Lunch and Learn Debut

CDI in the ED: Strategically Leading Change

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Presented By

Carol Berchenbriter, MSN, RN, is manager of clinical documentation improvement and auditing at Mercy Medical Center in Cedar Rapids, Iowa. She assumed this role last December and has been at Mercy for seven years.

Berchenbriter's prior experience includes:

- ACO care coordination
- Home health case management
- Inpatient acute care
- US Army Nurse Corps Reserves

Presented By

Lori DeCamp RN, CCDS, is a clinical documentation specialist on the ED implementation team at Mercy Medical Center in Cedar Rapids, Iowa. She has been at Mercy for seven years and obtained her CCDS certification in June 2018.

De Camp's prior experience includes:

- Principal financial group—utilization review and case management
- Acute inpatient neurology and rehabilitation

Presented By

Joyce Howe, RN, is a clinical documentation specialist on the ED implementation team at Mercy Medical Center in Cedar Rapids, Iowa. She has been at Mercy for three years.

Howe's prior experience includes:

- Case management with cancer center
- Principal financial group—utilization review
- Pediatric clinic, inpatient urology, residential psychiatric treatment program, outpatient and inpatient psychiatric nursing

Mercy Medical Center

- Independent, 300-bed hospital with a Level III Trauma facility serving Cedar Rapids and the surrounding eastern Iowa communities
- 54,000 emergency department (ED) patients treated annually
- One of only 7% of U.S. hospitals to achieve stroke door-to-treatment time in < 60 minutes

Polling Question #1

- Does your organization perform CDI in the ED?
  - Yes, we have an established CDI in the ED program (3+ years)
  - Yes, we have an emerging program (< 3 years)
  - Almost, we're in the process of developing or launching a program
  - No, but we're exploring the opportunity to create a program
  - No, and we have no current plans to do so

Strategic Change

Successful navigation from strategy development to implementation of change, within an organization, is often a big challenge. Developing and empowering the people on your team is the best way to successfully convert strategic plans into results. ("How to Accelerate Strategic Change," June 27, 2019, Forbes article)

Industry Drivers of Change

- "Progress is impossible without change." —George Bernard Shaw
- A 2010 *Becker's Hospital Review* article summarized five ways hospitals were expected to change over the next 10 years:
  - Redesign current processes rather than build new facilities
  - Have physicians, RNs, and physician extenders do work that's commensurate with their training
  - Fail, in some cases
  - Dedicate more energy to reducing readmissions
  - Increase focus on disease prevention
- 2020 is right around the corner!

Why CDI in the Emergency Department?

- Unique realities of the setting mean documentation often doesn't occur in real time
  - High volume, quick pace
  - ED patients require urgent or immediate care, and their conditions may stabilize or exacerbate
  - Care is provided by multiple practitioners and support staff and often involves many additional departments and services

What Were We Missing?

- Opportunity to:
  - Resolve possible under-coding relative to coding of services in comparable local hospital (i.e., under-coding of unspecified diagnoses) based on January 2019 Optum report
  - Capture higher percentage of ED visits with observation admit
  - Investigate lower levels of documented ED acuity relative to levels in local facility
  - Document a more accurate patient story
  - Increase reimbursement

CDI ED Launch Timeline

- **12/18:** Began development of CDI ED project
- **2/19:** Met with key ED stakeholders
- **4/19:** Presented proposal to senior management; trained CDI ED team
- **5/19–8/19:** CDI team was temporarily diverted from ED project to support observation/inpatient project
- **8/19:** Held biweekly meeting with CDI ED implementation team; secured access to ED track board; developed ED process
- **9/19–10/19:** CDI ED team shadowed ED care coordination team 2–3 x/week; monitored ED track board for query opportunities
- **11/2019:** Developed query process in ED; CDI educated ED team

First Steps

- Searched the literature to determine potential return on investment
  - More accurate patient story
  - Improved reimbursement based on more accurate coding
  - References:
    - https://www.icd10monitor.com/emergency-care-cdi-in-the-ed-part-i
    - https://www.icd10monitor.com/emergency-care-cdi-in-the-ed-part-ii
- Assessed resources
  - Current team of four inpatient CDI specialists
  - Senior leadership support
  - EPIC upgrade in Summer 2019
  - Optum Lynx for ED charge capture
- Developed a plan
- Recruited staff

Met With ED Stakeholders

- Scheduled meeting with:
  - Chief ED physician
  - ED director
  - ED nurse manager
  - CDI team
- Presented opportunities for CDI to:
  - Assist with proper assignment of principal diagnosis
  - Help ensure documentation captures patient acuity
  - Strengthen medical necessity of inpatient status
  - Help capture and preserve patient's initial presentation
  - Help determine present on admission (POA) status

Evaluated Current State

- Established baseline
  - Developed report with ED unspecified diagnoses, E&M codes, acuity, discharge status

	A	D	F	H	K
1	ED Admit Time	Prim. Billing DX	E&M Orig Payor	E&M Proc D	Tot Ins Pr
2	5/3/2018 7:49	A41.9 - Sepsis, unspecified organism	BLUECROSS BLUESHIELD	HC CRITICAL C	-58330.39
3	10/19/2018 8:45	I21.09 - ST elevation (STEMI) myocardial infarction involving other cor	UNITED HEALTHCARE (MEDICARE REPLACEMEN	HC ER LEVEL 5	-51386.64
4	8/25/2018 17:17	N32.89 - Other specified disorders of bladder	UNITED HEALTHCARE (MEDICARE REPLACEMEN	HC ER LEVEL 4	-49532.51
5	8/25/2018 17:17	N32.89 - Other specified disorders of bladder	UNITED HEALTHCARE (MEDICARE REPLACEMEN	HC ER LEVEL 3	-49532.51
6	8/25/2018 11:15	N32.89 - Other specified disorders of bladder	UNITED HEALTHCARE (MEDICARE REPLACEMEN	HC ER LEVEL 4	-49532.51
7	8/25/2018 11:15	N32.89 - Other specified disorders of bladder	UNITED HEALTHCARE (MEDICARE REPLACEMEN	HC ER LEVEL 3	-49532.51
8	11/5/2018 11:23	I21.19 - ST elevation (STEMI) myocardial infarction involving other cor	AETNA	HC ER LEVEL 5	-47023.15

  - Identified conditions frequently seen in ED
    - ETOH abuse with intox
    - Acute respiratory conditions
    - Chest pain
    - Abdominal pain
    - Back pain
    - Dental complaints

Reviewed Key Findings

- Care coordination is in ED 11 a.m.–11 p.m. daily to help determine patient status (InterQual tool)
- ED patient events and locations are monitored on ED track board in EPIC
- Optum Lynx is used for ED charge capture
- There are multiple ED providers
- Hospitalists admit, often without seeing patient until patient is admitted to floor

Formed the CDI ED Team

- Selected two CDI nurses to work on ED project
- Held biweekly meetings with CDI manager
- Used "CDI in the ED: Lessons Learned from an ED Physician" webinar to train CDI team
- Explored the literature
- Granted team access to ED track board in EPIC
- Developed a plan for how to begin
- Explored ideas for gaining buy-in for CDI in ED
- Collaborated with care coordination, coding, IT

Established Workflow for CDI in ED

- CDI team to:
  - Initially shadow ED care coordinators 2–3 days per week, for two hours at a time
  - Remotely monitor ED track board for frequently occurring diagnoses
  - Narrow initial focus to chief complaint of abdominal pain and chest pain
  - Review diagnosis, chief complaint for CDI opportunities
  - Collaborate with ED care coordination team to discover potential query opportunities

ED Scenario #1

- 79 y/o from nursing home has history of Alzheimer's dementia, DM, HTN, Foley intact, urine noted to be cloudy, Na 128, WBC 17.2, urine culture positive, treated with IV antibiotics
- DX: Complicated UTI, hyponatremia, pressure ulcer to buttock

ED Scenario #1: CDI Opportunities

- Query opportunities—clarify:
  - Whether there is a link between Foley catheter and UTI
  - The stage of the pressure ulcer
- Query outcomes
  - Without query, this would code to DRG 690 UTI, RW 0.7908, LOS 3.5
  - With query sent and clarification in the medical record of UTI due to chronic indwelling catheter, this would code to DRG 699 Other kidney & urinary tract diagnosis with CC, RW 1.0327, LOS 4.2
  - With documentation of pressure ulcer to buttock stage 3 present on admission, DRG would change to 698 Other kidney & urinary tract diagnosis with MCC, RW 1.6186, LOS 6.1

ED Scenario #2

- 65 y/o m presents from home with confusion and agitation, shortness of breath with productive cough of yellow sputum, noted to be febrile at home, has history of colon CA, HTN, CHF, CKD, DM, wbc 15, potassium 5.6, glucose 185, BUN/creatinine 32/3.0, GFR=22, CXR shows new airspace disease in left lung
- DX: pneumonia, acute renal insufficiency, AMS

ED Scenario #2: CDI Opportunities

- Query opportunity: Clarify diagnosis of acute renal insufficiency
- Query outcomes
  - Without query this would code to DRG 195, RW 0.6821, LOS 3
  - With query and clarification of diagnosis acute renal insufficiency to acute kidney injury, DRG would change to 194, RW 0.8886, LOS 3.8

ED Scenario #3

- 61-year-old male presents from home with cough productive of green sputum, shortness of breath, and increased work of breathing, was noted to have confusion at home. Patient has past medical history of COPD on 2L of oxygen at night and prn, chronic hypoxic respiratory failure, chronic diastolic heart failure, hypertension, and prostate cancer.
- Blood gases results: pH 7.24, pC02 53, p02 58 with respiratory rate 30. Patient was also noted to have difficulty speaking in sentences, use of accessory muscles, and pursed lip breathing.
- Patient placed on oxygen at 3L/min. Patient started on antibiotics and oxygen increased to BiPAP due to increased work to breath.
- DX: Pneumonia, COPD, chronic respiratory failure and chronic diastolic heart failure

ED Scenario #3: CDI Opportunities

- Query opportunity: Clarify diagnosis of acute respiratory failure
- Query outcomes
  - Without query sent and clarification this would code to DRG 194 RW 0.8886 and LOS 3.2
  - With query and clarification of diagnosis of Chronic respiratory failure to Acute on chronic respiratory failure with hypoxia, DRG would change to 193, RW 1.3335, LOS 4.2

Developed Strategy to Integrate CDI into the ED

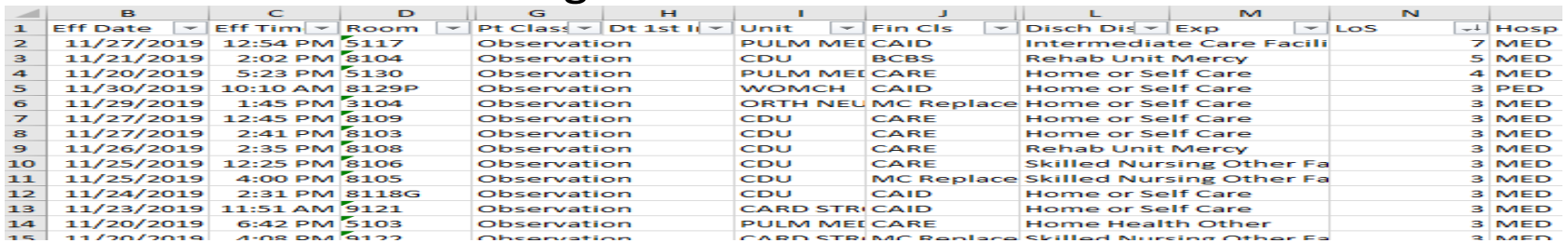
- Conduct concurrent CDI reviews on identified focus diagnoses
- Conduct retrospective CDI reviews for gaining understanding of diagnoses rich in CDI opportunities
- Discover optimal venue for educating ED providers
- Establish CDI/ED provider relationships
- Train entire CDI team on ED CDI process
- Be willing to try connecting with providers in new ways
- Develop ED query process

Polling Question #2

- Does your CDI team review for medical necessity in the ED?
  - Yes
  - No

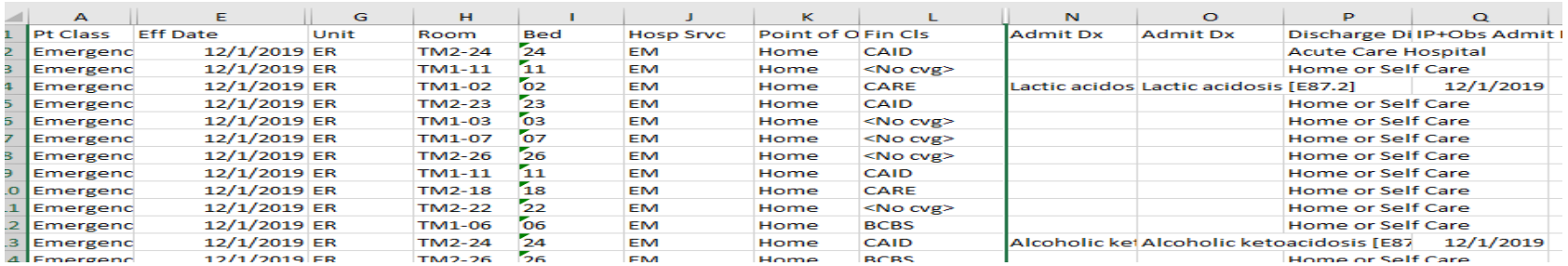
Tracking CDI Impact

- Create monthly tracking reports to monitor:
  - E&M codes trending



	B	C	D	G	H	I	J	L	M	N	
1	Eff Date	Eff Tim	Room	Pt Class	Dt 1st I	Unit	Fin Cls	Disch Dis	Exp	LoS	Hosp
2	11/27/2019	12:54 PM	5117	Observation		PULM MED	CAID	Intermediate Care Facili		7	MED
3	11/21/2019	2:02 PM	8104	Observation		CDU	BCBS	Rehab Unit Mercy		5	MED
4	11/20/2019	5:23 PM	5130	Observation		PULM MED	CARE	Home or Self Care		4	MED
5	11/30/2019	10:10 AM	8129P	Observation		WOMCH	CAID	Home or Self Care		3	PED
6	11/29/2019	1:45 PM	3104	Observation		ORTH NEU	MC Replace	Home or Self Care		3	MED
7	11/27/2019	12:45 PM	8109	Observation		CDU	CARE	Home or Self Care		3	MED
8	11/27/2019	2:41 PM	8103	Observation		CDU	CARE	Home or Self Care		3	MED
9	11/26/2019	2:35 PM	8108	Observation		CDU	CARE	Rehab Unit Mercy		3	MED
10	11/25/2019	12:25 PM	8106	Observation		CDU	CARE	Skilled Nursing Other Fa		3	MED
11	11/25/2019	4:00 PM	8105	Observation		CDU	MC Replace	Skilled Nursing Other Fa		3	MED
12	11/24/2019	2:31 PM	8118G	Observation		CDU	CAID	Home or Self Care		3	MED
13	11/23/2019	11:51 AM	9121	Observation		CARD STR	CAID	Home or Self Care		3	MED
14	11/20/2019	6:42 PM	5103	Observation		PULM MED	CARE	Home Health Other		3	MED

  - Acuity of patients seen in ED trending
  - ED to admit for obs/IP



	A	E	G	H	I	J	K	L	N	O	P	Q
1	Pt Class	Eff Date	Unit	Room	Bed	Hosp Srvc	Point of O	Fin Cls	Admit Dx	Admit Dx	Discharge Di	IP+Obs Admit
2	Emergenc	12/1/2019	ER	TM2-24	24	EM	Home	CAID			Acute Care Hospital	
3	Emergenc	12/1/2019	ER	TM1-11	11	EM	Home	<No cvg>			Home or Self Care	
4	Emergenc	12/1/2019	ER	TM1-02	02	EM	Home	CARE	Lactic acidos	Lactic acidosis [E87.2]		12/1/2019
5	Emergenc	12/1/2019	ER	TM2-23	23	EM	Home	CAID			Home or Self Care	
6	Emergenc	12/1/2019	ER	TM1-03	03	EM	Home	<No cvg>			Home or Self Care	
7	Emergenc	12/1/2019	ER	TM1-07	07	EM	Home	<No cvg>			Home or Self Care	
8	Emergenc	12/1/2019	ER	TM2-26	26	EM	Home	<No cvg>			Home or Self Care	
9	Emergenc	12/1/2019	ER	TM1-11	11	EM	Home	CAID			Home or Self Care	
10	Emergenc	12/1/2019	ER	TM2-18	18	EM	Home	CARE			Home or Self Care	
11	Emergenc	12/1/2019	ER	TM2-22	22	EM	Home	<No cvg>			Home or Self Care	
12	Emergenc	12/1/2019	ER	TM1-06	06	EM	Home	BCBS			Home or Self Care	
13	Emergenc	12/1/2019	ER	TM2-24	24	EM	Home	CAID	Alcoholic ke	Alcoholic ketoacidosis [E87		12/1/2019

  - Ongoing CDI audit to monitor ICD-10 capture and query opportunities

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Lessons Learned

- Work with nursing/providers to document conditions that are POA
  - Skin integrity: Make sure all wounds are documented
  - Insert a Foley in ED: Do urinalysis for baseline
  - Capture patient's initial presentation
- Clinical validation of diagnoses begins in the ED, where it can support inpatient status
- Verbal queries may work best in ED due to quick pace
- Document all verbal queries
  - Explore EPIC Secure Chat and In Basket as communication tools

Lessons Learned, *cont.*

- Consider conducting retrospective queries before coding is complete to allow time to review record. If clarification is needed, create an addendum after coding is complete.
- Telling the complete patient story ensures the patient appears as sick in the record as they do in the bed.
- If a condition is treated in the ED, code it!
- Watch for cases where the patient presents as very ill but, with aggressive treatment in ED, improves quickly. Capture acuity at presentation.
- Watch for linkage between s/sx and uncertain diagnoses—ask for more clarity.

Lessons Learned, *cont.*

- Make sure diagnoses address all signs and symptoms
- Increase CDI presence in ED for provider education
- Be creative with education—compile CDI tips and tricks
  - Document skin integrity reminder

Unexpected Discoveries

- Iowa Managed Medicaid (MCO) providers reimburse at a lower rate for more specific diagnoses that are not on their approved list of diagnoses (as listed on Iowa Medicaid Enterprise website)
- CMS has proposed elimination of E&M codes in 2020–2021

What's on the Mercy CDI Horizon?

- Our plan for the future of outpatient CDI
  - Outpatient specialty clinics
    - Wound/treatment center
    - Urology clinic
    - Cardiology clinic
    - ENT clinic
    - Pulmonology clinic
  - Primary care clinics

Questions?