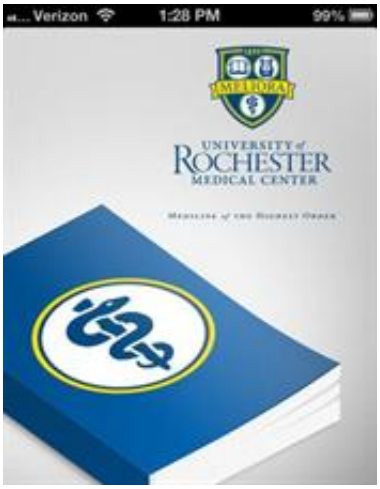
New mobile app helps providers better document conditions and care

December 18 2012



One of the key features of health care reform is the linking of outcomes with reimbursement, a development that places even greater urgency on the thoroughness and accuracy of documenting a patient's condition and care. A new suite of tools – include a mobile app for iPhones and iPads – developed by the University of Rochester Medical Center (URMC) helps health care providers paint a more precise picture of the health condition of patients they treat.

"The Centers for Medicare and Medicaid Services (CMS) has adopted significant coding revisions for reimbursement," said Yousaf Ali, M.D., the chief documentation officer at URMC's Strong Memorial Hospital.

"They marked a substantial step forward, paying close attention to other serious conditions that sometimes piggyback on a particular diagnosis, better capturing just how sick patients are by creating more specific diagnosis-related groups."

Meticulous documentation of complications present at the time of admission, co-morbidities, and the rationale behind care decisions are not only linked to reimbursement payments for hospitals, but to quality of care and performance on public report cards as well. Individual providers' quality of care score cards are also linked to their documentation.

For instance, a provider may decide that, for good medical reason, a given heart attack patient shouldn't receive the standard aspirin upon discharge. This is just one example of a routine "core measure" that CMS tracks to gauge how well hospitals adhere to best-quality practices. If the provider failed to note their logic in the patient's record, the missing aspirin appears to be a sloppy oversight – not a calculated choice.

Faced with this changing landscape, URMC leadership tasked Ali to work with physicians, mid-levels, and residents to better document care in a way that would translate into more thorough, appropriate coding. The result was *Documentation Improvement Tips for Physicians and Medical Providers*, a resource that provides quick, practical documentation advice.

URMC conducted a pilot test of with Nurse Practitioners in a Med-Surg patient care unit to evaluate how documentation practices would change – after instruction and using the tips that Ali developed – over the course of a month. After 30 days, the average risk of severity of patients cared for by NPs was coded 2.90 – a .2 increase over the prior month's 2.71. For an institution like Strong Memorial Hospital, every tenth of a

point corresponds to almost $1 million in reimbursement.

"This was a small study but it confirmed our suspicions that we were failing to fully document in a way that details the true acuity of the cases we take on," said Ali. "In order to stay competitive, earn back payments that are rightly deserved, and safeguard quality reputation, hospitals absolutely have to get better at this."

The Documentation Improvement Tips are available in several different formats. A new mobile app – called "URMC MDtips" – is available free of charge from iTunes . An Android version will be available soon. The tips are also available to license from URMC in the form of a pocket reference booklet and a software package for hospitals that enable the institution to periodically send tips to providers. URMC has found that this approach makes documentation a priority and keeps it "top of mind" with providers. Impressed by its breadth and utility, the American College of Cardiology, New York State Chapter has also licensed these tips from the Medical Center.

Provided by University of Rochester Medical Center