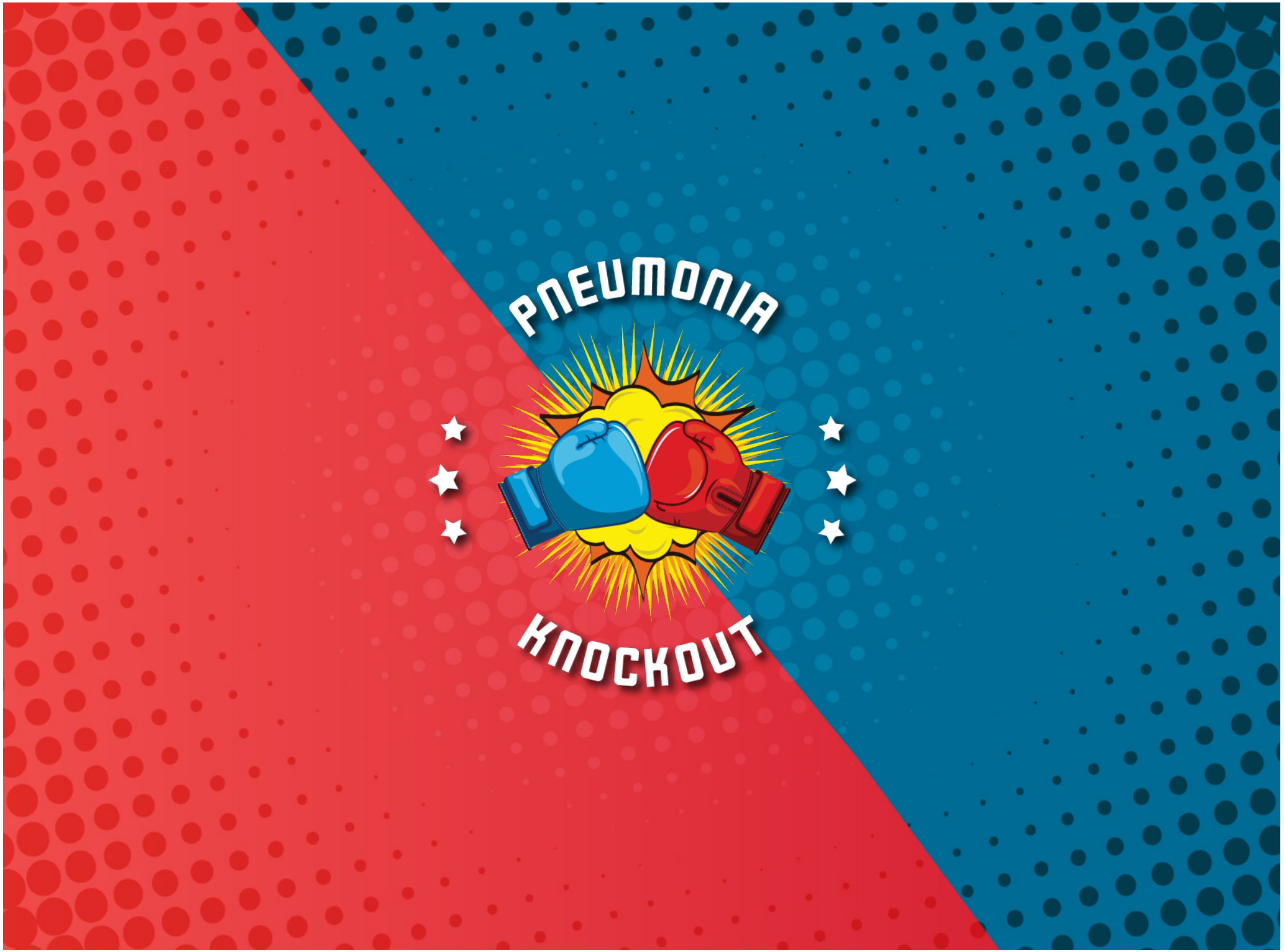

PNEUMONIA
KNOCKOUT

Concurrent Documentation Excellence: Getting it Right

NCHA – December 2017

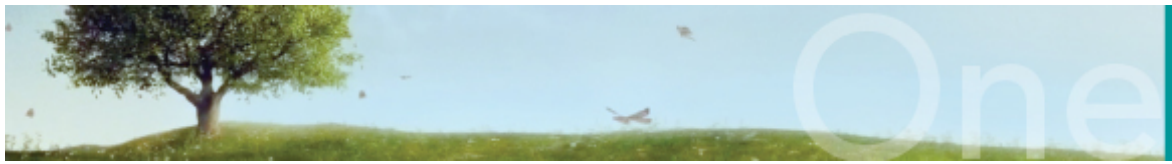
Stephen Wright, RN, MBA | AVP Invasive Cardiology
Heather Joyner, BS, Director | Documentation Excellence

WHO WE ARE

Mission: To improve health, elevate hope and advance healing for all.

Carolinas HealthCare System is one of the leading healthcare organizations in the Southeast and one of the most comprehensive, not-for-profit systems in the nation.

Vision: To be the FIRST and BEST choice for care.



WHERE WE ARE

CHARLOTTE METRO MARKET

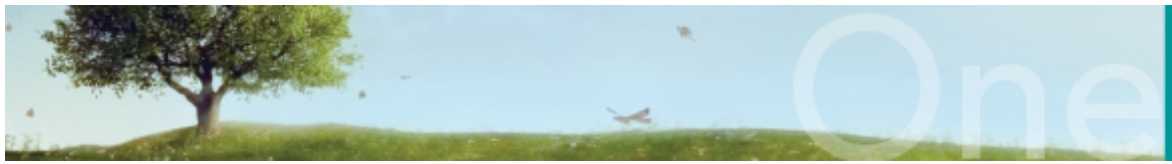
1. Carolinas HealthCare System Anson
2. Carolinas HealthCare System Cleveland
3. Carolinas HealthCare System Kings Mountain
4. Carolinas HealthCare System Lincoln
5. Carolinas HealthCare System NorthEast
6. Carolinas HealthCare System Pineville
7. Carolinas HealthCare System Stanly
8. Carolinas HealthCare System Union
9. Carolinas HealthCare System University
10. Carolinas Medical Center
11. Carolinas Medical Center-Mercy
12. Carolinas Rehabilitation
13. Carolinas Rehabilitation-Mount Holly
14. Carolinas Rehabilitation-NorthEast
15. Carolinas HealthCare System Behavioral Health-Charlotte
16. Carolinas HealthCare System Behavioral Health-Davidson
17. Carolinas HealthCare System Rehabilitation (Pineville)
18. Levine Children's Hospital

OTHER MARKETS

19. Alamance Regional Medical Center
20. AnMed Health Medical Center
21. AnMed Health Rehabilitation Hospital
22. AnMed Health Women's and Children's Hospital
23. Annie Penn Hospital
24. Behavioral Health Hospital (Cone Health)
25. Bon Secours St. Francis Hospital
26. Cannon Memorial Hospital
27. Carolinas HealthCare System Blue Ridge-Morganton
28. Carolinas HealthCare System Blue Ridge-Valdese
29. Columbus Regional Healthcare System
30. Elbert Memorial Hospital
31. Moses H. Cone Memorial Hospital
32. Mount Pleasant Hospital
33. Murphy Medical Center
34. Randolph Hospital
35. Roper Hospital
36. Scotland Memorial Hospital
37. St. Luke's Hospital
38. Wesley Long Hospital
39. Wilkes Regional Medical Center
40. Women's Hospital (Cone Health)

AFFILIATED ENTERPRISES

41. Betty H. Cameron Women's and Children's Hospital
42. New Hanover Regional Medical Center
43. New Hanover Regional Medical Center Behavioral Health
44. New Hanover Regional Orthopedic Hospital
45. New Hanover Regional Rehabilitation Hospital
46. Pender Memorial Hospital
47. Southeastern Health



Carolinas HealthCare System

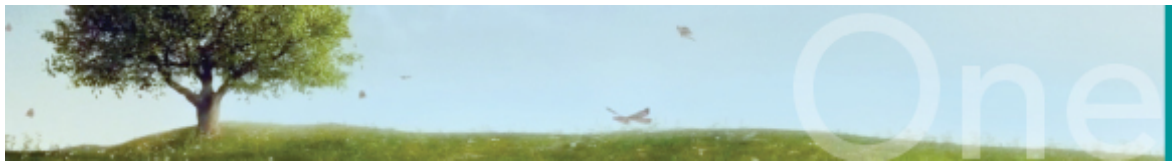
AT A GLANCE

At the end of 2016, Carolinas Healthcare System:

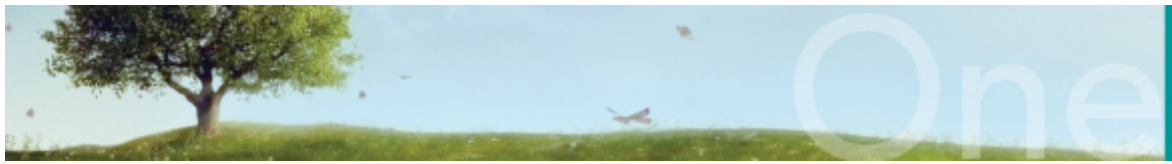
- Operated nearly **7,400** beds
- Employed more than **65,000** people
- Had an estimated **11.6 million** patient encounters
- Provided community benefit totaling **1.87 billion**

Carolinas HealthCare System owned, managed, or had strategic affiliations with **47** hospitals, and served patients at more than **900** care locations throughout the Carolinas.

The system has provided extensive support to medical research, operated top-notch undergraduate and graduate medical education programs, and launched many new outreach initiatives to boost population health and community health.



WHY



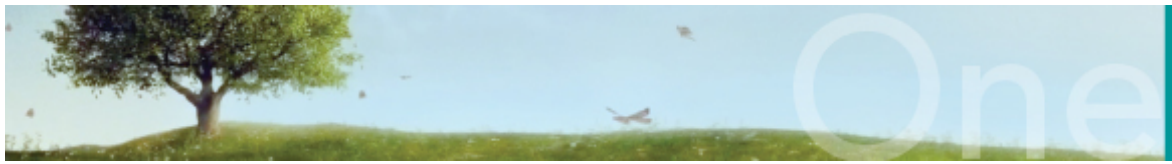
It All Started….

- 2013 30-day AMI mortality publically reported data directionally different from registry data – not good

- Cardiologists reviewed all MI cases
  - Told Coding that they were ‘coded wrong’
- Coding reviewed
  - Pointed to cases that were coded based on the documentation, oh.

A partnership was created!

WHO | WHAT | HOW



AMI Review

Short term action taken

- AMI expired review
  - Hard-stop built in HDM (expired with MI as pdx)
  - Reviewed by Documentation Excellence team
  - Referred to physician champions (they wanted to see them all no matter how clear)
- Relationship forged / trust gained / expertise shared

How do we build on this new foundation?

CONCURRENT!!

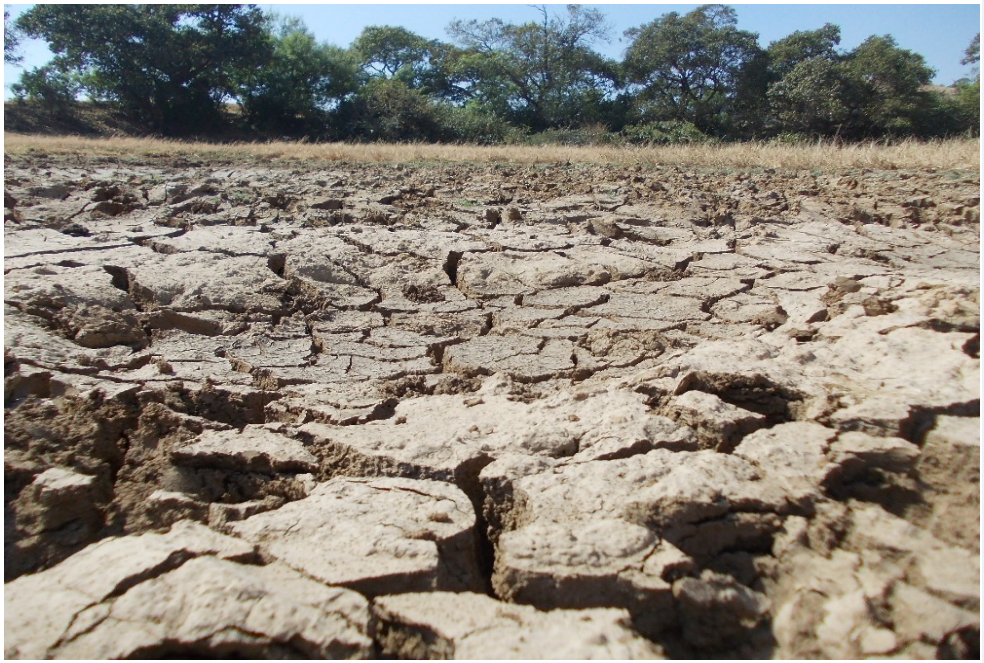
What is CDE and Why do it?

- Concurrent Documentation Excellence is a collaboration between Coding, CDI and Medical Staff Quality to:
  - Identify PSI / HAC concurrently
  - Reduce the number of retrospective Physician Documentation Clarifications (PDC)
  - Review all payer
  - Find documentation gaps, partnering with physicians to improve Severity of Illness (SOI), Risk of Mortality (ROM) and Expected LOS
- 3M 360 CDI dashboard gives us the single platform for all teammates to work from and communicate

Promotes One voice to the physicians

Why?

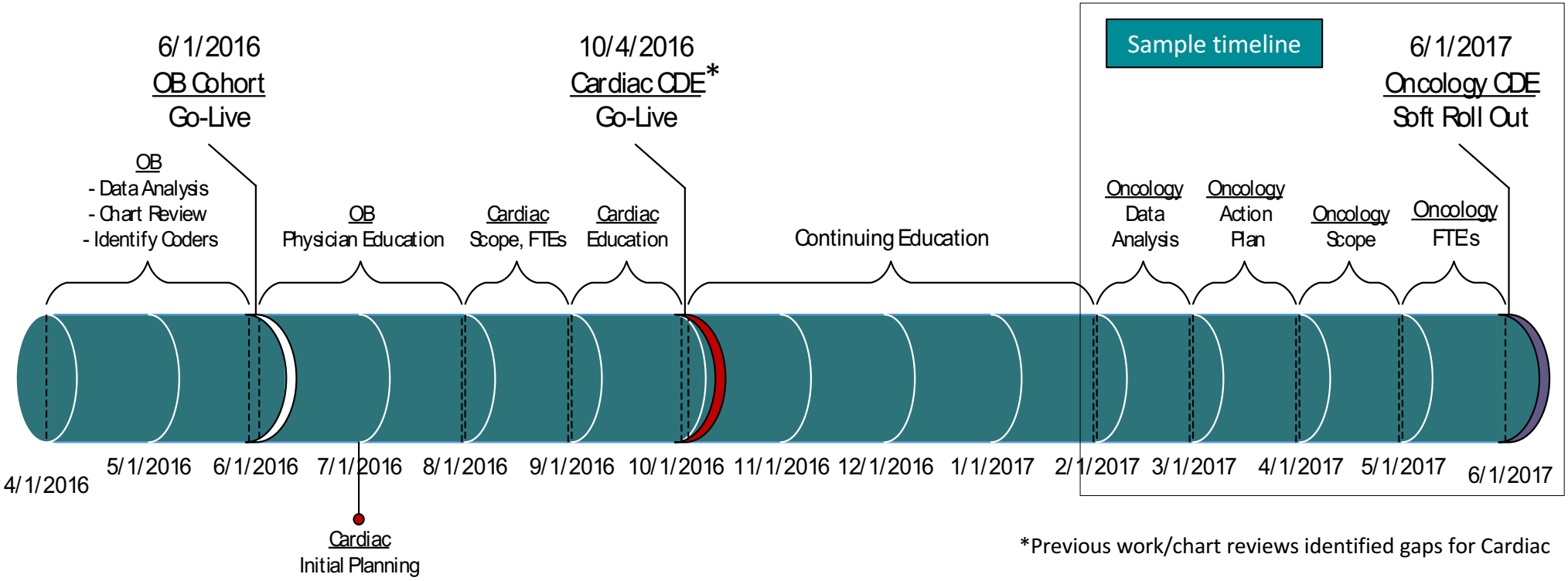
- Two sets of eyes on the documentation
- Teammates working to their strength
- Most accurate working DRG used at Interdisciplinary Rounds (IDRs)
  - Helps CDI conversation with clinician by:
    - supporting a longer LOS with best DRG
    - supporting expected mortality by capturing SOI/ROM
- Clarifications can all be done while the patient is in-house with the exception of new information introduced in the Discharge Summary or unanswered concurrent clarification



Weak, vague, inconsistent, conflicting documentation → Improved, clear, consistent, accurate documentation

Care | Collaboration | Communication

Concurrent Documentation Excellence



*Previous work/chart reviews identified gaps for Cardiac

Education

Strong Commitment by Cardiologists

- Cardiologists to Coders/CDI
  - AMI
  - Heart Failure
- Cardiac Advanced Clinical Practitioner to Coders/CDI
  - EP/Interventional
  - Cardiothoracic surgery
- Cardiologist to Hospitalist collaboration / education

Letter to Executives from a Physician

Subject: Cardiology Concurrent Documentation Excellence initiative

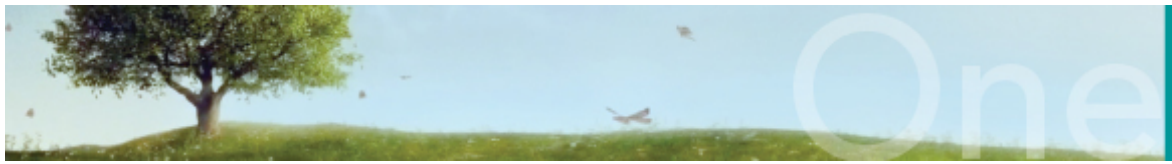
All,

As you know, the value of the work we all do is increasingly being scrutinized and measured and linked to compensation. In order for the quality and value of the work we do to be accurately depicted, we need to have our documentation and coding processes to be as good as the clinical work that we do. This is about how our work is portrayed to our patients and our community. It is also about how we will be rewarded and penalized as a system.

Over the past couple of years, we have worked closely with our coding colleagues to improve our processes and abilities to speak each others' languages. This has borne substantial fruit. For example, our MI mortality rate now much more accurately reflects the great care that we provide. However, our efforts to date have been largely a finger in the dike approach focused on mortality. Such an approach is inadequate to address all aspects of value.

We are therefore partnering with our Coding and Clinical Documentation colleagues to roll out a cardiovascular-specific Concurrent Documentation Excellence initiative. For the first time, there will be coders dedicated to cardiovascular patients. Over time, they will become experts. Coders and clinical documentation specialists will review the charts real-time while the patient is in the hospital. The documentation specialists will be based on our busiest floors so that they are readily accessible to us and us to them. The coders will not be on the floors, but will be in communication throughout the day with the documentation specialists. When questions arise or clarification is needed, the documentation specialist will reach out to you. Please welcome them as members of our team and remember that their questions are asked with the goal of making us look as good as we are. Getting this dedicated resource is a big win for CHS.

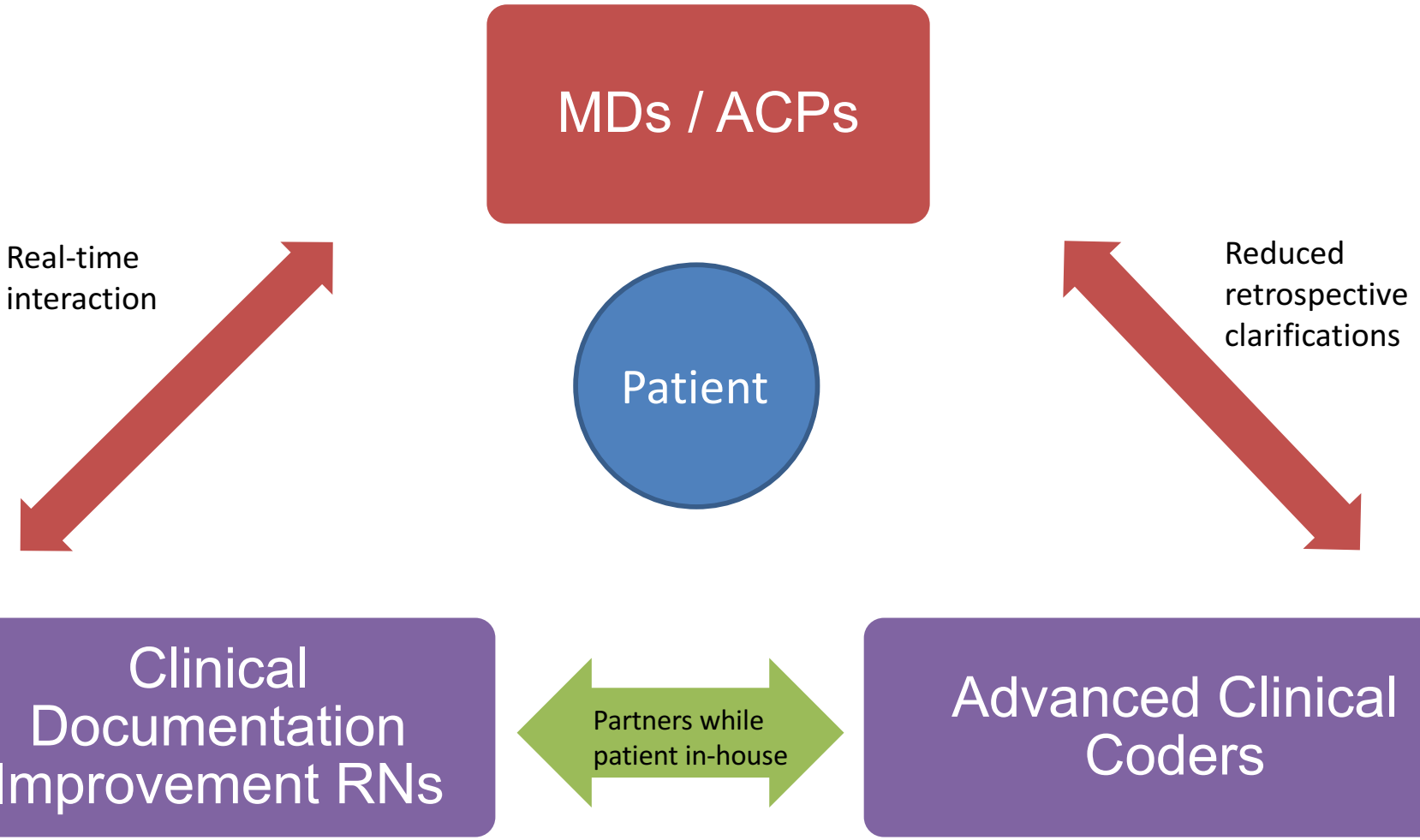
From the Medical Director | Interventional Cardiology



Concurrent Documentation Excellence

✓ Improved Outcome Reporting (mortality/readmissions)

✓ Accurate Risk Profile (capture all comorbidities) ✓ Appropriate expected LOS



Enhanced Process

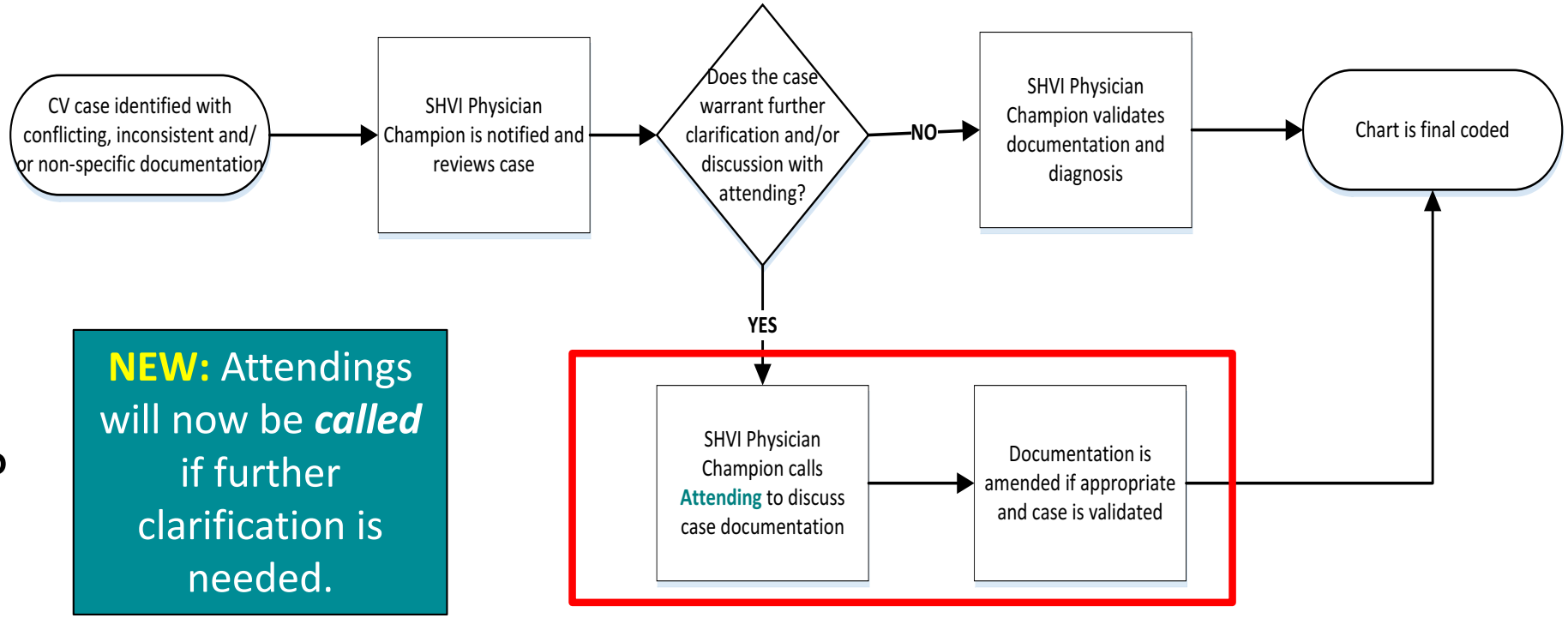
- Nurse Navigators- Heart Failure and AMI/PCI
- Improve Care Transitions: Readmission, Patient Experience

AMI | HF Documentation Excellence

WHY?

✓ Improved Outcome Reporting (mortality/readmissions)
✓ Accurate Risk Profile (capture all comorbidities) ✓ Appropriate expected LOS

HOW?



WHO?

NEW: Attendings will now be ***called*** if further clarification is needed.

*CHG, Charlotte Medical Clinic, MMG

WHEN? Pre-bill

Supported by our System CMOs

HF Review Processes (Pre-Bill)

Goal: Review documentation for accuracy when HF is identified as principal diagnosis

Concurrent (CMC /NE/ Pineville)

In-house patients with HF as principal identified by:
Nurse Navigator
CDI
Coder

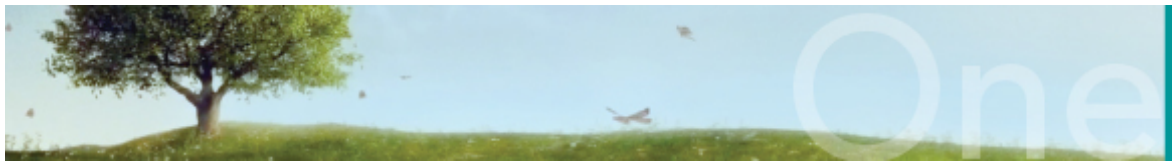
Hold
Review
Engage MD Champions if needed

- Nurse Navigator has report based on BNP and 3M swimlane based on HF assigned as principal dx
- CDI reviews select payors on non-concurrent units and all payors on concurrent units
- Coder codes in-house on select units and retrospectively other units

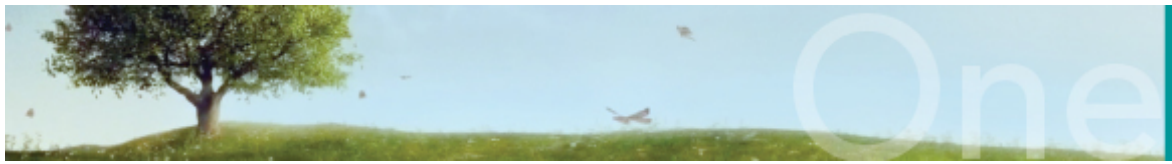
Mortalities (primary enterprise)

Pre-bill hard-stop in 3M for expired patients with HF as principal

Hold
MD champions review
Engage attendings if needed



RESULTS




SUCCESS
Because you too can own this face of pure accomplishment
DIYDESPAIR.COM

Impact?

Accuracy!

The patient's diagnosis is documented correctly then coded correctly so they end up in the right bucket to be measured!

30-day Mortality Rates and Readmissions are based on principal diagnosis

SHVI AMI Mortality**, LOS, Readmission Observed/Expected Ratios and CHS Medicare Cohort Observed Days in Acute Care (ODAC) 30-Days Post Discharge as of 11/22/2017

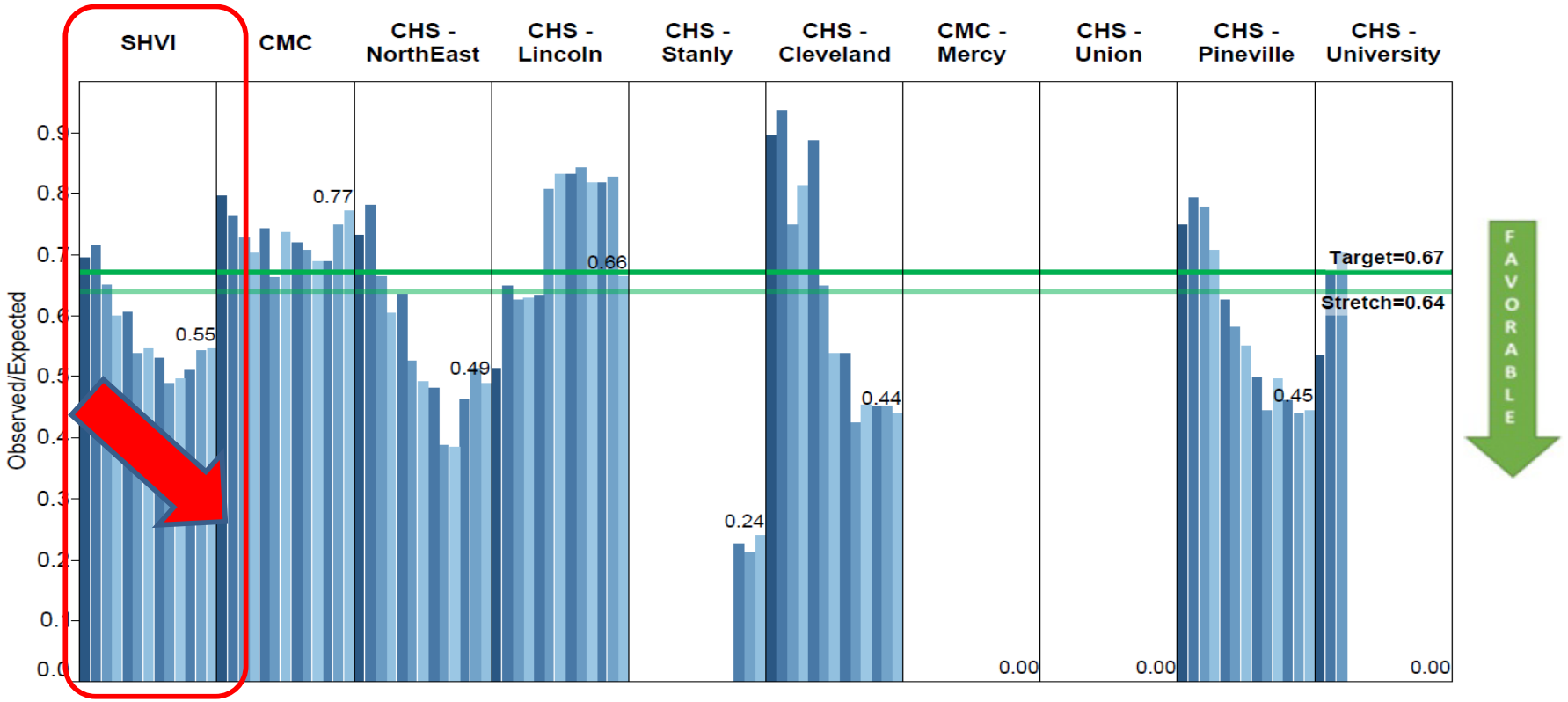
(Note: Data are shown for facilities with any index visits. Caution volumes may be small)

Measure List
Mortality

Facility Name
All

Select the Rolling Year Beginning Month
All

2017 Baseline
0.69



Time Period

NOV15-OCT16	MAR16-FEB17	JUL16-JUN17
DEC15-NOV16	APR16-MAR17	AUG16-JUL17
JAN16-DEC16	MAY16-APR17	SEP16-AUG17
FEB16-JAN17	JUN16-MAY17	OCT16-SEP17

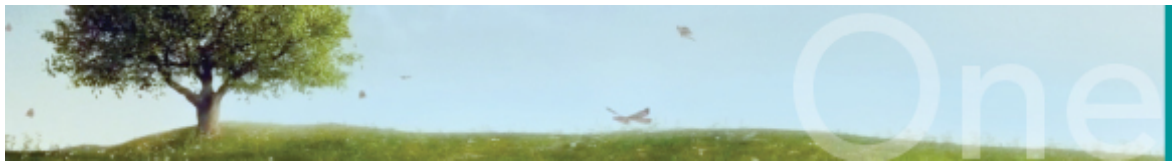
Click on this link to access methodology document Click on this link to access patient level details

Disclosure: Data may not be finalized and all patients may not be included for recent time periods.
For AMI CHS Medicare Cohort ODAC meetric, data shown only for CMC, CHS-NE and CHS-Pineville. "SHVI: includes all facilities excepting CHS-Stanly for ODAC Metric.

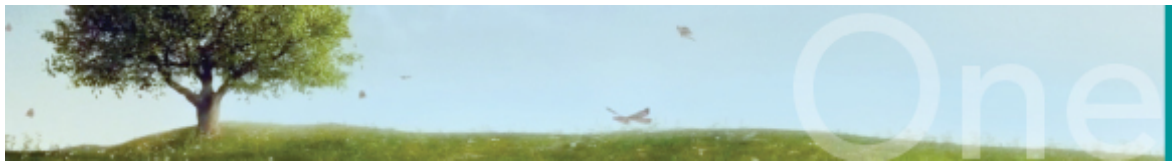
Other Results

- Reduced # of retrospective clarifications
- Reduced # of days between discharge and final bill
- Increased coder satisfaction
  - "For the first time in a while, I'm excited about going to work."
- Increased physician satisfaction – they wanted a closer connection to the coding process – they got it!
- Everyone got smarter!

Questions about AMI Mortality work?



EXPANDING CDE



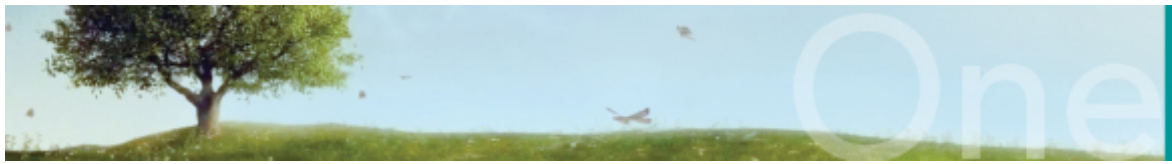
Pre-Concurrent Documentation Excellence Work

The transition to Concurrent Documentation Excellence (CDE) must be purposeful and planned to achieve the goals

- Data analysis / review
- Chart review based on data

AMI discovery opened this door

- Determine actions based on gaps and/or opportunities identified
- Determine scope of CDE deployment
- Create/provide education material for MDs, ACPs, Coding and CDI
- Identify Coders, CDI, MDs, Nurse Navigators
- Kick-off



How to Identify Patients?

Challenge

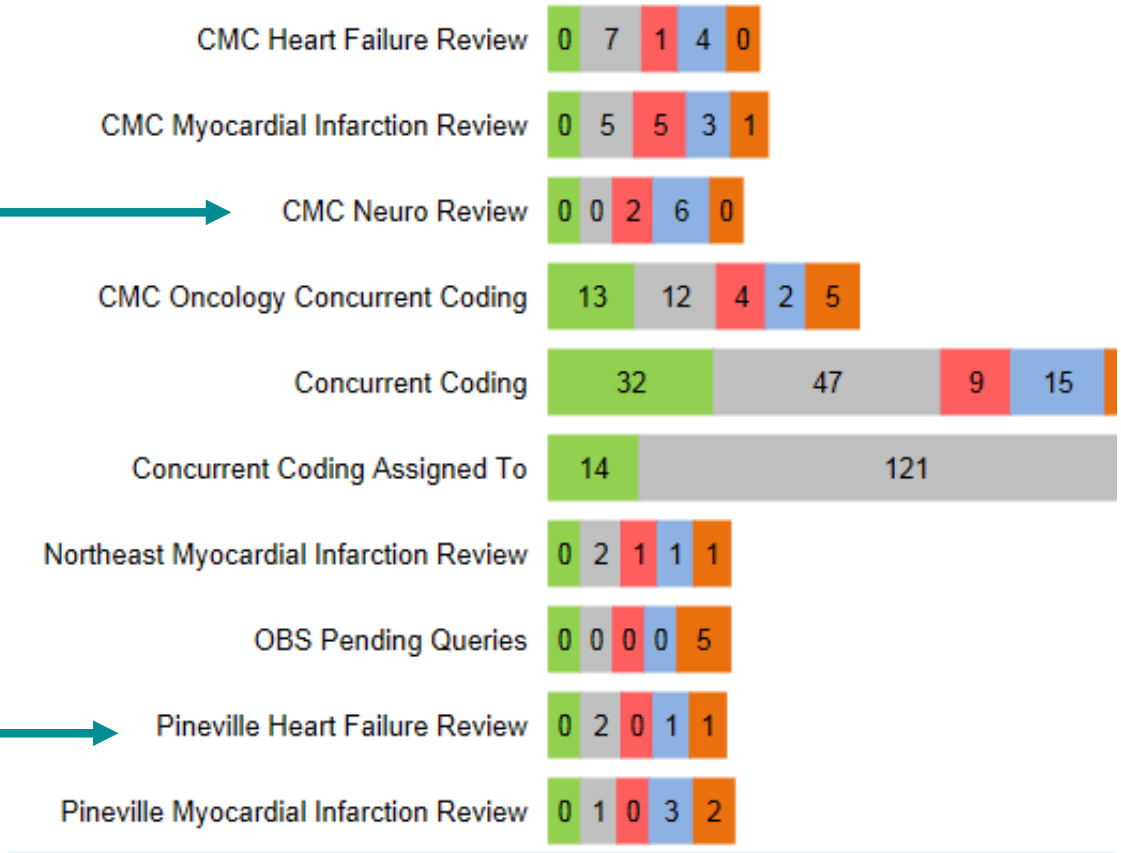
- Identify cardiac patients before they are coded
- Assign patients to dedicated teammates

Solution

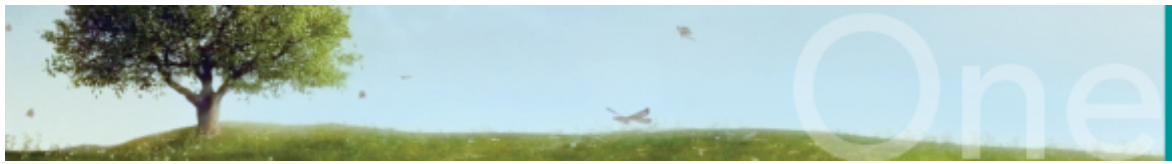
- Retrospective analysis to determine from which units cardiac patients are typically admitted to and discharged from
- Build swimlanes in 3M to funnel all patients from these identified units

Interdisciplinary Access

Examples of swimlanes built for clinicians, e.g. Nurse Navigators and Physicians



Questions?



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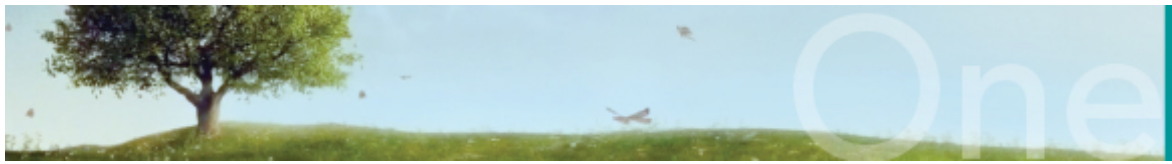

Pneumonia Knockout Education Series

Webinar #3

…And Now You Know the Rest of the Story

Date: Tuesday, January 23, 2018

Registration

Link: https://attendee.gotowebinar.com/register/8527123367589688833

Process improvement experts to explore how to successfully hard-wire in-depth analysis into your mortality and readmission case review processes. Apply evidence-based strategies for Whole Person Transitional Care from AHRQ's Hospital Guide to Reducing Medicaid Readmissions.

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