HOSPITAL CASE MANAGEMENT™

the monthly update on hospital-based care planning and critical paths

AHC Media LLC

IN THIS ISSUE

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Accurate documentation can improve your hospital's bottom line

Case managers are perfectly positioned to take charge

In today's health care environment, it's more important than ever for hospitals to make sure that documentation in the patient record reflects the severity of patients' conditions and the level of services they receive.

"There has been a big movement toward documentation improvement in hospitals. Hospitals are making an effort to get physicians to document completely and to use the most appropriate terms to capture severity of illness," says **Deborah Hale**, CCS, president of Administrative Consultant Services LLC, a health care consulting firm based in Shawnee, OK.

Since the inpatient prospective payment system using diagnosis-related groups (DRGs) started in 1983, the number of dollars a hospital receives in reimbursement has been directly linked to how effectively physicians document severity of illness and how well coding staff take the documentation and translate it into accurate codes, Hale says.

"When physician documentation accurately reflects the true clinical picture of the patient, it is easier to capture patient acuity, which in turn potentially increases the hospital's case mix index, leading to an increase in revenue," adds **Doris Imperati**, BSN, MHSA, CCM, managing consultant for Navigant Consulting, a consulting firm with headquarters in Chicago.

But it's more than just money, Hale points out.

In addition to increasing reimbursement, improved documentation will raise a hospital's case mix index, which, in turn, can improve the outcomes data used in public report cards used to measure performance by physicians and hospitals, Hale points out.

"Consumers are being told to check out their physicians and research a hospital they are considering at healthgrades.com. The accuracy of those report cards can be improved with a documentation enhancement program," she adds.

Facilities and physicians that appear to have higher mortality rates

actually may not get credit for the severity of illness of their patients because of poor documentation, Hale says.

"Physicians have now become more aware that if they don't document using appropriate terms, they don't get credit for severity of illness. The report cards make it look like they are providing substandard care if the mortality rate is higher than expected," Hale says.

In addition to improving reimbursement, a documentation improvement program can have a positive impact on clinical outcomes and indicators and can help reduce denials for medical necessity because the patient's severity of illness is accurately reflected in the medical record, adds **Lorraine Larrance**, BSN, MHSA, CPHQ, CCM, manager with Pershing Yoakley & Associates, a Charlotte, NC, health care consulting firm.

"We have moved from focusing on documentation enhancement so that the hospital gets more reimbursement to improving documentation because the way the public perceives a hospital or a physician is largely based on what is in the medical records," Hale adds.

Accurately documenting a higher patient acuity also helps the physician justify a longer length of stay, Imperati says.

For instance, Medicare allows a 3.2-day length of stay for patients with simple pneumonia, DRG 90. If the physician documents that the patient has atrial fibrillation or another comorbid condition, the patient acuity increases and the DRG will bump up to DRG 89. This increases the length of stay for that same pneumonia patient to 4.6 days, Imperati says.

"Furthermore, if the physician determines and documents that the patient's pneumonia is due to aspiration of food or vomitus, the DRG bumps up even higher to DRG 79, which allows a 6.7-day length of stay," she adds. These conditions commonly occur in elderly patients and often are underdocumented, she says.

Documentation enhancement will be even more important when the Centers for Medicare & Medicaid Services (CMS) changes to the severity-adjusted DRG system for reimbursement in the fall, Hale points out.

CMS has announced a comprehensive revision of the DRG model to tie reimbursement more closely to the severity of the patient's condition and to base reimbursement on all-patient refined DRGs (APR-DRGs). Most severity-adjusted DRG methodologists split the current DRGs into multiple levels of severity.

"These changes will require more documentation and more accurate documentation in order for a hospital to receive the reimbursement it is entitled to," Hale says.

CMS has hired the Rand Corp. to evaluate the various severity-adjusted DRG systems being considered for implementation. A report is expected in early May at the latest with the severity-adjusted DRG system slated to go into effect in fiscal 2008 beginning Oct. 1, 2007, Hale adds.

Hospital leaders and coders are acutely aware

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Editor: **Mary Booth Thomas**, (marybootht@aol.com).
Senior Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Associate Publisher: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@ahcmedia.com).
Senior Production Editor: **Nancy McCreary**.

Editorial Questions

For questions or comments, call **Jill Robbins** at (404) 262-5557.

of the fact that physicians do not always use the terminology that best describes the severity of illness, Hale says.

"If hospitals are to be paid an amount that accurately reflects the services they provide, someone must intervene with physicians to make sure they are documenting the right things, using the words recognized by the coding system," she says.

CMs in good position to help

Case managers in the acute care environment are in a good position to identify areas where documentation can be improved because of their clinical knowledge, their good relationship with physicians, and because their day-to-day activities already involve reviewing the medical record for medical necessity and continued stay documentation, Larrance says.

Documentation enhancement involves the critical clinical skills that case managers use every day, Larrance points out.

With some additional training on coding components and a very basic understanding of the Medicare prospective payment system and ICD-9 coding, case managers can help their hospitals capture the true picture of a patient's condition and treatment needs by working with physicians to make sure severity of illness is correctly documented in the patient record, she adds.

"Case managers are already in the chart, putting the clinical pieces together. With a basic level of coding information, they can team with the coders in the health information management department and facilitate the capture of information that the coders need," Larrance says.

Case managers often have an advantage over coding staff when it comes to approaching physicians with questions about documentation, points out **Carol Eyer**, RHIA, clinical compliance senior manager with Pershing Yoakley & Associates' Atlanta office.

"Case managers are ideally positioned to have a great impact on documentation improvement efforts. They are able to readily recognize clinical components of the patient's care as well as opportunities for clearer documentation that reflects true patient acuity, leads to appropriate coding compliance, and results in accurate reimbursement," Eyer says.

Case managers have access to the chart while the patient is still in-house and are able to meaningfully approach physicians as fellow clinicians with queries about the clinical picture, she adds.

"Physicians are accustomed to seeing the case managers on the floor. While they tend to raise barriers with coders' post-discharge queries, physicians are more accustomed to having these types of dialogue with case managers. There's a different dynamic there," she adds.

Having the case management staff involved in documentation enhancement gives the hospital the opportunity to capture the correct documentation in real-time before the patient is discharged, Larrance points out.

"In hospitals where there isn't a focus on DRG enhancement, coding tends to happen retrospectively. If there is someone on the floor, looking at the chart and taking the opportunity to clarify information with the physician, it can ensure that the highest level of documentation occurs while the patient is still in the hospital," Larrance says.

Hospitals want to drop the bills as soon as possible for financial reasons, Larrance points out; but bills can't be dropped until the coder completes the coding and that can't be done until the physician notes are complete.

"It all ties in with the revenue cycle, and when documentation enhancement is done retrospectively, you may end up with accounts that are not able to be billed at the severity level delivered," she says.

If the lack of appropriate documentation for an otherwise higher-paying DRG is discovered after the patient has been discharged, it's very challenging to get the necessary documentation in a timely and compliant manner, Eyer points out.

When there is retrospective question about documentation, coders must place a coding query on the discharged chart in the medical record department. The physician may respond to the query days or weeks later when completing other assigned chart deficiencies, Eyer says.

Coders must be careful not to lead or inappropriately prompt the physician to document conditions that are not supported in the medical record, she adds.

"It can't be documentation that just falls out of the sky. There has to be some evidence in the chart that offers a clinical indicator of something that is not clearly documented by the physician. There are huge advantages if clear documentation is entered while the patient is still in the hospital," Eyer says.

It's challenging to get physicians to review the charts of patients after discharge, she adds.

"Queries for post-discharge documentation are met with a cool reception — if not skepticism —

and the physician has moved on to the next patient," Eyer says.

From a compliance standpoint, coders have to be cautious when coding from late entries made to the chart.

"Information added several weeks after discharge, the information may appear out of context, depending on supporting documentation or lack thereof, elsewhere in the chart. Auditors are savvy to this when they review charts," Eyer says. ■

Communication key to improved documentation

Monitor your outcomes to measure success

Case management involvement in the documentation enhancement process can be limited to monitoring specific DRGs and collaborating closely with coding specialists to an environment where the case management department has staff whose entire focus is on documentation enhancement, asserts **Lorraine Larrance**, BSN, MHSA, CPHQ, CCM, manager with Pershing Yoakley & Associates, a Charlotte, NC, health care consulting firm.

How involved the case managers are depends on the hospital's philosophy, the other duties of the case management staff, and what the hospital wants to accomplish with the initiative, she adds.

When consultants guide a hospital through the documentation enhancement process, they typically review information provided by the hospital information system, conduct a chart review to validate the data, and identify opportunities for improvement, says **Deborah Hale**, CCS, president of Administrative Consultant Services LLC, a health care consulting firm based in Shawnee, OK.

"We ask the hospital to select clinical staff, usually nurses, who can be trained to take on the documentation enhancement project. We tell our case management clients that we are not trying to turn them into coders but we want them to use their clinical expertise to help make sure the documentation is clearly written in the medical record," she says.

Training is an important piece in the documentation enhancement process, Larrance points out.

Case managers need to have basic knowledge about coding principles, DRGs, and the reimbursement process to understand why it's important for documentation to be complete, adds **Carol Eyer**, clinical compliance senior manager with Pershing Yoakley & Associates' Atlanta office.

"Without this, the case managers are not thinking along the lines of reimbursement related to documentation in the chart. But with training, they can become the clinical extension to the health information management professionals to ensure that clinical documentation accurately depicts the patient's condition and treatment," she says.

When Eyer trains case managers on documentation enhancement, she presents classroom education, and then follows them through the process on the unit.

Before starting a clinical documentation improvement program, clearly define the scope of the process, and what you are trying to implement, Larrance says.

Identify what you are trying to accomplish, how you want to accomplish it, and where you want to focus, she adds. Clearly define the role of case managers in the process.

Among the options are having a specific group of case managers who do nothing more than documentation enhancement or including it in the duties of every case manager. Set out the relationship between the case managers and the coding staff. Consider whether you want the case managers to be solely responsible for the documentation enhancement piece or to develop a collaborative relationship with the coding staff.

A documentation enhancement program should be geared toward a hospital's payer mix, Eyer says.

"Where to focus on documentation enhancement parallels the same issues as looking at medical necessity or continued stays. Private payers may well have different medical necessity criteria or different agreements with hospitals, but there has to be a basic standard from which to operate," Larrance agrees.

If there is a heavy Medicare population, the program should focus on the Medicare guidelines from the Centers for Medicare & Medicaid Services (CMS). With a larger commercial population, the hospital may choose to focus some efforts on payer-specific guidelines, Eyer says. Many hospitals include patients covered by commercial payers as well as those covered by Medicare in their documentation enhancement projects, she adds.

"Medicare guidelines are often looked upon as an industry yardstick of sorts with managed care payers adopting similar standards," she says.

A lot of commercial payers are beginning to reimburse on the basis of the DRG payment, adds **Doris Imperati**, BSN, MHSA, CCM, managing consultant for Navigant Consulting, a consulting firm with headquarters in Chicago.

For instance, in New York state, many commercial payers are contracting with hospitals based on the Medicare DRG reimbursement schedule, she says.

Imperati suggests that hospitals initially concentrate on improving documentation for Medicare and other DRG reimbursement payers, and then expand the documentation improvement program to include all payers as soon as the Medicare documentation is going well.

"Initially, the improved documentation may only increase the case mix index and not the reimbursement with per diem contracts. However, if a hospital can show a higher case mix, which reflects increased patient acuity, the hospital may be able to use the higher case mix to negotiate a higher per diem reimbursement contract in the future," she says.

Start with a narrow list of DRGs to focus on, such as the top five problematic DRGs or the CMS core measure DRGs, which are reported as public data, Larrance suggests.

Case managers should educate physicians concurrently, reminding them through queries that written documentation can make a real difference in reflecting the severity of the patient's clinical picture.

"It's not an overnight change. The case managers must reach a comfort level to successfully assimilate documentation enhancement into their responsibilities," Eyer says.

Verbal inquiries to the physician save a lot of time and improve communication between the physician and the clinical documentation specialist, Imperati says.

"Ask them to explain what is going on clinically with the patient and then verbally query for clarification of their documentation in the medical record. It's tricky with compliance once you start putting queries in writing because you can't really have a dialogue about the patient's condition on a piece of paper. You have to always be careful so you are not leading the physician," Imperati says.

Some physicians tell Imperati "just tell me what to write."

This is a no-no, Imperati says.

"I tell them to just think about this case and write what is going on with the patient. I point out that the record should accurately represent the clinical nature of service and the care the patient received and the complexity of the patient's condition," she adds.

Try to steer away from the financial part of the equation when you talk to the hospital's physicians, Imperati advises.

"Otherwise, you're talking money and they're looking at patient care. It's better to keep them focused on documenting what they do for their patients in terms of quality because when the focus is on quality, everything else will fall into place," she says.

For instance, better documentation can improve a hospital's CMS report card, internal report cards, and report cards maintained by commercial payers because the improved documentation more accurately captures the severity of illness and helps to justify the length of stay and resource utilization.

"All doctors will tell you that their patients are sicker. We explain to them that our goal is to help them capture that in the documentation," says Imperati.

Imperati tells physicians that learning what to document in the hospital also can translate into better documentation in their office practice.

"Medicare is heading toward pay for performance for physicians in their office. Documentation improvement in the hospital gets them headed in the right direction," she says.

Encourage communication

When your project begins, encourage communication between the health information management staff and the case managers so the coders understand the goals and benefits of the program — and that case managers aren't interested in taking their jobs, Eyer suggests.

"Experienced coders often have considerable clinical knowledge and will welcome the opportunity to team with case managers to secure the documentation they so badly need in order to code accurately," she says.

Arrange regular meetings between the case management staff and coding staff to brainstorm on difficult cases and share successes, she adds.

After the training process, the hospital should measure whether the documentation enhancement initiative is making a difference, Hale says.

Monitor the hospital case mix index and top DRGs over time to determine your successes in capturing complications and comorbidities, Eyer suggests. Track physician compliance and physician feedback and communicate them to the appropriate

people within the organization, including senior management and physician leadership.

Another way to measure success is to track the rate of the assignment of cases to a certain DRG after the training compared to baseline. The information is reported in your hospital's Program for Evaluating Payment Patterns Electronic Report data but case management directors may find it useful to track the data on a monthly basis, Hale says.

Look at the paired DRGs and track how many you report without complications or comorbidities. If your hospital ranks lower than your state's median, it indicates an opportunity for improvement, Hale says.

"With DRG-based reimbursement contracts, you can measure the financial difference from the moment the chart gets coded if the improved documentation puts the patient into a better-paying DRG," Imperati says. ■

A few words may affect case mix, reimbursement

Ensure documentation reflects patient's condition

When it comes to coding, a rose by any other name may mean that your hospital isn't getting the reimbursement it deserves.

In fact, a few words can make the difference in an accurate DRG assignment and have an impact on the reimbursement your hospital receives, the hospital case mix index, and ultimately how the hospital and the physician fare on public report cards.

If documentation isn't clear or specific enough, it can't be coded at the greatest accuracy. The hospital may receive less than the reimbursement deserved for resources expended on a patient's care because the assigned DRG does not represent the true severity of illness and the level of care, says **Carol Eyer**, RHIA, clinical compliance senior manager with Pershing Yoakley & Associates' Atlanta office.

"Seasoned coders often are able to look at the clinical indicators and recognize what the patient is treated for but they are not able to make leaps in clinical judgment as nonclinicians or make coding decisions when this is not clearly documented by the physician," Eyer says.

Coders are closely regulated from a compliance standpoint and must be cautious not to make clinical assumptions they are not qualified to make, she points out.

Better documentation allows the hospital to more closely reflect the resource consumption of the patient, which is essential since the current DRG system payment rates are based on resource consumption, **Deborah Hale**, CCS, president of Administrative Consultant Services LLC, a health care consulting firm based in Shawnee, OK.

For instance, if someone comes in with chest pain and the only documentation in the chart is "chest pain," the patient's diagnosis falls into a DRG with a low relative weight. But if the documentation is clearer, indicating angina in a patient with known coronary artery disease, it changes the relative weight and increases the geometric mean length of stay and reimbursement, Hale says.

Surgical patients often represent an opportunity for improved documentation and higher reimbursement by documenting comorbidities and complications, Eyer says.

However, surgeons typically focus on the condition that requires a procedure, rather than the other medical conditions that affect the patient's course of treatment, she says.

But if comorbid conditions or complications, such as congestive heart failure, diabetes, or urinary tract infection, are clearly documented in the chart, it may bump the patient into a higher-weighted DRG, she adds.

"When patients are moved into a higher DRG, the increase in relative weight for that case may be only incremental; but if you have 100 patients, an incremental bump in relative weight can significantly can change the case mix index and can result in more revenue," adds **Doris Imperati**, BSN, MHSA, CCM, managing consultant for Navigant Consulting, a consulting firm with headquarters in Chicago.

In order for coders to correctly assign a DRG to the patient's diagnosis, the clinical terms used by the physician to document the patient's condition must match the current coding definitions issued by CMS, Imperati adds.

For instance, physicians tend to use the term "urosepsis" when a patient has a urinary tract infection and the bacteria leaks into the general vascular circulation, causing septicemia or the lab and vital signs support the diagnosis of sepsis.

"Physicians all over the country call the scenario 'urosepsis' and when they do, the coders cannot represent the true clinical condition of the patient," Hale says.

For coders, "urosepsis" translates to a common urinary tract infection that would not warrant

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CRITICAL PATH NETWORK™

CMs, social workers collaborate on difficult cases

Nephrology unit poses discharge challenges

At Ingham Regional Medical Center in Lansing, MI, social workers and case managers work closely together to arrange post-discharge care of dialysis and ventilator patients on the nephrology unit.

"The patients on this floor have a lot of needs and a lot of issues. I work closely with the social workers to meet their needs. We have a lot of difficult cases and it's helpful for both of us to work together on them," says **Carolyn Terry**, RN, BSN, case manager for the unit.

Case managers are assigned by floors and social workers are assigned to multiple floors. The case managers handle discharge planning, utilization review, and communication with insurers. The social workers concentrate on psychosocial issues, transfers for substance abuse and psychiatric issues, and guardianships and durable powers of attorney.

When it comes to arranging a safe discharge for difficult-to-place patients, such as indigent or homeless patients or those who are on a ventilator and need inpatient dialysis, it may take both disciplines to ensure that the patients' discharge needs are met.

"I call on the social worker to help me find a discharge destination and set up community services for indigent patients and those who are homeless and to counsel with the families who are stressed over their loved one's illness," she says.

Terry typically manages the care of about 25 dialysis and ventilator patients each day.

The majority of her patients have end-stage renal disease, end-stage chronic obstructive pulmonary disease or lung cancer or amyotrophic lateral sclerosis. She and the social worker on her unit meet every morning to discuss every case and how to best meet each patient's discharge needs.

The entire case management and social work team meets every other week to brainstorm on difficult or interesting cases.

"As soon as patients are admitted, we start working on the discharge plan to make sure that everything is in place when they are ready to be discharged. We work as fast as we can but remain very conscientious about patient safety," Terry adds.

When new patients are admitted to her unit, Terry makes sure they meet inpatient criteria, calls the insurance company if necessary to get approval for treatment, and starts on the discharge plan.

"I have patients who need outpatient dialysis, some who need to be in a long-term ventilator unit, and others who need hospice care. I look at each individual patient to determine the safest and best discharge plan for them and their families," she says.

When a new patient comes onto the unit, Terry meets with the family and starts discussing the discharge plan. "A lot of cases can be difficult because the families want the patient to stay here because it's a safe place," she says.

Most of the patients are discharged to a post-acute facility rather than going home.

"If the family seems to be very emotional about the situation or resistant to discharging the patient, I call in the social worker who is skilled at working with people who are under stress. She helps get them moving along the path of discharge," she says.

Terry contacts post-acute facilities that might

be able to take the patient, gathers the information the facilities need to make a decision, and faxes it to them. Meanwhile, the social worker is guiding the family as they choose a facility for their loved one. Terry recommends that families visit several post-acute facilities and choose which ones they like best.

She has made it a point to visit every facility in the area so she can be better informed when she talks to the families. "This way, I know what the place is like when I'm talking to the families about a placement," Terry says.

In some cases, patients on a ventilator can be discharged to home if their families can provide the needed care. The family must have two full-time caregivers who are committed to learning how to care for the patient.

If a family commits to caring for their loved one at home, Terry calls in the hospital's ventilator unit to conduct a home inspection and interview the family to determine if the family can safely handle the patient's care.

Families who are approved to care for the patient at home stay in the hospital, in the patient's room, for several days and receive training as they go about caring for the patient, much as they will do at home. Terry arranges for training from physical therapists, occupational therapists, respiratory therapists, and the outpatient ventilator company.

The social work/case management team's biggest challenge is placing patients who are on a ventilator and need dialysis and who must be transferred to a facility out of state because there are no long-term care facilities or nursing homes in Michigan that provide both services. The closest facility that takes ventilator and dialysis patients is in Illinois, which puts a huge burden on families who want to visit their loved ones, she adds.

"When I do have to place ventilator and dialysis patients in other states, the social worker spends a huge amount of time with them and their families, working to convince them that there is no other option," she says.

Terry and the social work team work together on finding a place for homeless patients to go after discharge. "They exhaust every possibility, calling family, friends, and neighbors. If there's no option, the social workers can get a voucher from the Red Cross to pay for housing for a few weeks or find a place at a shelter," she says.

Ventilator patients qualify for some type of insurance and can usually be placed in a ventilator unit.

"If they come in with no insurance, the social workers start on an emergency Medicaid application so they can go to a skilled facility as soon as they are ready for discharge," Terry says. ■

QI program reduces length of stay after hysterectomy

Focus on scheduled hysterectomy admissions

A quality improvement project for hysterectomy patients resulted in a decrease in length of stay from 1.89 days to 1.24 days for patients receiving a vaginal hysterectomy and from 2.59 days to 2.23 days for patients receiving an abdominal hysterectomy at Ingham Medical Center in Lansing, MI.

Before beginning the project in 2002, a multidisciplinary team from the hospital headed by the obstetrics/gynecology department chair, worked with the nursing staff and office staff from physician practices to develop standing orders for hysterectomy patients. The hospital owns the three main obstetric and gynecological practices that admit the majority of patients to the hospital.

The patients receiving hysterectomies had varying length of stays and many times did not meet the length of stay expected by insurance. In most cases, the insurance companies authorized a one-day stay for a vaginal hysterectomy and two days for an abdominal hysterectomy.

"We wanted to raise awareness of reimbursement to the hospital. We don't get paid for each day the patient is in the hospital. We were absorbing the extra care," says **Barbara Zielinski**, LMSW, CCM, case manager for the hospital's women's and children's unit.

The initiative focuses only on scheduled and planned hysterectomy admissions. Gynecological oncology patients were not included in the initiative because of their varying lengths of stay due to complications and other factors.

Pat Skerritt, RN, utilization supervisor for the hospital, organized a meeting of representatives from each physician office along with Zielinski and the surgical case manager.

"We educated the physician offices about the necessity of alerting the patients to prepare for a one-day or two-day length of stay, depending on the procedure, before they come to the hospital. No patient will be discharged until she is stable

but we wanted them to know what length of stay they could expect," she says.

During the meeting, the hospital team educated office staff about the hospital's discharge screen for patients leaving the hospital.

"We discussed the components of the discharge screen and what was considered acceptable for discharge. For instance, most of the patients are going to have some degree of pain when they go home and they receive prescriptions for oral pain medication," Skerritt says.

Skerritt worked with the chief obstetrical/gynecological resident to develop preprinted standard postoperative orders for hysterectomy so that the physician would not have to write out individual orders for each patient.

For instance, most physicians had different methods of advancing patient mobility after surgery. Some might say dangle the legs off the bed the day of the surgery; others were putting it off until the second day.

"The orders don't wait to start progressing activities. They specify how soon after returning to the floor the patient should dangle their legs off the bed," Skerritt says.

The orders specify when the patient-controlled analgesia should be switched off and the patient changed to oral pain medicine and has a checklist of anti-emetics, oral pain medications, bowel stimulants, and other medications, which the physicians use to select the medications they want to prescribe.

Part of the initiative involved communication between the case managers and the nursing staff about the length of stay, Zielinski says.

"I educated them to expect that the patients would be going home in 24 hours or 48 hours, depending on their type of surgery and the importance of progressing care, so that the patients could be discharged in a timely manner," she adds.

Before the initiative began, Zielinski talked to patients who were admitted for abdominal hysterectomies and asked them when they expected to go home.

"They would tell me that their doctor said they should expect to stay three or four days. This was setting the stage for a longer length of stay," says Zielinski.

Now, some of the surgeons dictate into the history and physical that patients have been advised to expect an overnight stay or a two-day stay, depending upon the procedure.

"Not all go home within the time frame we set — medical progress varies from person to person and we are sure that they are stable enough to go home," Zielinski says.

Zielinski encourages physicians to take a proactive approach to discharging patients, making sure that everything is in place for a timely discharge.

"I may ask the physician to reevaluate the patient later in the day for discharge or to review the treatment plan if they are staying longer than expected," she says.

For instance, a patient might not be ready for discharge in the morning but may show significant progress during the day. In these cases, Zielinski suggests that a resident see the patient later in the day and write the orders for discharge, she says.

"Alternatively, physicians are asked to consider writing the discharge order in the morning, conditioned upon the patient meeting the discharge screen," she says.

For instance, the physician may write "discharge if tolerating regular diet."

A key piece of the initiative involved tracking patient length of stay and giving the information to the admitting physicians, she adds.

"Each physician got data about their own length of stay compared to the department's average. The department chair got information on everybody," she says.

The medical director of the case management team provides feedback to the physicians about length of stay and prepares a trend chart, which has shown a steady decline in length of stay since the initiative began. ■

Hospital CoP changes affect EMTALA compliance

Time, signature issues cited

A one-word change in the Conditions of Participation (CoP) regulations that went into effect Jan. 26, 2007, will make a dramatic difference in compliance requirements for Medicare and EMTALA, says **Stephen A. Frew**, JD, a web site publisher and risk management specialist (www.medlaw.com).

That change, which is "buried deep" within 22 pages of CoP regulations, requires that every entry in the medical record be timed, Frew adds, and it may influence how medical records affect

malpractice claims.

"Most risk managers have pushed for timed entries in the medical record to help document sequence and timeliness of care," he notes. "Often EMTALA and other compliance issues hinge on the time of various entries."

Calling time "the new documentation trap," Frew points out that most hospitals that have not gone to electronic medical records have very few timed entries.

The Centers for Medicare & Medicaid Services (CMS) notes in its comments that "the timing of medical record entries is crucial for patient safety and quality of care. Timing applies to all medical record entries, not just to the authentication of verbal orders. This would include orders, progress notes, procedure notes, patient assessments, H&Ps [histories and physicals], etc.

"Timing establishes when an order was given, when an activity, intervention, treatment or procedure occurred, or when an activity, intervention, treatment or procedure is to take place," CMS goes on to state in the final regulations. "Timing and dating of entries establishes a baseline for future actions or assessments and establishes a timeline of events. Many patient interventions or assessments are based on time intervals or timelines of various signs, symptoms or events.

"We proposed minor revisions that would clarify that all patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form," the regulations state.

The first applications of the rule likely will occur in EMTALA investigations in the "dedicated emergency departments" of a hospital — the ED or the obstetrics, psychiatric or urgent care areas, Frew says.

The lack of timed entries, he notes, will now be a potential standards level violation for medical records that could turn out to be an EMTALA 21-day Notice of Termination citation.

"On the medical malpractice side," Frew adds, "ambiguities in treatment records caused by lack of timed entries might be fodder for a plaintiff's attack on the record's accuracy."

Risk managers should conduct immediate policy and procedure reviews to assess their facility's exposure, he advises. "Policy changes, staff education, and intense quality auditing will be required in most facilities."

Another change that will affect EMTALA compliance has to do with the new federal standard for verification of verbal orders, Frew says, specifically in the area of phone orders for transfers — including discharges in many obstetrics triage areas — when a physician is not present.

"The current rule indicates that the 'qualified medical provider' [QMP], typically a registered nurse or physician assistant, may effect a transfer and sign the transfer certification after conferring with a physician by phone if no physician is present," he explains. "The rule requires that the physician sign the order after the fact, but no time was specified."

Under another CoP change that went into effect Jan. 26, *all* verbal orders must be verified by an electronic or manual signature within 48 hours unless a state law or rule requires a different length of time, Frew says.

Some states have rules specifying times ranging from 24 hours to 30 days, he adds, and those rules will not be changed by the CMS regulations. States without existing standards will be required to meet the federal standard, Frew adds.

"An interesting twist in the rule is that the actual person giving the verbal order does not have to validate the order," he points out. "Partners, for instance, can sign the order for up to five years. The provision seems to anticipate that electronic systems will be fully in place by 2012."

Frew cautions, however, that the EMTALA rule for co-signature appears to require that the physician actually giving the verbal order for transfer must cosign the transfer created by the QMP.

"I recommend that the hospital policy continue to require co-signature by the individual physician consulted by the QMP," he adds. ■

CMS offers guidance on HIPAA security rule

The Centers for Medicare & Medicaid Services has released guidance to help organizations comply with HIPAA security standards when they allow remote access to electronic protected health information (EPHI) through portable devices or external systems or hardware.

Entities covered by HIPAA should be "extremely cautious," CMS said, about allowing offsite use of or access to EPHI , and must implement policies and procedures to protect EPHI that is stored on remote or portable devices/media or transmitted over an electronic communications network. ■

(Continued from page 54)

admission to the hospital.

The correct term would be septicemia or sepsis, secondary to a urinary tract infection, Hale says.

Documentation enhancement does not mean misrepresenting that patient's condition or the treatment provided; it clarifies what really happened. In this case, it means that a localized urinary tract infection has developed into a systemic infection, or a systemic inflammatory response to that infection, Hale says.

"In many cases, the documentation in the chart doesn't translate into the patient's severity of illness. The patient's condition seems obvious to the doctor from a clinical standpoint but it's not so obvious to the coder and it cannot be most accurately coded from the documentation provided," Eyer says.

For instance using the term "type 2 diabetes — poorly controlled" does not qualify for higher severity but "type 2 diabetes — uncontrolled" does, Hale says.

"Physicians learned a different lingo in medical school. Knowing how to document to accurately represent the patient's severity of illness is not education that most physicians get as part of their training," Hale adds.

Sometimes physician documentation actually reflects a better picture of the patient condition than the clinical term used to code the same condition, Imperati says.

For instance, if a patient has blood in the urine, the physician may write "cherry red urine" on the chart so other health care providers have a clear picture of the urine's color at that point in time. Unless the physician uses the word "hematuria" in the documentation, the true condition of the patient can't be coded, Imperati says.

"We work with the physicians and educate them on language that is codeable. In this case, we ask them to use the word 'hematuria' in addition to the description of the urine, which adds further clarification to the color or extent of the hematuria," Imperati says.

Another common coding problem is the documentation of "blood loss anemia," Imperati says.

"There are several different types of anemia but they are not all comorbidities that will bump up the diagnosis to a higher-weighted DRG. Blood loss is a common cause for anemia, but it is often documented only as 'anemia,'" she says.

To be coded as a comorbidity, the anemia must be linked to blood loss using documentation such

CE *questions*

13. If a patient has pneumonia due to aspiration of food or vomitus, which falls into DRG 79, what is the Medicare length of stay?
A. 3.2 days
B. 4.6 days
C. 5.3 days
D. 6.7 days

14. The Centers for Medicare & Medicaid Services has announced its intentions to shift to a severity-adjusted DRG system. When is this scheduled to happen?
A. Oct. 1, 2007
B. Jan. 1, 2008
C. Oct. 1, 2008
D. April 1, 2008

15. According to Doris Imperati, BSN, MHSA, CCM, managing consultant for Navigant Consulting, it is OK for case managers to tell physicians what to write in patient documentation when prompted.
A. True
B. False

16. The term "urosepsis" is the correct way to document septicemia or sepsis caused by a urinary tract infection in which bacteria leaks into the general vascular circulation.
A. True
B. False

Answer key: 13. D; 14. A; 15. B; 16. B

CE 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. ■

as "anemia due to blood loss," "anemia due to GI bleeding," or "acute blood loss anemia," Imperati adds.

Physicians often think that the slash mark (i.e., GI bleed/anemia) infers that the conditions are linked. In reality, the conditions can exist independent of each other, which is why documentation has to reflect that the anemia is directly related to the blood loss, she adds.

"Anemia due to blood loss, acute or chronic, is an often-missed complication/comorbidity [CC] and in cases that do not have another CC, this can make a difference in the correct DRG assignment and reimbursement," Eyer says.

The lab values may reveal that the patient has decreased hemoglobin and hematocrit levels and the chart may reflect a transfusion of two units of blood but the physician does not document that the reason for the transfusion was anemia, she adds.

"Coding guidelines indicate that clinical assumptions may not be made on behalf of the physician and this includes interpreting diagnostic test results. The physician would need to document that condition being treated, such as suspected blood loss anemia, before this documentation could be coded as CC," Eyer says.

(Editor's note: Check out the May issue of Hospital Case Management *for a case study of a documentation improvement project.)* ■

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Administrators fall short of full recognition of CM duties

Staffing models often out of date

Until a hospital's executive administrators truly acknowledge that case management is part of the cost of doing business, it's likely that those charged with performing that task will continue to struggle with daunting workloads and inadequate staffing, says **Karen Zander**, RN, MS, CMAC, FAAN, principal and co-owner of the Center for Case Management in South Natick, MA.

"It's like people who want to run a department store but don't want to buy clothing or racks or cash registers," she adds. "Then the ones who need those things are in the position of saying, 'What is our return on investment?'"

Although there is some movement toward recognizing case management as part of a health care organization's basic structure, Zander says, it often fails to include a full acceptance and understanding of all the necessary case management functions — utilization review (UR), discharge planning, access, and care coordination. **(See related story, p. 63.)**

With increasingly complex cases and more and more uninsured patients, traditional case management staffing models have become obsolete, suggests **Kate Tenney**, RN, manager for case management at Sutter General Hospital in Sacramento, CA.

"In the old days, with the original case management staffing models," she adds, "you took the overall census and determined which patients would need utilization review, which would need discharge planning and some coding documentation, and then calculate staffing based on, for example, UR takes 20 minutes and discharge planning maybe 45 minutes."

With current patient acuity levels, however, those time studies are no longer accurate, Tenney says. "I have case managers who have large caseloads of

homeless, uninsured, young patients with multiple diagnoses.

"It used to be that if a patient was 45 years old, he didn't require anything but UR," she says. "Now that 45-year-old has hypertension, diabetes, is a smoker, and has peripheral vascular disease."

In addition, that patient might be a drug user with wounds that are infected because he lives on the street, Tenney adds. "Since he has no insurance and is homeless, there is no place in the community he can go. Skilled nursing facilities are not geared to the young."

The picture doesn't even have to be that bad for the case to be a challenge, notes **Barbara Leach**, RN, director of case management for Sacramento Yolo Sutter Health.

"Say the person is a skilled worker, works for a mom-and-pop operation [and so doesn't have insurance] and barely pays the rent," she says. "We have a 57-year-old who has lived [in the hospital] more often than not because [he needs post-acute care] and there isn't anywhere else for him to go."

Adding to the pressure is the faster turnarounds that have been expected since the advent of the hospitalist program, Leach points out. "If there is a test in the morning, [hospitalists] are expecting to do something by that afternoon."

In the past, case managers would open a case in the morning, spend 30 minutes on it, and not touch that case again for 24 hours, adds Tenney. Now, the hospitalist handling the case might come back to it during the day — multiple times — necessitating more involvement by the case manager.

Not only is medical care more complicated, there are more accompanying questions that need to be asked, Zander says, citing a hospital case on which she recently consulted.

"The patient had a burst aneurysm and was pretty much out of it, and had a bad skin breakdown from being in a nursing home," she explains. "The hospital staff was upset because there was no DNR order. The patient, who now was having an infectious process, had already been in the hospital eight days, but nobody had talked to her husband about any of this."

The man didn't come in at a time when it was convenient for a member of the staff to talk with him, and the patient was still sick enough to need utilization review, Zander says. "Nobody was talking about 'the middle part' of care. We can save her life, but does her husband actually even know how her body looks under the sheets, how deep the wounds are? You don't come back from that."

In this instance, the hospital involved didn't have case management, she notes, so there was no one saying to the husband, "If [the patient] goes into a code, what do you want to do?

"The case manager is the catalyst for asking the right questions," Zander says.

New staffing models in order?

Despite these increasing demands on the case manager's time and expertise and the demonstrated need for someone whose job is to ask those kinds of questions, Tenney says most hospital budgets are dependent on that initial staffing model.

A reevaluation of staffing ratios is obviously in order, Leach says, but the fact that models vary a great deal among hospitals complicates the issue.

"Some hospitals do not have what we call an integrated model," she adds. "At Sutter, our case managers do UR, discharge planning, and a fair amount of care coordination. In other hospitals, those are all distinct roles, which makes it hard to compare models and staffing."

At some hospitals, notes Tenney, social workers do a great deal of discharge planning, and at others they don't do any part of it.

Leach says she has done some "work sampling," whereby one identifies categories of work that are expected to occur and then observes staff to see what category they are performing at particular intervals.

"You can say you spend 30% of your time doing this, and 60% doing this," she explains, but work sampling can reveal that those percentages are way off. In an "80-20 world," where the most intense work takes up 20% of one's time, Leach adds, "20% feels like more. You always write down the things that drive you insane."

To help relieve the staffing crunch, she says, Sutter Health has added "nurse extenders" to help relieve the staffing crunch, she says.

The drawback there, however, is that most of the increased demands on case managers require nursing expertise, Leach notes. "The nurse extender can't assess the results of a critical test or resolve a complicated family dynamic or determine what level of care the patient needs."

At Sutter Health, explains Tenney, these nurse extenders are known as case management specialists. They act as assistants to the case managers and do provide invaluable help, she says.

"The job description requires some college education and some background in medical care," Tenney says. "[Case management specialists] are responsible for the entire placement process once

the case manager has identified what is needed."

A certain percentage of time in the staffing model is calculated for placement, she notes. "The nurse extender can pull that [function] out of the nursing model, and the case manager can handle twice as many patients that will need placements because of the nurse extender positions."

At Sutter General, four specialists do 800 placements a year, Tenney says. "The other piece [they perform] is that once the case manager has determined that a patient will go to an SNF, the specialist will meet with the family, coordinate the actual transfer including transportation, communicate with the SNF, and copy charts.

"So basically, the specialist will make all the arrangements and follow through and then back it up with documentation," she adds. "So a case manager can hand off the rest of the case to that person. It's one thing to have a clerical person who can make copies, but to have a person you can hand a case to is a huge help for case managers."

While the nurse extender helps with a piece of the case manager's work, what Leach refers to as "how long it took to Xerox something" has been eliminated from the case manager's schedule. "It took away that down time, that time to think.

"Because we've moved hospitals into a 24-7 operation," Tenney adds, "case managers are constantly trying to maneuver patients and keep up with documentation."

Under normal circumstances, managers would go to the hospital's administrative team and say more case managers are needed because of the acuity of the patients, she says, "but in the current environment, that's not an option anymore."

Instead, the focus at Sutter General is to bring down the number of full-time equivalents per discharge, Tenney continues, because it's higher than at other facilities in the community.

To make the most of the staffing that is available, she says, "we concentrate on making the case managers as efficient as possible. We try to train them not to take on other people's jobs."

The tendency, Tenney explains, is for case managers to do a lot of things that are not part of the case management role, such as helping nurses and physical therapists with their tasks, because it facilitates discharge.

"For instance, the physician writes that the patient can go home as soon as his labs are normal," she says. "The case manager will go to the nurse and say, 'The labs are normal. Is the physician going to discharge?'"

The nurse, Tenney adds, will respond, "I don't know. I didn't know the labs were normal." Under normal circumstances, she says, the case manager will then call the physician and go back to the nurse and say, "Here are your orders for discharge."

Other staff members may not be as aware of time and length of stay, as well as other patient issues, as case managers, Tenney notes, which can lead to another potential drain on case management resources.

"Traditionally, on any hospital unit, the case manager was the center of information if someone didn't know what was going on," she says. Being that resource for a unit is very time consuming, Tenney adds, and not realistic in today's environment.

"Ask yourself," she advises case managers, "Can you afford to take every phone call of every nurse and physician that comes by to talk to you? Time is such an issue. That [pattern] may have to change."

Another lesson case managers may need to learn, Leach points out, is when to give up — at least for the time being.

CE 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

- ■ Managing the discharge of patients with lengthy stays
- ■ Staff who may free up case managers for patient care duties
- ■ How to collaborate closely with your physician advisor
- ■ How an express discharge system can pay off

In many instances, she says, case managers will concentrate on a very difficult case, in which the living conditions, the age and attitude of the patient, and perhaps the lack of family involvement make it extremely unlikely that the patient can be readied for discharge.

"When staff tell me about a situation like this," Leach says, "I tell them, 'Put this down. Work on it again tomorrow. It wouldn't get done today anyway, and you need to move on to the five other patients you haven't seen at all. Make sure you don't [negatively] impact cases you can make a difference on.'"

(Editor's note: Karen Zander may be reached at KZander@cfcm.com. Kate Tenney may be reached at TenneyK@sutterhealth.org. Barbara Leach may be reached at LeachB@sutterhealth.org.) ■

It takes *all* CM functions to provide necessary care

Care coordination 'least recognized'

Many top hospital decision makers still fail to recognize that case management is a core function of patient care, not an optional service that needs to prove return on investment, says **Karen Zander**, RN, MS, CMAC, FAAN, principal and co-owner of the Center for Case Management in South Natick, MA.

Even those who do acknowledge that case management is part of the basic structure of a hospital may not see all of its components as crucial, says Zander.

Hospitals have accepted that **utilization review** (UR) has "tightened up" so that it is no longer just about having good contracts with payers, but must be practiced on a daily basis and must be done mostly by nurses, she says. "Case managers have to implement the contracts. UR has gone from a blanket, 'We'll get paid, just send this off' to having to explain why we deserve to be paid for this day for this patient."

"If we say, 'This is what we need for UR,' [administrators] wouldn't balk at that, but the functions keep evolving and growing," Zander adds. "If we start with one staff [member], they say, 'OK, we understand,' but then we keep throwing more responsibilities on that staff [member] and the complexity of cases [keeps increasing]."

Having an electronic medical record makes the job of UR easier, she notes. "The problem is that no one has a complete electronic record, so you have to look at the computer for some information, the paper chart for the rest, and then you have to track down the physicians to see who's covering for whom."

The next most acknowledged case management function is **discharge planning**, Zander continues. "People know that patients can't live in the hospital for the rest of their lives, so they have an intuitive understanding that discharge planning has to happen.

"They also know that length of stay and getting paid are connected, so there is even more recognition of the importance of discharge planning, and there is a target attached," she says.

"In fact, there are several targets attached," Zander adds. "The more the quality targets rise, the harder the job. It's not just finding a place for the patient to stay, but, [asking], 'Have we done the right thing to prevent readmissions, are we doing the right work in the hospital, and are we sending the person to the right level of care?'"

There are long-term acute care hospitals, but they don't usually take Medicare, she notes, "so you might have a patient who can use that, but has the wrong payer."

The Center for Case Management estimates that 45% of a hospital's medical-surgical patients should be going somewhere besides home at discharge "and we think that [percentage] is low," Zander says. "The recovery phase of [hospital] care got amputated with DRGs.

"What we mean by 'somewhere,'" she adds, "is somewhere where there is nursing oversight and actual nursing care, such as long-term acute care, hospice care, home care. Even one home visit we count."

In actuality, Zander says, most hospitals are at 20% and, with readmission rates on the increase, "will have to ramp up."

The **access** function is the third, less acknowledged, component, she says, "although it has always been a foundation of case management. It is about getting patients connected with health care services, especially the front end of the care.

"That includes getting patients into and through the emergency department; getting them a bed if needed; acquisition of a primary care physician, appointments, transportation, and other resources," Zander adds. "Liaison staff to community agencies are also working in the access function."

The fourth function of case management, **care coordination** — "the middle of the care" — is the

least recognized, she says. "It's about team leadership, treatment planning, and quality, not just what the physicians are doing, but what all the other services are doing in regard to basic care, like pain management and mobility and patient education.

"Are they getting confused? Are they dehydrated? What is their pulse oxygen? Are we mobilizing them correctly? Do they understand how to take care of themselves?"

If caregivers aren't paying attention to those questions, Zander points out, "four days can turn into 40 days. It slips into that very fast if you don't manage those things.

"We have a little poem at the [Center for Case Management]," she notes. "UR is accountability for the *pay,* care coordination is accountability for the *day,* discharge planning is accountability for the *stay,* social work is accountability for the *way,* and access is accountability for today."

If a hospital's executive team doesn't understand all the necessary functions, and how case management will serve those, and if there are no real targets in place to show where a hospital wants to get, Zander says, whatever staffing was allocated at a case management department's inception is likely to remain.

"If social workers did discharge planning and nurses did utilization review [originally], then you are stuck with that unless the hospital sees the access and care coordination issues," she adds. "Unless [administration] sees the scope of what you have to achieve, you get into a fall-back position instead of an aggressive one."

(Editor's note: Look for a case management staffing model developed by Karen Zander for the Center for Case Management in the next Discharge Planning Advisor.) ■

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Correction:

In the March issue of *Hospital Case Management,* question 12 should have read: What percentage of patients do hospitalists admit at St. Vincent's Medical Center in Jacksonville, FL?

We sincerely apologize for the error. ■