Optimizing Physician Documentation to Capture Lost Value in Case Mix Index for Acute Care and Trauma Surgery

Purav Brahmbhatt, MSMS; Riley Santiago, BS; Alison Smith, MD, PhD; Juan Duchesne, MD, FACS
Tulane University School of Medicine and Tulane Hospital, Division of Acute Care Surgery
1430 Tulane Ave, New Orleans, LA 70115

Project Background

The Case Mix Index (CMI) is a metric used by the Center for Medicare and Medicaid Services to indicate the complexity of patients being treated at a medical institution. Based upon the CMI score, the CMMS will then indicate appropriate reimbursement levels for that institution. Thus, it is incumbent upon the institution to properly document the true complexity of its patients in order to be appropriately reimbursed. Historically, Tulane Medical Center has reported a CMI much lower than that of similar hospitals with similar patient populations. A high prevalence of complex patients with significant co-morbidities can result in increased healthcare-associated costs, both in terms of value-added time (facetime with physicians) and in gross finances. This complexity should reflect in a higher CMI for the institution, yet it does not. Likely, this discrepancy is due to non-standardized, incomplete, and inadequate documentation methods and training. Further, numerous interventions at similar institutions have demonstrated both an increase in CMI as well as increases in revenue and profit for the institution.

Project Scope and Aims

We propose the implementation of an optimized, standardized documentation template for use by Tulane surgical faculty, residents, and medical students in the care of acute care/trauma surgery patients. We plan to leverage the interdisciplinary insights from medical professionals, coding specialists, billing specialists, and administration to create a template that is optimized to capture the true complexity of our patient population. The goal of this project is to increase our CMI, our revenue, and our profit. Further, as an academic institution, we hope to instill the value of thorough and complete documentation strategies to the fellows, residents, and medical students we train.

Project Methodology

The project will be conducted in three phases: Template Development, Implementation, and Assessment. Each phase will have a designated timeframe, specific objectives, and a designated interdisciplinary project team. Interdisciplinary teams will be led by the project leaders and will consist of faculty, research team members, residents, billing specialists, coding specialists, and administration. Communication amongst teams will primarily be through email, and in-person interdisciplinary meetings will occur as necessary. The project teams will meet weekly. Feedback from faculty and residents will be collected during the implementation and Assessment phases using anonymous, online surveys. Finally, the project’s success will be assessed after implementation using the metrics of CMI, Revenue, and Profit.

Creating an Optimized, Standardized Template

- **Template Development**
  - **Objectives**: Research most common diagnoses affecting trauma, examine existing templates from other institutions, synthesize input from Coding Team and Billing Team.
  - **Tasks**: Develop template in Meditech, develop anonymous feedback form.
  - **Timeframe**: March 2nd, 2017 to October 31st, 2017.

- **Implementation**
  - **Objectives**: Introduce template to faculty and residents, acquire “buy-in”.
  - **Tasks**: Develop template survey to assess resident preparedness in documentation, disseminate feedback.

- **Assessment**
  - **Objectives**: Assess resident preparedness in documentation.
  - **Tasks**: Conduct survey, assess financial metrics, implement post-survey.
  - **Timeframe**: April 1st to April 30th, 2017

Coding and Billing Specialists

- **Objectives**: Translate HCP documentation into code.
  - **Tasks**: Arrange for billing of code, determine the most frequent and the highest billed codes for our department.

Interdisciplinary Team Approach

- **Objectives**: See and treat patients, document what they see and do.
  - **Tasks**: Examine existing templates from other institutions, synthesize input from Coding Team and Billing Team.
  - **Timeframe**: March 2nd, 2017 to October 31st, 2017.

Expected Challenges

Technical:
A standardized template will be developed using our institution’s electronic medical record system, Meditech. We must utilize the skills of Meditech and IT specialists. We anticipate that there will be a learning curve for healthcare providers to utilize this template. We will work closely with the hospital billing and coding personnel to also ensure that this new system is working.

Compliance:
We foresee that changing the documentation habits of our current faculty and residents will be difficult. Faculty and residents of long tenure have well-established documentation practices. We plan to address this issue by designating leaders in our program who can motivate others to use our template. Further, given the frequent turnover of medical students, residents, and some faculty, we plan to educate our staff about our documentation template during routine orientations to our service.

Sustainability:
This intervention’s sustainability will be driven by its ease of use; the returns it generates, and most importantly, how well we orient new medical students, residents, and faculty to our template. It is imperative that we have a complete educational presentation about our template during orientations. Lastly, we expect that problems will arise with the template that we do not foresee. We will provide an electronic form where healthcare providers can submit feedback on issues as they arise.

References: