ABSTRACT: 2015 ELAM Institutional Action Project Poster Symposium

Project Title: Integration of Clinical Documentation, Quality, Compliance, Financial and Information Technology teams to improve clinical documentation in the Surgery Department of the University of New Mexico Health Science Center

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Background, Challenge or Opportunity:
The Federal government has mandated programs to improve quality of healthcare and contain costs. Clinical documentation (CD) is emphasized in these programs, with a focus on electronic health records (EHR), hospital and professional payments influenced by quality reports, documentation compliance and transition to ICD-10 coding. Because healthcare providers receive instruction for clinical documentation improvement (CDI) from different sources, it is often confusing and/or contradictory.

Purpose/Objectives:
The objective of this project is to improve clinical documentation and provide ICD-10 education in the Surgery Department of University of New Mexico through a comprehensive CD curriculum that includes quality, compliance and financial qualifications that fulfill government and local quality and cost initiatives.

Methods/Approach:
A team of coding, quality, compliance, financial and information technology (IT) specialists started meeting in February 2015 to develop a clinical documentation curriculum that addresses CD requirements for quality, financial and compliance objectives. This CD curriculum is presented in lectures, case studies, Precyse mobile apps and e-learning modules. Queries to enhance CD are sent to providers and CD tips are embedded in EHR templates. Dynamic Documentation with Dragon Speak may ease the increase in CD burden. A specialist will be available via a "Bat phone" to providers to answer CD questions. Providers will be able to access immediate coding information about a CD via a computer assisted coding program.

Outcomes and Evaluation Strategy:
Severity of illness (SOI), risk of mortality (ROM), case mix index (CMI) and DRG scores for nine surgery divisions are obtained from the University Healthsystems Consortium (UHC) database and compared to other UHC level 1 trauma centers. Clinical outcomes such as readmission rates, peri-operative venous thromboembolism, post-op sepsis or respiratory failure are monitored by the Surgical Care Improvement Program (SCIP) and compared to other UHC centers. Internally, response rates to queries and delinquent documentation are monitored.
We hypothesize that CDI will result in more accurate SOI, ROM and CMI scores. In turn, this will lead to better patient care reflected in higher SCIP quality scores and lower readmission rates. Institutional and professional payments should also improve with CDI. We will generate reports with metrics on documentation, quality and financial payment in the near future.

Integration of Clinical Documentation, Quality, Compliance, Financial and Information Technology Teams for Clinical Documentation Improvement

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Introduction

Background

The Federal government has mandated programs to improve the quality of healthcare and contain costs. Accurate clinical documentation (CD) is emphasized because of :

1) Hospital and professional payments influenced by quality data
2) Public reporting of quality metrics
3) Transition to ICD-10 coding

Accurate CD is challenging because healthcare providers receive documentation instruction from hospital coding, professional billing, quality, and compliance educators that is often confusing and contradictory. Further challenges will be encountered with a significant increase in documentation requirements with ICD-10. A reduction of up to 40% of clinical revenues is anticipated with ICD-10 implementation (October 2015) due to insufficient clinical documentation.

Objectives

The goal of this project is to provide a CD improvement and ICD-10 training curriculum that results in better patient care and reimbursement. Merging ICD-10 coding, quality, and compliance objectives should clarify documentation requirements that results in:

1) Accurate quality metrics that will direct efforts to improve quality of patient care
2) Better capture of primary diagnosis and comorbidities for higher reimbursement
3) Appropriate ICD-10 documentation that avoids payment denials

Collaborators

Gary Iwamoto, MD; Aaron Jacobs, MD; Ella Watt, CPA; Richard Crowell, MD; Stuart Freedman, MPH; Anthony Masciotra, CPA, MBA; Susan Welker, MBA, FACHE; Jacqueline Hargrave, CMC, CPC

Approach

Methods

Clinical documentation education performed independently by different departments produced a modest CD improvement in 2014. In response to modest results, a team of coding, quality, compliance, financial and information technology specialists began development of a CD curriculum in February 2015. The curriculum includes:

1) Lectures about CD
2) Review of case studies at conferences looking for opportunities to improve CD
3) ICD-10 mobile apps and e-learning module
4) Queries sent to providers to enhance CD
5) CD tips embedded in electronic health record templates
6) Dynamic Documentation with Dragon Speak
7) A CD specialist available via a "Bat phone" to answer CD questions

Evaluation Strategy

Through the quality organization, University Healthsystems Consortium (UHC), we monitor:

1) Severity of illness (SOI)
2) Risk of mortality (ROM)
3) Case mix index (CMI)
4) Surgical Care Improvement Program (SCIP) clinical outcomes such as:
   a) peri-operative venous thromboembolism
   b) post-op sepsis
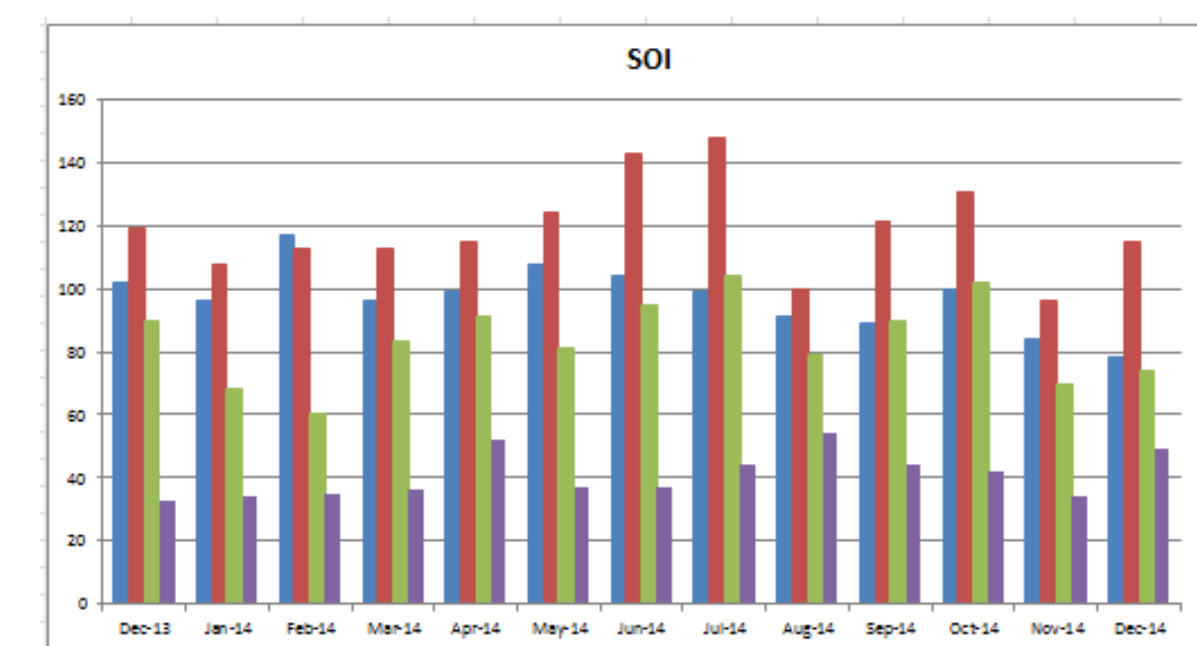   c) respiratory failure

Internally we monitor:

1) Response rates to queries
2) Delinquent documentation
3) DRG levels and hospital payment
4) Professional payment

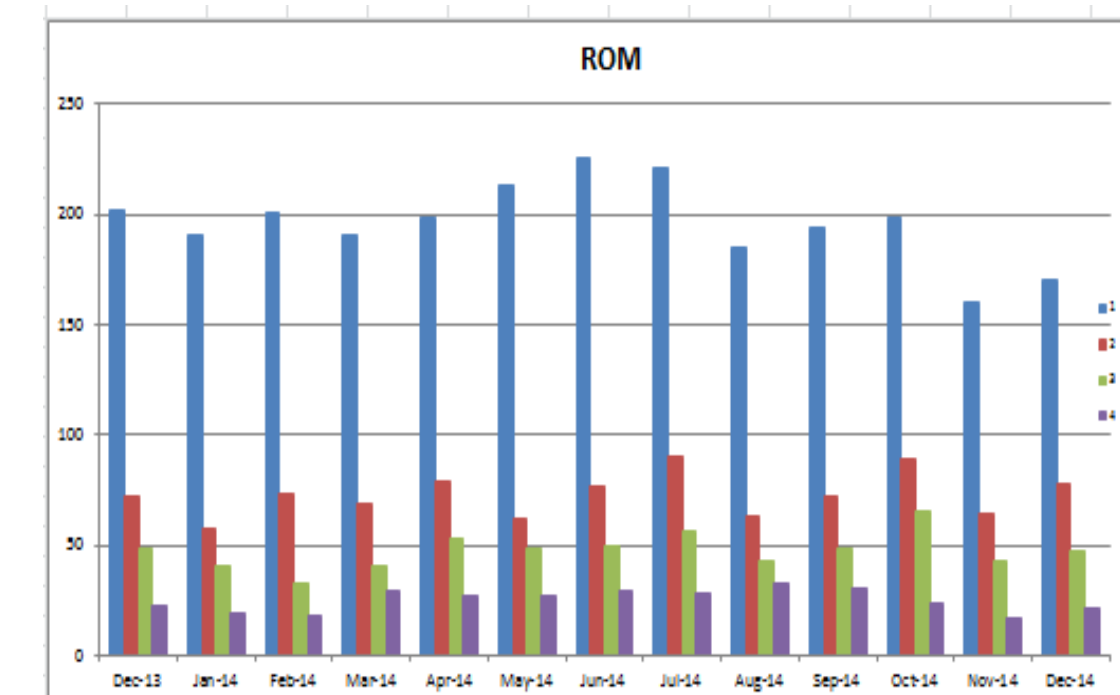We will compare pre- and post-curriculum quality, compliance and financial metrics from the surgery department.

Results (2014)
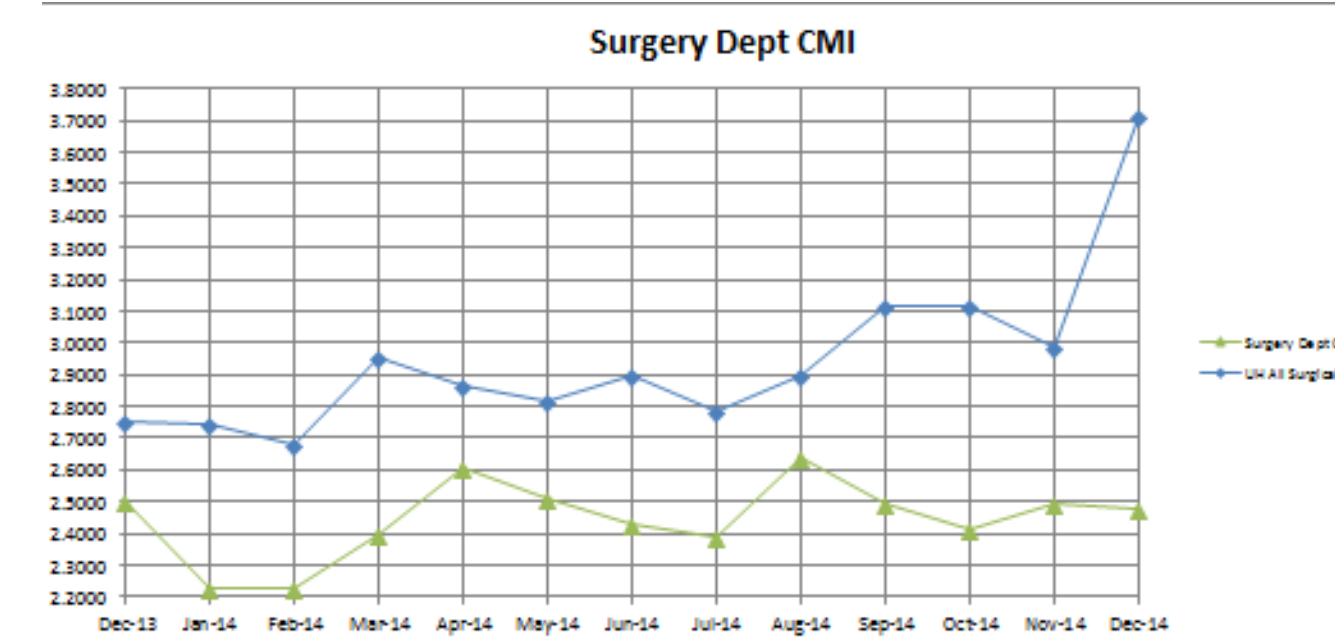
Case Mix Index: Moderate Increase
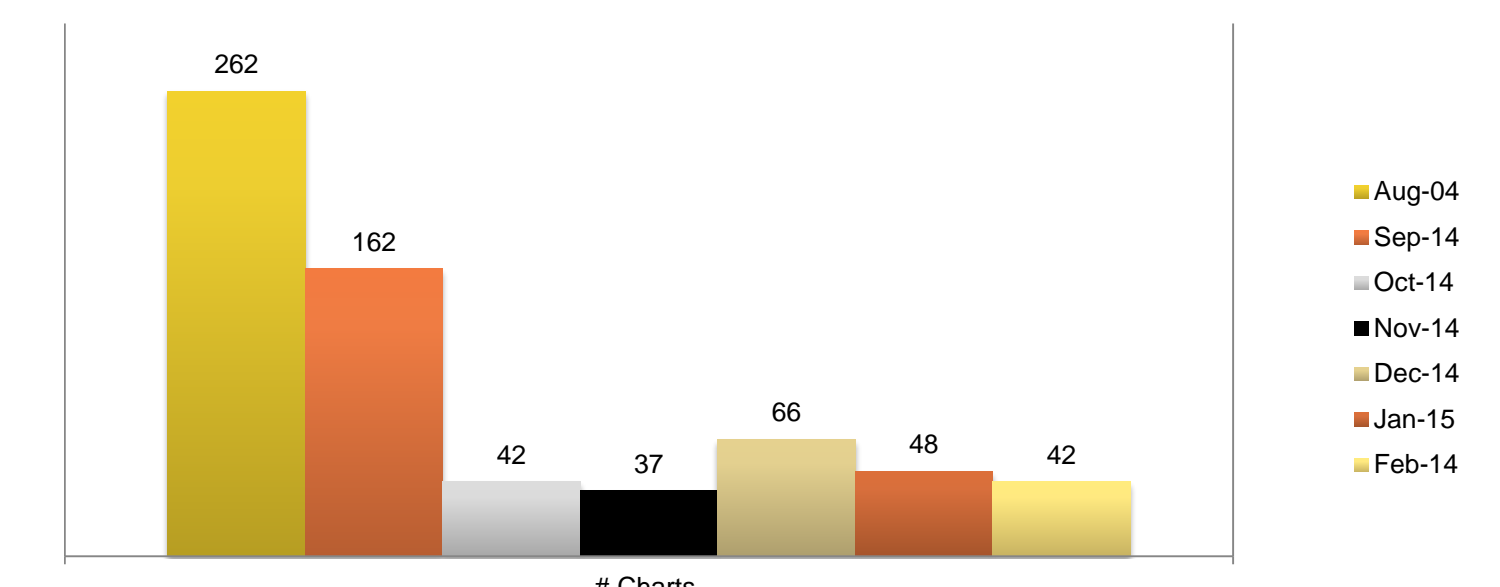

Severity of Illness: Modest Increase

Risk of Mortality : No Change

	UNM	Target	UHC Mean
Respiratory Failure	14.5	11.1	9.4
Wound dehiscence	7.4	2.2	0
Peri-op DVT	7.4	6.7	7.4
CLABSI	0.3	0.7	0.4

SCIP Outcomes

Results (2014)

Delinquent Charts

Conclusions

We hypothesize that this comprehensive CD curriculum will result in more accurate quality metrics that will guide our quality improvement efforts and improve the quality of patient care. Better CD compliance and higher DRG levels from capture of diagnosis and comorbidities will result in higher hospital and professional reimbursement. Appropriate ICD-10 documentation should prevent denial of payment from federal and private insurance companies.

Presented at the 2015 ELAM® Leaders Forum