Clinical Definition Standards Case Study

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By Katherine Lusk, MHSM, RHIA

With the October 1, 2014 date for prospective payment for inpatient pediatric Medicaid discharges looming, Children's Health System of Texas identified an organizational need to reboot and formalize its clinical documentation improvement (CDI) program. The journey began with three core tenets:

1. No additional full time equivalents
2. Leverage technology
3. Work smart

To prepare for reimbursement changes, an initiative was launched across the organization to increase operational efficiency and hold firm on staffing levels. As an organization, Children's Health has a long history of leveraging technology to improve operational efficiency. The capital outlay of $65 million for the electronic health record (EHR) was paid back in five years based on efficiencies gained with the EHR. This journey created a culture of pushing technology and work flow redesign to improve operational efficiency.

Historically, the health information management (HIM) department's work with CDI had been focused on record hygiene, regulatory compliance, and efficiency. However, classifying patient encounters—with deference to accurately reflecting patient acuity with resultant appropriate reimbursement—had not previously been a focus. Assuring financial stability with the upcoming reimbursement changes created a sense of urgency. The organization quickly recognized there was a need to standardize clinical definitions and incorporate those into the CDI plan.

Standardizing the Clinical Definition of Malnutrition

In reviewing medical records, the CDI team found diagnostic terms that were inconsistent with symptoms, manifestations, and documentation irregularities. The initial clinical definition standard development encompassed malnutrition—the team believed this diagnosis was significantly underused. Clinical malnutrition documentation included terms such as "wasted," "poor weight gain," "failure to thrive," "light for age," and "underweight"—with only an occasional definitive diagnosis. An evaluation of the data revealed 56 inpatient encounters with a diagnosis of malnutrition against total inpatient discharges of 18,280 in 2011.

Children's Health provides services to the Dallas County market with 55-plus subspecialties, primary care clinics, and a financial mix comprised of 65 percent Medicaid patients. The organization's data showed that subspecialty delivery included populations where malnutrition is known to be an associated co-morbid condition. It became clear that the low number of malnutrition diagnoses was not an accurate depiction.

This hypothesis was validated through further consultation with the nutrition department, which confirmed that the number of diagnoses did not reflect the services delivered by their department. Finally, conversations with the provider community revealed there were issues with reimbursement for patient care services due to a lack of definitive diagnosis, and inconsistency with the malnutrition diagnosis. This knowledge, coupled with the nutrition department view, provided the CDI team with the leverage to engage providers in establishing a clinical definition standard for malnutrition.

The team assembled a multidisciplinary workgroup comprised of physicians, advance practice nurses, nutrition professionals, coders, and CDI specialists. The work effort began with the team defining the problem and conducting an extensive literature review. It then secured a physician champion from the gastrointestinal division and sought participation from disciplines to serve as subject matter experts.

The CDI specialist facilitated the meetings, pulled the information together, and wrote/managed the multiple drafts of the case definition of malnutrition. Then the case definition document was socialized, which enabled the team to receive valuable

feedback. The socialization process included meeting with providers one on one, holding department meetings, presenting case studies, creating posters, and hosting lunch-and-learn engagement sessions. The latter were hosted for the provider community on a weekly basis, providing the CDI team face time with a diverse audience.

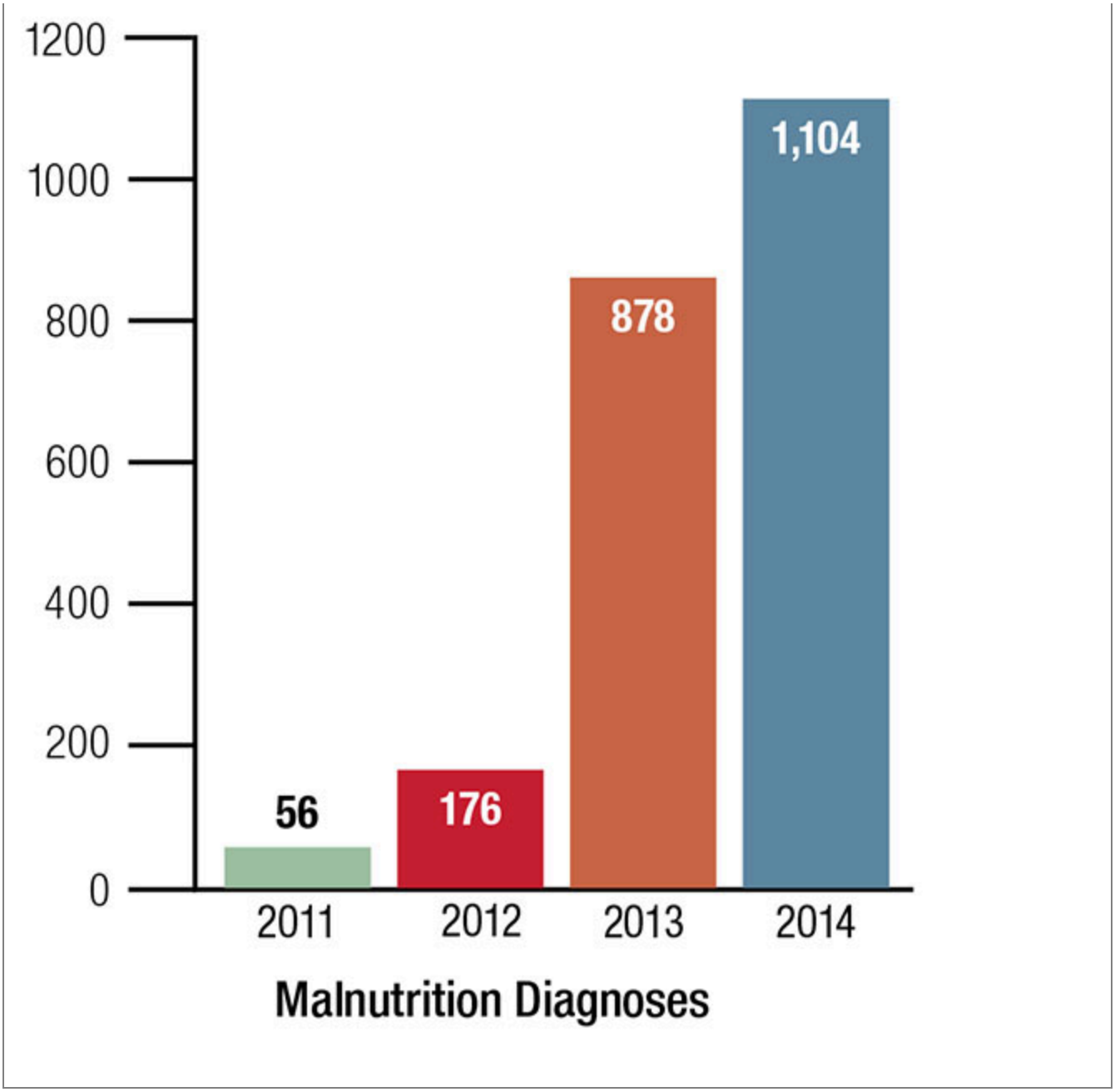
The resulting case definition document was then triangulated against literature review to ensure a solid scientific base. With the vetting process being tied to scientific evidence, the team was able to accomplish and sustain the culture change necessary to gain adoption of a standardized documentation of malnutrition.

Remarkably, throughout the vetting process and socialization process, use of the clinical diagnosis “malnutrition” grew. In 2012 there were 176 patients with the diagnosis of malnutrition—a three-fold increase from the 56 diagnoses in 2011. It’s important to note that this increase was not due to a change in the population served, but rather a vetting process that gave the clinical community a standard for representation of malnutrition diagnosis.

In 2013, the team finalized the document “Malnutrition Clinical Definition,” published it on an internal website dedicated to physicians, and circulated it to the medical community. In 2013, there were 878 patients with the diagnosis of malnutrition and 1,104 in 2014. Children’s Health believes these statistics are the result of acceptance across the disciplines and recognition of the value of a standard definition for malnutrition in the pediatric population.

Table 1 below illustrates the progression of the process, growing acceptance, and sustainability.

Table 1: Malnutrition Diagnosis Assignment Growth



Putting the Standard to Use

Standard clinical definitions have been incorporated into resident and new provider on-boarding and training within respective disciplines. This serves as a means to standardize clinical communication and ensure sustainability. To further promote sustainability, queries from the CDI team and coders to the provider community reference the definitions as appropriate. Finally, standard clinical definitions are included in division-specific materials for resident and fellow training, and the definitions are included in examples when training on the use of the EHR.

The journey did not end there. The organization continues the process of identifying clinical terms that lack standardization across its community. The process has been successfully replicated in other areas by defining standards in the clinical diagnoses of obesity, anemia, respiratory failure, heart failure, sepsis, epilepsy, asthma, and renal failure. Because clinical definition standards are an accepted practice in the medical community, the process was endorsed by the medical staff. It's also clear that the value of streamlining clinical communication with a succinct, standard definition has been well received.

Finally, as an added financial bonus, this process ensures the provider and the hospital are accurately represented with patient acuity.

Share Your Story
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If you are interested in sharing your organization's story about the role of HIM professionals in setting standards for clinical documentation improvement, please contact AHIMA's Diana Warner at diana.warner@ahima.org. Your story could be shared in an upcoming *Journal of AHIMA* Standards Strategies column.

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