admission criteria for a hospital stay. In addition, it skews quality data if it appears that patients are dying of urinary tract


**EXECUTIVE SUMMARY**

Medical language and coding language are not the same, which means that physicians often write what they learned in medical school to describe a patient's condition: if it doesn't contain the proper language, the coders can't accurately code the chart.
• Educate physicians to use appropriate language to reflect the condition of the patient.
• Look for hints in documentation by other clinicians that the physician documentation might not be accurate.
• Ensure that documentation is complete to indicate major complication/comorbidity rates (CCs or MCCs).

infections. "Instead, physicians should write `sepsis due to a urinary tract infection,' which is codable as sepsis and indicates that the patient is critically ill and has a high risk of mortality," Morris says.

Coding guidelines don't use the same information doctors learned in medical school and coding language doesn't match with medical language, says **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY. "We have to transition physician documentation to accurately reflect the complexity of the patients and to make sure the documentation contains the appropriate language so the coders can use the correct code. This presents a challenge to the clinical documentation staff and to physicians as well."

**Doris Imperati**, MSN, MHSA, CCM, associate director, Navigant Consulting, a consulting firm with headquarters in Chicago, says, "When they examine patient charts, clinical documentation specialists should look for the nuances in the physician's language and the notes from other clinicians for hints that the physician documentation may not be complete. Medicare rules say that coders can't use documentation from nursing, physical therapy, or any other clinician who is not a licensed provider and is giving hands-on care. They may use documentation from nurse practitioners and physician assistants but if there is a report from a radiologist who is interpreting a test, they can't use that. However, documentation improvement specialists can read the nursing progress notes or chart notes from the nutritionists, the physical therapy, or other ancillary staff and use that information as prompts to query the doctor," she says.

For example, if you read in the nurse's notes that a pneumonia patient has a decubitus ulcer, but the physician didn't document it, query the physician as to whether he concurs with the nurse's note and, if so, write it in the chart in order to capture the acuity. Imperati says, "Doctors are likely to be concerned about treating the pneumonia, and the skin problems are of secondary importance to them. However, if a patient with pneumonia has bed sores, it will take more resources to care for that patient and if the decubitus stage and location are documented, it will add a CC [complication or comorbidity] or a MCC [major complication or comorbidity] to the DRG, which increases both the approved length of stay and the financial reimbursement. Heart failure is another case in point. The term 'heart failure' is a broad one, and physicians have to document it carefully and completely, in order for the hospital to be paid appropriately."

For the hospital to be paid appropriately, the physician has to document what kind of heart failure the patient has (systolic, diastolic, or a combination of the two, or rheumatic heart failure) and whether it's acute or chronic. "If the physician just writes 'heart failure,' the coder doesn't know what it really means and has to assign a code with a lower reimbursement," Imperati says. "Heart failure as a second diagnosis can result in adding a CC or a MCC to the DRG. A lot of elderly patients have some elements of heart failure, which means that documentation specialists should look carefully at the charts of Medicare patients to see if there are hints that heart failure is a comorbidity."

For example, if a patient comes in with pneumonia, and the physician orders IV Lasix and/or an angiotensin-converting enzyme (ACE) inhibitor, take the opportunity to query the physician and ask, "This patient was admitted with pneumonia and is also being treated with Lasix and an ACE inhibitor. Please document the diagnosis associated with this treatment."

Imperati says, "Chest pain is a symptom, not a diagnosis, and the underlying cause should be documented." It doesn't matter how many CCs or MCCs a patient has, if the principal reason for admission is chest pain (MS-DRG 313), the expected length of stay is 1.7 days. "Many patients who are admitted with chest pain stay longer for additional work up to determine the underlying cause," she says. If the underlying cause of chest pain is related to an acute episode of heart failure, the physician should state it in the chart, which will bump the expected length of stay up to 2.8 days. "Otherwise, the insurance company will expect the patient to be discharged in 1.7 days," she says, adding "the hospital's publicly reported data will be more accurate and reflect better outcomes if the suspected etiology of chest pain is documented, rather than just the diagnosis of `chest pain.' Malnutrition, especially in oncology patients, represents another opportunity for improvement in documentation and reimbursement. These patients often have nutritional issues due to the cancer themselves, as well as due to the treatments which cause nausea, vomiting, diarrhea, loss of appetite, and weight loss."

There are three levels of malnutrition: mild, moderate, or severe, which translate into a CC or an MCC, which can be evaluated through laboratory values of pre-albumin, serum protein, serum calcium, and serum albumin.

Imperati says, "Malnutrition, when described as severe, is a MCC, but if the doctor writes 'under-

nourished,' it doesn't count for anything in coding language. The nurse may write that the patient is frail and thin. The nutritionist may write 'protein calorie wasting', or the doctor may document cachexia. These all are indications that the clinical documentation specialist should look at the laboratory values, weight loss, and other factors and ask the doctor for more specific documentation regarding the patient's nutritional status."

A diagnosis of pneumonia does not necessarily translate as simple pneumonia. It might be a respiratory infection that has a higher length of stay and better reimbursement. Bacterial pneumonia is simple pneumonia, but if the doctor specifies the organism, such as "klebsiella pneumonia," the diagnosis is more serious and qualifies as a respiratory infection.

Imperati says, "Sometimes the doctor can't specify an organization but can say he suspects gram negative pneumonia, which is difficult to treat and uses more resources. This can be coded as a respiratory infection." ■

# Documentation staff can alleviate CM duties

*Separate, expert staff is needed*

A few years ago, it was a common practice for case managers to be responsible for clinical documentation improvement along with their other duties, but that should no longer be the case, according to **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY, and partner and consultant in Dallas-based Case Management Concepts, a case management consulting firm.

"In today's healthcare environment, there's a limit to how many tasks you can add to the case managers' role and have them continue to be effective. We see clinical documentation improvement as a part of case management, but it should not be the responsibility of case managers. We recommend a separate role for clinical documentation improvement," Cesta says. "CMs can usually handle the clinical documentation in hospitals with 50 or fewer beds, but in larger facilities, they may struggle to juggle all the tasks they are asked to do. If your hospital has more than 50 beds, be very cautious about embedding the clinical documentation improvement function into the case management role."

Hospitals need staff dedicated to clinical documentation to fill in the gap between the documentation in the chart and what is being coded, Cesta says.

"Clinical documentation improvement is a complex issue that involves more than just looking at the chart, getting physicians to add more documentation, and hoping to get a better DRG. It's a very complicated and time-consuming process, and it should be handled by people with specialized expertise," she says.

When choosing clinical documentation staff, look for people with good communication skills who are self-starters, have critical thinking skills, are able to work independently, and have experience working with physicians, suggests **Beverly Cunningham**, RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital, and partner and consultant in Case Management Concept. They should know the clinical, coding, and compliance aspects of documentation, have an understanding of public reporting, and be able to articulate the purpose of the clinical documentation program to their peers and clinicians in other disciplines, Cunningham adds.

The clinical documentation specialists have to understand the MS-DRG process, how a CC (complication or comorbidity) and MCC (major complication or comorbidity) are extracted from the documentation in the medical record. They need to understand ICD-9 codes and what might increase the risk of mortality and severity of illness. They should have clinical credibility and be able to ask questions of physicians in a non-threatening way, Cunningham says.

Case managers make good clinical documentation specialists because they already have a good rapport with physicians, and that rapport is the key to a successful program, adds **Doris Imperati**,

(Continued on page 91)

**EXECUTIVE SUMMARY**

Hospitals need a separate, dedicated clinical documentation staff to fill in the gap between what is documented in the chart and what is coded. Case managers have too many other duties to take on this complex task.

- Candidates should be able to work independently, have good communication skills, good rapport with doctors.
- They need to have clinical credibility and understand the MS-DRG system, public reporting, and ICD-9 codes.
- Staff needs extensive training, preferably by an outside consultant.

CASE MANAGEMENT INSIDER
Case manager to case manager

# Case Management Report Cards — Keep it Simple, Keep it Clear

**By Toni Cesta**, PhD, RN, FAAN ,
Senior Vice President
Lutheran Medical Center
Brooklyn, NY

The report card that begins below is an example of a method for aggregating and reporting all the measures that we have reviewed in the last two issues.

The sections included in this exemplar are length of stay, denials, avoidable delays, and discharge planning. The first column includes the categories with detail below each label. The next column includes the baseline, target, and month's data. The baseline should be the prior year's performance in that metric. The target should be this year's goal, and the month's data is the actual metric achieved for the month being reported.

This report card serves as an example only. You should consider adding or deleting from this as needed based on the data you are collecting.

You might also want to consider an executive summary of the data that explains those outcome metrics that performed poorly for the reporting month with an explanation as to why.

Regardless of which measures you use, be sure they are clear, measurable, and accurate.

| HOSPITAL NAME | | | |
|---|---|---|---|
| | **BASELINE** | **TARGET** | **MONTH** |
| **LENGTH OF STAY** | | | |
| ALOS | | | |
| Medicine | | | |
| Surgery | | | |
| # of Patients with LOS 7-10 days | | | |
| % of Total Discharges | | | |
| # of Patients with LOS > 10 days | | | |
| % of Total Discharges | | | |

| DENIALS BY REASON IN DAYS — PENDING | | | |
|---|---|---|---|
| | BASELINE | TARGET | MONTH |
| **CONCURRENT** | | | |
| Medical necessity on admission | | | |
| Continued Stay | | | |
| Delay in service | | | |
| Late notification | | | |
| Clinical info not provided | | | |
| Appropriateness of setting | | | |
| **RETROSPECTIVE** | | | |
| Medical necessity on admission | | | |
| Continued Stay | | | |
| Delay in service | | | |
| Late notification | | | |
| Clinical info not provided | | | |
| Appropriateness of setting | | | |

| DENIALS BY REASON IN DAYS — OVERTURNED | | | |
|---|---|---|---|
| | BASELINE | TARGET | MONTH |
| **CONCURRENT** | | | |
| Medical necessity on admission | | | |
| Continued Stay | | | |
| Delay in service | | | |
| Late notification | | | |
| Clinical info not provided | | | |
| Appropriateness of setting | | | |
| **RETROSPECTIVE** | | | |
| Medical necessity on admission | | | |
| Continued Stay | | | |
| Delay in service | | | |
| Late notification | | | |
| Clinical info not provided | | | |
| Appropriateness of setting | | | |

| DENIALS BY REASON IN DAYS — UPHELD | | | |
|---|---|---|---|
| | **BASELINE** | **TARGET** | **MONTH** |
| **CONCURRENT** | | | |
| Medical necessity on admission | | | |
| Continued Stay | | | |
| Delay in service | | | |
| Late notification | | | |
| Clinical info not provided | | | |
| Appropriateness of setting | | | |
| **RETROSPECTIVE** | | | |
| Medical necessity on admission | | | |
| Continued Stay | | | |
| Delay in service | | | |
| Late notification | | | |
| Clinical info not provided | | | |
| Appropriateness of setting | | | |

| INPATIENT THROUGHPUT | | | |
|---|---|---|---|
| | **BASELINE** | **TARGET** | **MONTH** |
| Avoidable days due to no sub-acute vent bed available | | | |
| Avoidable days due to no sub-acute vent/dialysis bed available | | | |
| **AVOIDABLE DAY REASONS — FACILITY/SERVICE LINE** | | | **(OCC/DAYS)** |
| MRI | | | |
| EEG | | | |
| ECHO | | | |
| CT | | | |
| Cath | | | |
| Radiology/X-ray | | | |
| Vascular lab | | | |
| Vascular surgery | | | |
| Stress test | | | |
| Physical therapy and PT consult | | | |
| GI procedure and/or colonoscopy | | | |
| OR booking and/or cancel OR booking | | | |

| | BASELINE | TARGET | MONTH |
|---|---|---|---|
| **AVOIDABLE DAY REASONS — RESOURCE** | | | **(OCC/DAYS)** |
| Guardianship | | | |
| No aide available for home health care | | | |
| No nursing home bed available | | | |
| Ed issue — inappropriate admission | | | |
| **AVOIDABLE DAY REASONS — PATIENT/FAMILY** | | | **(OCC/DAYS)** |
| Family refuses | | | |
| Family unable to pick patient up at discharge | | | |
| Patient non-compliant | | | |
| Patient refuses test/procedure | | | |
| Unable to reach family | | | |
| Pending custodial care | | | |
| Family delay in Medicaid application | | | |
| Guardianship/conservatorship issues | | | |
| Difficulty with decision making | | | |
| **AVOIDABLE DAY REASONS — PAYER** | | | **(OCC/DAYS)** |
| Delay in approval | | | |
| Delay in discharge | | | |
| Delay in processing forms | | | |
| Insurance issues | | | |
| **AVOIDABLE DAY REASONS — PROVIDER** | | | **(OCC/DAYS)** |
| Patient not acute, MD refuses discharge | | | |
| Inappropriate transfer from another hospital | | | |
| Consult delay | | | |
| Decision-making delay | | | |
| Delay in medical clearance | | | |
| No consent for treatment | | | |
| Delay in surgery | | | |
| Awaiting procdure/ none specified | | | |
| Preadmission issue | | | |
| Delay in GI procedures | | | |
| Delay in coordination of services | | | |
| ***AVOIDABLE DAYS TOTAL*** | | | |

| **DISCHARGE PLANNING** | | | |
|---|---|---|---|
| Completion of initial assessment/discharge plan within 24 hours | | | |
| **REFERRALS TO POST-ACUTE CARE** | | | |
| Home w/No Services (as % of discharges) | | | |
| Home Care (as % of discharges) | | | |
| Acute Rehab (as % of discharges) | | | |
| Sub-acute rehab (as % of discharges) | | | |
| Sub-acute medicine (as % of discharges) | | | |
| Sub-acute vent (as % of discharges) | | | |
| Long Term Care (as % of discharges) | | | |

(Continued from page 86)
MSN, MHSA, CCM, associate director, Navigant Consulting, a consulting firm with headquarters in Chicago.

"Case managers know how to read a chart, and they're already familiar with admissions guidelines and continued stay guidelines. They know how to look for the underlying meaning of what the doctor is saying and get it into the chart," Imperati says.

At Stony Brook University Medical Center, the clinical documentation specialists are experienced case managers and work in the case management department. They are assigned by unit.

"We use nurses instead of coders because they have the clinical background to speak to the physicians," says **Catherine Morris**, RN, MS, CCM, CMAC, executive director of care management and clinical documentation improvement administrator at the Stony Brook, NY, facility. *(For details on how Stony Brook's clinical documentation specialists ensure that the hospital's mortality index is accurate, see related story on p. 91.)*

When Medical City Dallas Hospital looked for opportunities for improving documentation, one of the areas the team identified was the oncology transplant unit.

"We identified the opportunity to increase documentation and severity of illness for these complex patients," Cunningham adds. As a result, the hospital hired a nurse practitioner with expertise in stem cell transplants to review the oncology service line documentation to ensure that it was complete and accurate.

Cesta says, "Educating the interdisciplinary team on clinical documentation improvement is a tremendous undertaking, and it's often more effective to call in a consultant who understands all the intricacies of the process." *(For details on how one hospital revised its documentation program with the help of a consultant, see related story, right.)*

Cunningham says, "When you interview consultants, get details on exactly what they are going to provide during the assessment process and as you go through the implementation process, and how they are going to follow up down the road." Find out what kind of software they have to help you track all the data you need to determine the effectiveness of the program.

Ask for references, and talk to people who have used the consultant, Cunningham recommends. Ask whether the consultant helped the department make the business case for more staff, how they worked with you during the implementation process, and how they helped you plan for education and training. ■

# Pre-billing review will improve mortality index

*Initiative aims at ensuring severity of illness*

As a result of a pre-billing review of charts of patients who die in the hospital, the mortality index at Stony Brook University Medical Center has remained steady at under 1 except for one month when it was 1.04, according to **Catherine Morris**, RN, MS, CCM, CMAC, executive director of care management and clinical documentation improvement administrator at the 591-bed medical center in Stony Brook, NY.

The mortality index is the ratio of observed mortality to expected mortality. Coders use a software program to assign the expected mortality rate for patients who die based on documentation in the chart. The expected mortality rate ranges from 1 to 4, with 1 designating the lowest chance of mortality.

"Mortality data is included in a lot of publicly reported quality data, including the Centers for Medicare and Medicaid Services Hospital Compare web site, Health Grades, Leapfrog, U.S. News, and other hospital rating web sites. Our main goal for mortality reviews isn't concerned with increased revenue. Only a few cases actually result in increased revenue. The goal is improved quality documentation. We want to make sure that our reported data accurately represents the severity of illness and the risk of mortality for patients who died in the hospital," Morris says.

When a patient dies in the hospital, the coders run the software to assign a risk of mortality, put a billing hold on the case and assign a mortality review code which flags the case for review. The clinical documentation specialists are assigned by unit and take turns each month performing the mortality reviews along with their regular duties.

**EXECUTIVE SUMMARY**

At Stony Brook University and Medical Center in Stony Brook, NY, clinical documentation specialists conduct pre-billing reviews of the charts of patients who die in the hospital to ensure that risk of mortality is accurately represented.

- Staff reviews charts of all patients with an expected mortality rate of 3 or lower.
- Review is pre-billing because publicly reported mortality data is based on billing information.
- When physician query is returned, coders can re-code the chart.

They pull the charts of all patients who die in the hospital who have an assigned risk of mortality rate of 3 or lower and determine if the documentation in the chart accurately described how sick they are.

"We chose to conduct the mortality rate pre-billing because most public reporting is based on billing data, and if the risk of mortality is not correct when the bill drops, it will impact the hospital's rating," Morris says.

If it appears that the documentation is not complete or does not support the patient's mortality risk, the clinical documentation specialist sends a query to the physician asking him or her to more specifically define the patient's condition. For example, if a patient is in a coma, in order for the coders to assign the code for "coma" the physician has to write "coma" in the chart, rather than writing that the patient is unresponsive or has a Glasgow Coma Scale rating of 5.

After the physician answers the query, the documentation specialist sends the information back to the coders who recode the chart and send the information through the software system again to obtain an attestation of the risk of mortality, according to **Theresa Adell**, RN, MS CNRN, CCM, case manager/clinical documentation specialist supervisor at the hospital. For example, a 57-year-old man came into the emergency department in cardiac arrest and later died. The documentation did not contain any comorbidities, and the software showed that his risk of mortality was a 1.

"Based on the documentation, we wouldn't expect this patient to die. He just didn't appear to be that sick. But when we reviewed the chart, we found clinical information that was not written in codable language," Adell says.

The patient came into the hospital in a coma, but the physician wrote "unresponsive" rather than using the word "coma." The coma was secondary to intracranial hemorrhage and cerebral edema. When the additional documentation was in the chart, the patient's mortality risk became a 4, which is the highest risk possible. ■

# Reorganization adds staff and improvements

*Potential financial gain outweighs cost of staff*

After working with a consultant to determine how to improve clinical documentation, the care coordination department at Wake Forest Baptist Medical Center in Winston-Salem, NC, revamped its clinical documentation program, adding more staff and shifting the team from unit-based to service-based.

"We had the program in place for 12 years, and the administration felt it would benefit the whole institution to re-educate the physicians, the reviewers, and the coders. With ICD-10 coming along in two more years, the documentation is going to have to be more specific to fit the codes. We brought in a consultant in January 2011 to look for opportunities for improvement and to help us revamp the program," says **Tamara A. Hicks**, RN, BSN, CCS, CCDS, ACM, manager of care coordination at the 885-bed academic medical center.

At Wake Forest Baptist, the clinical documentation improvement is handled by BSN-prepared nurses who are called clinical documentation consultants. Before the reorganization, the department had 11 clinical documentation consultants with one supervisor covering the entire hospital. Based on the recommendations of the consultants, the hospital now has an additional four clinical documentation consultants.

"The consultants looked at the actual records and identified opportunities for improvement. They were able to estimate the potential financial gains we'd have from improving documentation and concluded that the potential additional reimbursement was far more than the cost of adding additional staff," Hicks says.

The clinical documentation staff members were unit-based before the reorganization. Now they are assigned by service and work as a team with the case managers and other members of the multidisciplinary team on the service.

"This arrangement makes it easier for the clinical documentation consultants to track cases and collaborate with the case managers. The case managers have a close working relationship with the physicians and are able to assist with documentation," Hicks says.

**EXECUTIVE SUMMARY**

Wake Forest Baptist Medical Center in Winston-Salem, NC, reorganized its clinical documentation program and added more staff after working with a consultant to determine opportunities for improvement.

- Staff members are assigned by service and work as a team with case managers.
- The hospital added four clinical documentation consultants.
- Clinical documentation consultants, coders, physicians received training over four weeks.

The goal is for the clinical documentation consultants to review all patients, regardless of payer. "We are still bringing the new staff on board and haven't gotten to that point yet. The priority right now is to review Medicare, Medicare Advantage, and Medicaid patients first," Hicks says. "We don't have productivity measures for this staff, in terms of the number of records they have to review each day. We want to give them the time they need to make a thorough review of the documentation."

Another initiative is for the clinical documentation consultants to become more compliant with American Health Information Management Association (AHIMA) recommendations for language used in clinical documentation improvement queries to physicians. "We are trying very hard to learn how to phrase the query so we aren't leading physicians or putting words in their mouths. For instance, we can't ask a physician if the patient has pneumonia. We can ask only for more information about the significance of the evidence on the X-ray," Hicks says.

A team that included Hicks and other members of the department leadership reviewed several vendors and what they offered, listed the pros and cons of each, and worked with the hospital's chief financial officer to choose a vendor. The consultants were on site for a week completing the assessment, and they spent an additional four weeks training the staff. Pediatrics was one area where the consultants recommended improvement. "The staff was trying to cover all payers, and the volume was getting to the point that the clinical documentation consultants were not able to manage the workload and stopped reviewing the pediatric patient charts," she says.

The coders and clinical documentation consultants spent three weeks in the classroom. In addition, the clinical documentation consultants spent clinical time with the consultants working on actual cases. "Reviewing the documentation process was very helpful to the staff. We had gotten stale and weren't being as thorough as possible.We gave them more resources and urged them to slow down," Hicks says.

The consultant team included a physician who presented in-service education to more than 600 physicians who admit patients to the hospital. "They showed them the difference that documentation can make in severity of illness, why it matters, and how it affects the hospital and the physician profiles," Hicks says.

Several of the clinical documentation staff have achieved the certification of certified clinical documentation specialist (CCDS).

"I encourage the staff to take the test to achieve their certification," says Hicks who worked with the Association of Clinical Documentation Improvement Specialists to develop the certification test. ■

# Notifying patients of their right to complain

*Rule would require formal notification*

Case managers are likely to have additional duties added to their workload under a proposed rule issued by the Centers for Medicare and Medicaid Services (CMS) that would require providers to formally notify Medicare beneficiaries of their right to communicate concerns about the quality of the care they received to the state Quality Improvement Organization (QIO).

The proposed rule (CMS-3225-P) also would require providers to give all patients, Medicare or otherwise, the name and contact information for the state survey organizations and to document that all inpatients and outpatients have received the information in writing.

"The rationale for this proposed rule is to raise awareness among Medicare beneficiaries about how they can exercise their right to complain to the QIO or state surveyor about the care they received," says **Jackie Birmingham**, RN, MSN, MS, vice president of regulatory monitoring and clinical leadership at Curaspan Health Group.

The proposed rule would apply this requirement to patients receiving care in the hospital and in the outpatient setting as well. Other facilities including ambulatory surgical centers, hospices, long-term care facilities, home health agencies, comprehensive outpatient rehabilitation facilities, critical access hospitals, rehabilitation agencies, portable X-ray


**EXECUTIVE SUMMARY**

A proposed rule issued by the Centers for Medicare and Medicaid Services would require hospitals and other providers to formally notify Medicare beneficiaries about their right to complain to the state Medicare Quality Improvement Organization (QIO).

- Rule applies to outpatients as well as inpatients.
- Process is likely to tie into value-based purchasing.
- Case managers should take proactive steps to deal with complaints.

services, rural health clinics, and federally qualified health centers would also have to provide the information and document it.

"This rule comes on the heels of the CMS notice about the value-based purchasing program for the acute care prospective payment system. Value-based purchasing for hospitals will base payments on quality and outcomes, rather than volume, and patients are one of the best sources of information about quality. When patients have a bad experience, they will have a local name and phone number to contact. I suspect that the number, type, and outcome of patient complaints to the QIO will eventually feed back to the value-based purchasing method of payment," Birmingham says.

She adds that a section in the proposed rule for value-based purchasing proposes to change the rule about what information QIOs can release, what is protected, and what will be open to inquiries.

It's not too soon to develop strategies about how to inform your patients of their rights and to take proactive steps to improve the patient care experience and the process for handling complaints, Birmingham says. Look for ways to empower patients to provide feedback good and bad and make it easier for patients to contact you about quality concerns, she says. Find out what the patients are concerned about, and act before the patient feels the need to take their complaints further, she suggests.

"It's not just about giving patient a piece of paper with contact information. It's reminding patients at every opportunity that you care about them," she says.

**SOURCE/RESOURCE**

For more information, contact: **Jackie Birmingham**, RN, MS, Vice President of Regulatory Monitoring for Curaspan Health Group. E-mail: jbirmingham@curaspan.com.

To access the proposed rule in the Feb. 2, 2011, *Federal Register*, visit http://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-2275.pdf ■

AMBULATORY CARE
QUARTERLY

# ED connects patients to better venues of care

*Long-term goal: Change consumer behavior*

As reform helps more Americans gain access to health coverage, experts predict that the nation's EDs will be bulging at the seams. This increase clearly could complicate efforts to rein in costs, as ED visits are more expensive than care delivered through physician office visits or urgent care centers. However, to address this problem before it escalates, Albuquerque, NM-based Presbyterian Healthcare Services (PHS), an integrated system including eight hospitals, a health plan, and a growing medical group, is using what it calls ED navigators to re-direct patients with non-emergency issues to the most appropriate care setting for their needs.

In the model, providers determine whether a patient should be navigated to a less-acute setting during the medical screening exam. In these cases, an ED navigator will schedule the patient to be seen by another provider within 12 to 24 hours, explains **Mark Stern**, MD, medical director of medical management and endcare coordination and an emergency medicine physician at PHS. "Most, if not all, emergency physicians will say there is a better venue of care for these types of patients in which they will receive better care at a cheaper cost," he says. "It usually doesn't work that way. That's one of the reasons why we began doing this in the emergency department."

This program is now consistently navigating 12% to 14% of the ED volume to a more appropriate setting of care, but program developers believe there is much more opportunity yet to be realized. Furthermore, they are particularly enthusiastic about the fact that only 3% of navigated patients have returned to the ED at a later date. This suggests navigated patients have been connected with a more appropriate care setting that they can turn to for their non-emergency needs, but it also makes financial sense for PHS, explains **Lisa Farrell**, CPA, chief financial officer of Presbyterian Health Plan. "If our return rate continues to be that low, then we expect to realize a cost reduction in the next three to six months," Farrell says.

## Get physicians on board

While health system administrators saw the ED as offering the greatest opportunity for improvement in re-directing patients to more appropriate settings of care, the task of implementing the ED navigator program was by no means simple, Farrell emphasizes. "We went to the media, we went to advocacy groups, and we went to regulators," she says. "We really wanted to get out very broadly what we were doing."

However, the most critical piece involved

explaining the program to ED physicians and getting them on board. "Where I started from is trying to shift the paradigm of the ED being the safety net for all patients in the community," says Stern. "What we wanted to do was leverage the integrated system by spreading out the safety net to all parts of our system, so ED physicians had to kind of change their mindset."

Stern says he had to get the physicians to trust that there is a better place for the non-emergency patients to go. Still, the physicians had several concerns, including how long it would take for the navigated patients to be seen and treated. "That was a deal-breaker for this program. If we couldn't get the patients to another venue of care within 12 to 24 hours, then we [agreed] we would stop the program that day," says Stern, noting that this also helped to ease concerns some of the physicians had regarding liability. "Most of the physicians agreed that these [navigated] patients would, in fact, be safer than the patients who are seen in fast track and then sent home, because the navigated patients would be guaranteed of being seen by a second provider within 12 to 24 hours."

Another significant issue for the physicians was cost. They were concerned about patients having to pay for a second visit if they were navigated to another provider, so Stern offered a guarantee that the patients would at least be seen once at another venue of care at no cost to them.

## Track and report benchmarking data

When the program first launched, the physicians were comfortable with navigating only patients with just a handful of minor diagnoses, such as sore throat, ear infection, urinary tract infections, and minor abrasions, notes Farrell. In addition, they stipulated that any patient under the age of 5 or over the age of 65 would not be navigated. However, the physicians' comfort level with the approach grew rapidly.

"Within about a week of launching the program, they said they were comfortable with the over-age-65 population. Within a couple of weeks, they were comfortable with the under-age-5 population, and now any child over the age of 3 months can be navigated," explains Farrell, noting that the physicians themselves notified administrators when they were ready to expand the program.

While physicians have clearly warmed to the program, there are, nonetheless, varying degrees of acceptance. "There are some physicians who really embraced this early and are navigating upward of 25% of the patients they see on a daily basis, but there are also some physicians who are still at zero or very low levels," explains Farrell.

Stern emphasizes that physicians are not under pressure to navigate patients, but he provides constant feedback on their use of the navigator program. "On a weekly basis, they get to see how they personally compare to their peers in navigating patients, so they know if they are in the 20th percentile, zero percentile, or 28th percentile," he says.

Stern will meet physicians who are low users of the program to hear their concerns and reinforce the reasons behind the approach. "I don't force anybody to do anything, but I try to understand what their thoughts are and why they have been unwilling to navigate more patients," he says. "I have met with three physicians so far, and all of them were surprised that their numbers were so low. My guess is the next time we have this discussion, their numbers will be up."

### SOURCES

For more information on connecting patients, contact:
- **Mark Stern**, MD, MBA, FACP, Medical Director, Medical Management and Endcare Coordination, Presbyterian Healthcare Services, Albuquerque, NM. Phone: (505) 841-1234.
- **Lisa Farrell**, CPA, Chief Financial Officer, Presbyterian Health Plan, Albuquerque, NM. Phone: (866) 388-7737. ■

## 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

- ■ Extending case management beyond hospital walls
- ■ Preparing your facility for the RAC audits
- ■ Tips on preventing readmissions
- ■ Why collaboration is the key to success

## CNE questions

21. According to Toni Cesta, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY, what is the national productivity benchmark for clinical documentation staff?
    A. 10 to 15 charts a day
    B. 15 to 20 charts a day
    C. 20 to 25 charts a day
    D. 30 to 35 charts a day

22. Doctors were taught in medical school to use "urosepsis" to describe severe urinary tract infections, but if they write it on the chart, it codes out to a urinary tract infection, which does not meet medical necessity criteria, according to Catherine Morris RN, MS, CCM, CMAC, executive director of care management and clinical documentation improvement administrator at Stony Brook University Medical Center in Stony Brook, NY. What should the physician write instead?
    A. severe urinary tract infection
    B. septicemia
    C. severe sepsis
    D. sepsis due to a urinary tract infection

23. According to Beverly Cunningham RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital, most hospitals need a clinical documentation role that is separate from the role of case manager if it has how many beds?
    A. 50
    B. 75
    C. 100
    D. 150

24. The goal of mortality reviews at Stony Brook Medical Center is to increase revenue. True or False?

Answers: 21. B; 22.. D; 23. A; 24. False

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