Successful Collaboration in Healthcare

A Guide for Physicians, Nurses and Clinical Documentation Specialists

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Preface

The creation of this book was initially vague because I did not have a definite emphasis. However, when I was encouraged to write something I was passionate about, the focus became clear. I frequently have been asked by colleagues, friends, and family what I do at work. Because the clinical documentation specialist (CDS) role is still new, I believed a book might help others understand the role better, as well as its relationship to other roles in healthcare. With my background in case management and nursing, I was able to apply various pieces to outline the CDS role.

THE JOURNEY: FROM BEDSIDE NURSE TO CDS

Beginning at the Bedside

To understand how healthcare collaboration can be successful, I will start with my professional journey that began more than 20 years ago. My first nursing role was a part-time evening charge nurse in a hospital skilled nursing unit. Because the unit was new and did not require multiple staff, I learned early to know who my resources were. This included a certified nursing assistant who had previously worked in another area of the hospital and knew where I could find anything I might need during my shift, including ordering tests and obtaining supplies. In addition, I counted heavily on the evening nursing supervisors for policies, procedures, clinical questions, and advice. As I grew professionally, I wanted to increase my clinical experience and began working on a medical-surgical-orthopedic unit as a staff nurse and an evening charge nurse. This provided me a strong clinical base. As my knowledge increased so did my desire for an expanded challenge. I decided to spread my wings and began working in an intensive care unit (ICU) to broaden my knowledge. Although this move opened up an entire world of exciting experiences, it was not to be my final calling.

Minimum Data Sets Care Coordinator Role

My next phase took me back to the hospital skilled nursing unit as a staff nurse and minimum data sets (MDS) care coordinator. The MDS coordinator role was a nursing position that completed the required MDS paperwork for the federal government in a skilled nursing unit. Although this role did not seem to be a normal transition following the world of intensive care, there was a purpose behind this unusual change in my career. My career change occurred before the inception of the prospective payment system (PPS) for skilled nursing units with the Balanced Budget Act of 1997. Instead of skilled nursing units being paid by Medicare for reasonable costs, they would be paid per diem following the PPS. This payment would cover ancillary services, nursing care, and capital costs. In addition, this per diem rate would include coverage for the majority of services given to patients in a skilled nursing unit with a few exceptions, such as certain predetermined outpatient procedures, computerized axial tomography (CT) scans, and magnetic resonance imaging (MRIs). Instead of being able to charge separately for lab tests, basic x-rays, therapies, and other services, most were bundled in this payment. This concept of payment was a significant change for these skilled facilities because they needed to have a thorough understanding of how the payment was determined and what influenced it. The payment was determined by the patient's clinical condition and the services he or she received within a specific period as defined by the MDS manual. This information would be entered into the MDS form, which would place the patient into a specific category called a resource utilization group (RUG). For example, if the patient received more than 500 minutes of physical therapy 5 days a week, it would place the patient in one RUG category. If the patient received intravenous antibiotic therapy and required specific nursing care, he or she would be placed in a different RUG category. Each RUG category correlated to a rate that would be used as the multiplier to determine the per diem rate for the patient for a set period. Because this payment RUG was determined by the information entered in the MDS, the MDS care coordinator played a vital role in obtaining the accurate information from the patient, reviewing the medical record, and entering the information into the MDS form. The role required an intense understanding of the MDS manual, detailed chart reviews, and accurate documentation of the patient's corresponding information.

Implementing the transition to PPS was not as simple as understanding the MDS role. Many hours went into in-depth research of understanding the PPS system, RUGs, MDS, and care coordination. In addition, computerized documentation was initiated in the skilled nursing unit to reflect the required verbiage of the MDS. Staff training was implemented regarding the description of terms used in the MDS. This helped staff to understand the documentation required to correspond with the MDS wording. Because the terms "limited" assist or "extensive" assist had specific descriptions in the MDS manual, staff were trained to understand how they applied in the documentation of patient care. In addition, because the MDS form was multidisciplinary, the care coordinator collaborated with workers in other disciplines, such as the dietician, physical therapist, occupational therapist, and activity director, to complete the form. Weekly team meetings with staff from each discipline brought together everyone's experience and education for the benefit of the patient. This group collaboration with staff, understanding the link between the clinical and financial aspects of the MDS, and being able to correlate it to patient care and government regulations seemed to be an entirely different perspective of nursing than what I originally understood. Although I did not realize it at the time, the change to this role was a turning point in my career.

Health Case Manager

The next phase of my journey was a more obvious transition as I took a position in the acute care side of the hospital as a health case manager. This provided an avenue for me to combine my knowledge as an MDS care coordinator with my clinical background of medical, surgical, orthopedic, and intensive care nursing into a more holistic view of case management. I combined clinical, social, financial, quality, and regulatory aspects into the role. I had past experience with the role of quality monitoring in the ICU and skilled nursing facility with data collection, monitoring for patterns, trends, and outcomes, and implementing changes through staff education. Although many clinical, social, financial, quality, and regulatory aspects changed over the years, applying the holistic view did not. In addition, the case management role provided another opportunity for my professional growth, as this position was a physician-based case management model. Although I had worked with physicians before as a staff nurse, I began to see healthcare from the physician's perspective. When I was still the nurse, I began to see how various disciplines interacted differently. Physicians

appeared to look at patients from a more factual and data-driven perspective. What were the vital signs? What were the lab results? What were the test results? The focus was not how the information was obtained or what the process was but what were the outcomes or results. Although the physicians did consider the patient as a person, they tended to keep a more focused approach because hospital patient rounds were only a part of their complex day. The nurse was more involved with the "how-to" assignments and processes of getting the work done. In addition, the nurse focused intensely on his or her patient group during an 8- or 12-hour shift; however, the nurse was able to go home when the shift was over. Although a nurse did not necessarily forget about the work, he or she could hand off patient care responsibilities to the oncoming nurse. In contrast, the physician may be called multiple times during the 24-hour period about this patient and others while handling his or her office workload, meetings, and other crises. This is not to say one role is more important than another, but each has different foci and responsibilities. Another contrast was how information was interpreted differently between physicians and nurses. A physician would write an order at 6:00 PM to "Increase furosemide to 60 mg daily." Although the physician may think this is a clear order, the nurse may question whether the physician wants the medication increased today (because the patient already had 40 mg of furosemide at 8:00 AM) or with the next morning dose. This may seem simple, but it demonstrates how two people can interpret the same information differently. In addition, as I spent more time on rounds with physicians, I began to see how miscommunication and frustration could occur from both nursing and physician perspectives. Just as the unit nurse may not see the challenges the physician faces in balancing his or her office and hospital worlds, the physician may not understand the complexity of completing orders and taking care of one patient while assuming the care of four or five other patients, along with admissions, discharges, and other situations that arise throughout a shift. Seeing both sides of the fence enlightened me as I continued my career journey.

Clinical Development Specialist

The next phase of my career had a different emphasis as my pathway shifted to nursing staff development. Although this did not seem to be a branch off my earlier paths, it offered an opportunity to advance my education and understand nursing and growth from a different perspective. The clinical

development specialist role focused on mentoring new and current nurses through their professional careers. Obtaining my master's degree in nursing education and developing my own professional career was challenging, but reaching out to help others develop shone another light on my professional path. I needed to understand my own growth and development and where I was in the continuum of life before I could begin to understand how to help others build their paths. Although I did not continue teaching new nurses as a professional role, I had a greater understanding of others' behaviors and thought processes depending on where they were in their own careers. Was this a novice person just starting out, or had this person become adept in his or her field? This awareness helped me realize that not everyone is at the same career stage at the same time. Nor does everyone reach the same levels at the same pace. In addition, people communicate and learn differently. To help others, one needs to have an awareness of different learning styles and communication behaviors. Again, this part of my career provided another building block to my future as I took on a new endeavor.

Clinical Documentation Management Professional

During the clinical development specialist role, I was asked to pilot a clinical documentation role that focused on physician's documentation. The accuracy of physician documentation was becoming a new initiative in healthcare as positions were created to assist physicians in the accuracy of their documentation and to demonstrate how documentation relates to the clinical picture of the patient, as well as having financial and quality impacts for an organization. This position allowed me to take pieces of my various earlier nursing roles and incorporate them into the clinical documentation management professional position. Within the first year, the program was determined to be a success, and the role was made permanent. Although this role will be explained in the following chapters, understanding my journey provides insight on how this role fits into healthcare collaboration. The purpose of this book is to provide a guide on how the clinical documentation management professional role (also known as a clinical documentation specialist) can successfully collaborate with physicians and nurses in healthcare. Although this book may not be applicable in all settings, it provides a guide to understanding the role. Use of the material should be at the reader's discretion, as it was designed to provide an understanding of the role and not absolute criteria.