The ‘Coding for Complexity’ Project

Presented By:
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Gold Coast, QLD
The ‘Coding for Complexity’ Project

Presentation Overview

• Introduction to Epworth HealthCare
• In the beginning
• The ‘Coding for Complexity’ project is born
• Getting started
• What we did
• Results so far
• Key take-home messages
Introduction to Epworth HealthCare

• Victoria’s largest not-for-profit private health group delivering comprehensive Acute and Rehabilitation Services
• 20% of Melbourne’s private hospital beds
• Five divisions over seven campuses
  – Epworth Richmond
  – Epworth Freemasons (Clarendon Street and Victoria Parade in East Melbourne)
  – Epworth Cliveden (also in East Melbourne)
  – Epworth Eastern (in Box Hill)
  – Epworth Rehabilitation (in Richmond, Brighton and Camberwell)
  – Epworth HealthCare - Corporate services
# The ‘Coding for Complexity’ Project

## Introduction to Epworth HealthCare

<table>
<thead>
<tr>
<th>Key Statistics</th>
<th>2010/11</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Bed Days</td>
<td>382,648</td>
<td>383,436</td>
</tr>
<tr>
<td>Total Patient Episodes</td>
<td>114,911</td>
<td>115,097</td>
</tr>
<tr>
<td>Overnight Occupancy %</td>
<td>88.5%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Operations Performed</td>
<td>72,362</td>
<td>72,558</td>
</tr>
<tr>
<td>Emergency Department Attendances (Richmond only)</td>
<td>28,393</td>
<td>28,137</td>
</tr>
<tr>
<td>Intensive Care &amp; Coronary Care Unit Bed Days</td>
<td>15,762</td>
<td>16,241</td>
</tr>
<tr>
<td>Outpatient Rehabilitation Attendances</td>
<td>126,023</td>
<td>137,308</td>
</tr>
<tr>
<td>Day Oncology Attendances (includes chemotherapy &amp; related care)</td>
<td>13,241</td>
<td>13,949</td>
</tr>
<tr>
<td>Births</td>
<td>3,502</td>
<td>3,425</td>
</tr>
</tbody>
</table>
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In the beginning…

Average cost weights
August 2011
O/night & Sameday combined

Epworth Richmond – 1.38
Epworth Eastern - 0.99
Epworth Freemasons – 0.93

…but our patients are so sick… why doesn’t your data reflect the acuity of our patients?

Benchmarking – August 2011

<table>
<thead>
<tr>
<th>V 4.2</th>
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</tr>
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<tr>
<td>ADRG</td>
<td>% A split</td>
<td>% A split</td>
<td>% A split</td>
</tr>
<tr>
<td>B02</td>
<td>22.16%</td>
<td>26.98%</td>
<td>53.85%</td>
</tr>
<tr>
<td>B03</td>
<td>6.20%</td>
<td>18.18%</td>
<td>7.14%</td>
</tr>
<tr>
<td>F05</td>
<td>38.89%</td>
<td>58.75%</td>
<td>60.81%</td>
</tr>
<tr>
<td>F08</td>
<td>20.25%</td>
<td>39.44%</td>
<td>38.89%</td>
</tr>
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<td>F14</td>
<td>6.52%</td>
<td>21.43%</td>
<td>22.73%</td>
</tr>
<tr>
<td>F41</td>
<td>35.23%</td>
<td>43.94%</td>
<td>58.33%</td>
</tr>
<tr>
<td>I09</td>
<td>20.43%</td>
<td>25.54%</td>
<td>40.40%</td>
</tr>
<tr>
<td>I10</td>
<td>8.18%</td>
<td>15.91%</td>
<td>18.70%</td>
</tr>
<tr>
<td>I12</td>
<td>13.29%</td>
<td>34.43%</td>
<td>31.11%</td>
</tr>
</tbody>
</table>

Coding? What’s it got to do with me?
In the beginning…

From the HIS/Coding perspective:

• Medical record documentation was poor

• Discharge summary completion rates were poor

• Nursing staff utilised care pathways to document – and variances to those pathways were rarely well documented in the progress notes, nor documented in a way that could be used for coding purposes

• Coding staff had a clinician query process in place, but it was extremely time consuming, resource intensive and had a poor response rate.

Discharge summary completion rates
August 2011
Epworth Richmond – 44.6%
Epworth Eastern – 28.9%
Epworth Freemasons – 33.5%
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In the beginning…

• Coding staff did not have a great understanding of DRGs
  – Our patient administration system gave very little visibility to what drove DRG allocation.
  – We had an offline grouper but it was rarely used

• However, we had routinely received good results in our external coding audits, with a low percentage of DRG changes.

2011 External Coding Audit Results

<table>
<thead>
<tr>
<th>Hospital</th>
<th>DRG Change %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epworth Richmond</td>
<td>2.4%</td>
</tr>
<tr>
<td>Epworth Eastern</td>
<td>3.7%</td>
</tr>
<tr>
<td>Epworth Freemasons</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

Note: Our external auditors average DRG change rate from all other hospital/hospital groups audited in the 12 months prior was 8.3%
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The ‘Coding for Complexity’ project WAS BORN!
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How we got started…

• Evidence from the benchmarking exercise, amongst other things, was provided to the Epworth Executive team; who then gave us the **support and resources** to get the project going.

• Spoke to people in other local organisations who had already undertaken similar projects

• Undertook **targeted medical record audits** on specialty areas that compared most poorly in our benchmarking exercise. It was of concern that these were our most prolific specialties…
  – Orthopaedics
  – Cardiac
  – Vascular
  – Neurosciences (Neurology & Neurosurgery)
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How we got started...

From the audits we found:

- DRG changes due to coding errors
- DRG changes due to missing documentation
- Education opportunities for coding staff
- Education opportunities for clinical staff
- DRG education
- Education on coding queries – when / how
- Opportunities to improve clinical documentation
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What we did… for the Nursing staff

• Set up a presentation for the nursing staff which covered basic DRG education, how they could improve their documentation for us and the benefits for doing so

• The presentation had a strong quality emphasis, and focused very little on revenue improvements

• Visited all of the overnight wards at Epworth Richmond, multiple times, at handover to ensure our presentation was seen by as many staff as possible.
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What we did… for the Nursing staff

• Created lanyards for the staff to wear that contained both generic and specialty-specific documentation tips

• Set-up tri-weekly ward meetings with senior nursing staff to discuss patients on their wards who’s LOS >5 days

• These meetings were coordinated by a senior nurse from the Epworth Richmond Executive Team, and in the meeting we utilised a purpose-built ‘traffic light’ report...
This report is used to ensure that any of the flagged conditions/problems are discussed with the ward nursing staff, and if relevant, that they have been appropriately documented in the medical record.
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What we did... *For the coding staff*

- Developed a half-day *workshop* which covered:
  - DRG education & offline grouper education
  - How to structure good documentation queries
  - The nursing education & lanyards
- Developed a working document on where/how to find evidence in the medical record of common conditions
- Developed a ‘traffic light’ report (similar to that used on the wards) for coders to utilise for episodes that coded to a ‘without cc’ DRG
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## Co-morbidities and Complications

**Documentation Tips for HIMs/Clinical Coding staff**

This document aims to assist the coding process by providing tips on where staff may find evidence in the medical record of common co-morbidities and complications, and the types of treatment that might be expected for those conditions.

This may assist staff in determining whether a co-morbidity or complication meets ACS 9002.

<table>
<thead>
<tr>
<th>Co-morbidity / Complication</th>
<th>Where to find evidence / documentation</th>
<th>Typical treatment / Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acidosis</td>
<td>Blood gases (on the NATA/RCP laboratory results)</td>
<td>Sodium bicarbonate</td>
</tr>
<tr>
<td></td>
<td>pH levels</td>
<td>Mechanical Ventilation</td>
</tr>
<tr>
<td></td>
<td>Low bicarbonate level</td>
<td>IV fluids</td>
</tr>
<tr>
<td>ARF (Acute Renal Failure)</td>
<td>Progress notes – documentation of decreased urine output, oliguria, anuria</td>
<td>IV fluids</td>
</tr>
<tr>
<td></td>
<td>Biochemistry result – looking for increased potassium, urea and creatinine</td>
<td>IV fluids</td>
</tr>
<tr>
<td>AF (Atrial Fibrillation)</td>
<td>ECG Interpretation (across the top of the A4 ECG printout)</td>
<td>Dobutamine</td>
</tr>
<tr>
<td>AMI (Acute Myocardial Infarction)</td>
<td>Biochemistry results – look for raised troponin levels</td>
<td>Angiography</td>
</tr>
<tr>
<td></td>
<td>ECG Interpretation (across the top of the A4 ECG printout)</td>
<td>Aspirin</td>
</tr>
<tr>
<td></td>
<td>ST elevation/ST depression</td>
<td>Thrombolysis therapy</td>
</tr>
</tbody>
</table>

## Complexity Report

**Patient Details**

- **ID:** 0087021
- **Name:** Patient Z
- **DOB:** 01/01/1941
- **Sex:** F
- **Admit Date:** 02/12/2011
- **Disch Date:** 14/03/2012
- **LOS:** 55
- **Unplanned Readmit 7 Days:** N

**Inpatient Details**

- **Bladder, bleed, diet:** N/P, pre-op, nil per mouth, N/P, morphine
- **Bill < 18.5:** N
- **Bill > 30:** N
- **BMI:** N
- **Diabetes:** N
- **Hypertension:** N
- **Smoker:** N
- **Pharmacy Review:** N
- **ICU Stay:** Y
- **CCU Stay:** N
- **ICU Days > 3 Days:** Y
- **CCU Days > 3 Days:** N
- **Mechanical Ventilation > 96 hours:** N
- **Extending > 24 hours in ICU after initial intubation in theatre:** N
- **Unclassified Admission to ICU:** N
- **Unclassified Readmission to ICU:** Y

**Riskman Incidents**

- Riskman Incident Reported: Y

**Theatre Details**

- **Unplanned Stay in PACU > 2 hours:** N
- **Use of Supgation:** N
- **Complex Spinal:** N

**Pathology Results**

<table>
<thead>
<tr>
<th>Haematology/Histology</th>
<th>Date Reported</th>
<th>Test Description</th>
<th>R Units</th>
<th>Low R</th>
<th>High R</th>
</tr>
</thead>
</table>

**Microbiology**

**Histopathology**

- Conclusion:

**Pharmacy Results**

<table>
<thead>
<tr>
<th>Drug Group</th>
<th>Drug Name</th>
<th>Ward</th>
<th>Dispense Date</th>
</tr>
</thead>
</table>
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What we did... *For the coding staff*

• Commencement of **Coding Auditor roles** (1 EFT Vacant!)
  – Strengthened the presence of the two coding educators across all campuses

• Developed a cross-campus **coding audit plan**, which included:
  – Daily PICQ™ error reports (given to the coders to correct)
  – Monthly ‘Coding for Complexity’ audit – any case that groups to a ‘without cc’ DRG and is above a best value length of stay
  – Monthly targeted audits
  – Random audits as required
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What we did... For (about) the Doctors!

• Consider the situation – private organisation, majority of doctors are visiting medical officers (VMOs) – most come and go, difficult to engage

• Discharge summary completion statistics were published in the Epworth VMO newsletter
  – These stats are collected by the coding staff at the time of coding
  – Not only a ‘Yes’ or ‘No’ but coders rate the quality of the discharge summary – Poor, Good or Excellent
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What we did... For (about) the Doctors!

• Executive **sent letters or met with** those VMOs who had poor discharge summary completion rates

• Made a change to allow Registrars to complete discharge summaries on behalf of the VMOs (much like in the public sector)

• Strengthened our **Medical Fellow review process**
  – Hospital salaried doctors come to HIS on a bi-weekly basis to review all ‘without CC’ DRG episodes
  – These doctors also review basic coding queries, where there is evidence of a condition, but it is perhaps not documented in a way that meets coding standards.
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What we did... For (about) the Doctors!

• Coding queries that don’t receive a prompt response are escalated to the Executive Management team at each campus

• Incomplete summaries (for overnight episodes) are faxed direct to the doctors consulting rooms for completion

He had taken every side street he knew, but the paperwork was still on his tail.
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Results so far...

• As a result of the education and a push from senior nursing staff / Executive team, nurse-led initiatives began to pop-up:
  – A laminated nursing documentation tips document was included in the patient bedside medical record folder
  – Specialty-specific, detailed nursing documentation instructions were written up by an ANUM
  – Nurses created education posters & put them up in staff tea rooms
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Nurse Educators created documentation posters & put them up in staff tea rooms
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Results so far...

• For the coding staff there is improved **education** and **regular feedback**

• There is an **increased awareness** across the organisation of the coding process

• More **timely responses** to queries and more discharge summaries in the record at the time of coding

• **Improved relationships** with Nursing & Executive staff

• **Improved job satisfaction**
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Results so far...

Average cost weights
August 2012
O/night & Sameday combined
Epworth Richmond – 1.69 (23% increase)
Epworth Eastern - 1.03 (4% increase)
Epworth Freemasons – 1.02 (10% increase)

Discharge summary completion rates
August 2012
Epworth Richmond – 62.5% (40% increase)
Epworth Eastern – 56.1% (94% increase)
Epworth Freemasons – 54.0% (61% increase)

Revenue has moved in line with the acuity of our patients, as it should

Benchmarking – August 2012

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<td>16.3%</td>
<td>12.9%</td>
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<td>36.4%</td>
<td>44.0%</td>
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<td>20.2%</td>
<td>31.5%</td>
<td>42.5%</td>
</tr>
<tr>
<td>I10</td>
<td>6.2%</td>
<td>6.6%</td>
<td>11.9%</td>
</tr>
<tr>
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<td>7.1%</td>
<td>25.0%</td>
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</table>

Still room for improvement!
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Key take-home messages

• Get the **support** of Executive team & an Executive ‘sponsor’ of the project

• Get senior nursing **support** – they can ‘talk the language’ of the nursing staff

• **Education** of the coding staff is vital
  – DRG & clinical knowledge wasn’t great, and is still a work-in-progress
  – Epworth has purchased the 3M Codefinder to improve DRG visibility to coding staff

• Don’t underestimate the **time and resources** it will take to see improvements…!
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