North Middlesex University Hospital NHS Trust

Engaging Clinicians: Linking coding to revalidation

Date: October 2014

Outline

- Background of my hospital
- National guidance on clinical engagement
- Identified barriers
- Our approach
- Our issues going forward

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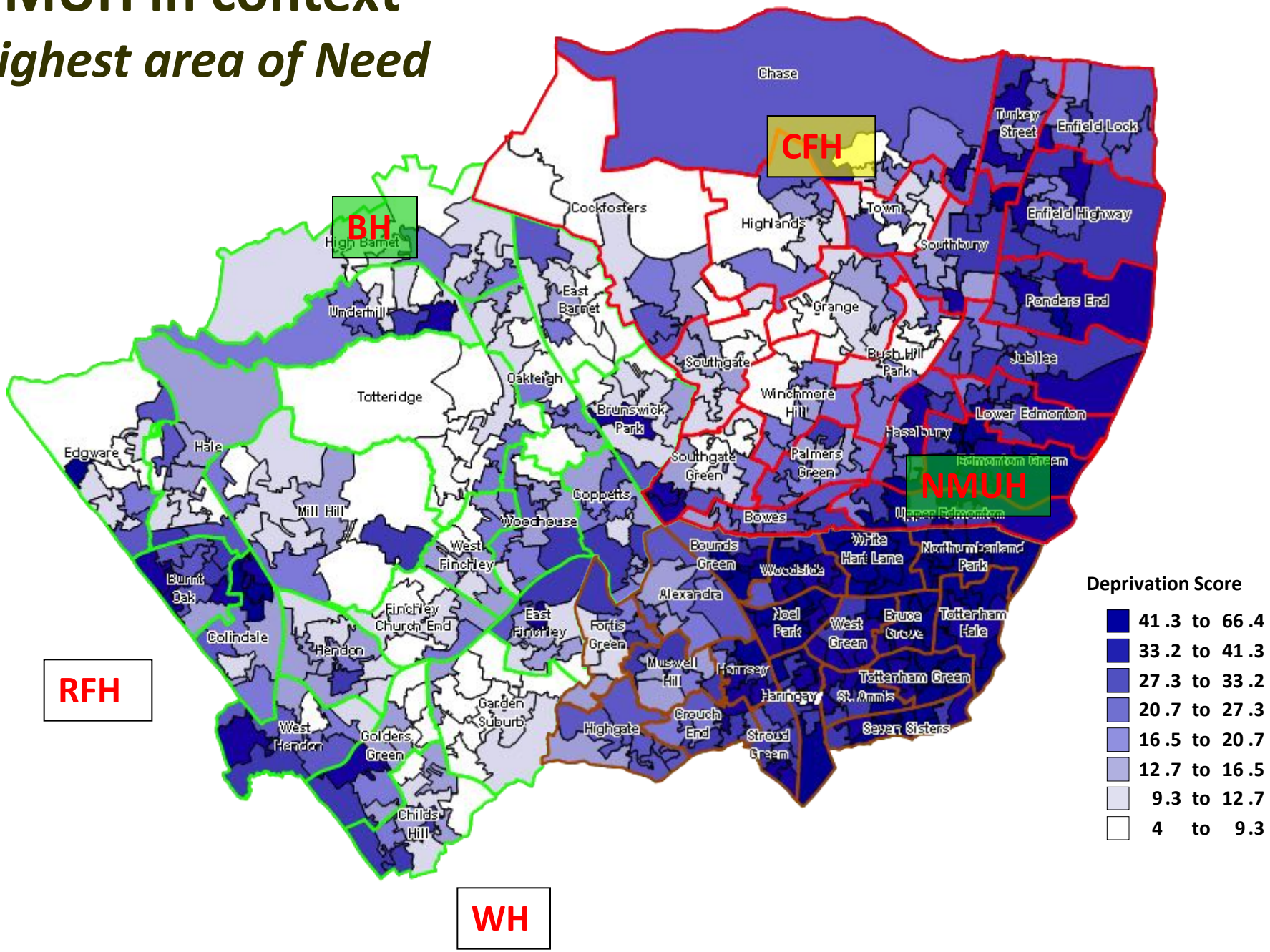
NMUH in context -

Highest area of Need



Deprivation Score

41.3	to 66.4
33.2	to 41.3
27.3	to 33.2
20.7	to 27.3
16.5	to 20.7
12.7	to 16.5
9.3	to 12.7
4	to 9.3

Introduction to North Middlesex University Hospital NHS Trust (NMUH)

• Located in North London, we provide a full range of acute services, including 24-hour accident and emergency, elderly, paediatric, cancer, heart, surgical and emergency medicine as well as comprehensive diagnostic and outpatient services.

•We've modernised and grown with over £200m of investment in our buildings and services over the last five years.

• Due to the BEH Strategy, the level of activity has grown during the last 10 months by a 40 %.

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Introduction to North Middlesex University Hospital NHS Trust (NMUH)

We have:

•450 more doctors, nurses, midwives and health specialists (2,800 staff in total)
•a brand new maternity unit led by our award-winning midwives – see our new pictures and video.
•a new neonatal unit and labour ward
•new medical and surgical wards
•a new stroke unit
•a refurbished cancer ward
•more accident and emergency services – we're currently one of the largest in London

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Engaging clinicians in improving NHS data

- **Royal College of Physicians Recommendations:**
  - Hospitals should routinely share clinically relevant analyses of local activity data with consultants to increase their involvement in the collection, validation and use of these data.
  - If centrally submitted data are to be used to monitor the performance of individuals, substantial work is required to develop information systems which can better reflect current working practices.
  - The education and training of undergraduate and junior medical staff needs to provide a better understanding of how health information is managed and the role that is plays in providing safe and effective patient care.

Source: Health Informatics Unit, Royal College of Physicians' iLab (September 2006)

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Nationally identified barriers: coded data and clinicians engagement

- **Instinct**: general “feel” for quality of data, lack of understanding of the data language and limitations
- **Engagement with process:** lack of good communication with Trust Information Department and coding staff; clinician coding or validation of coding
- **Lack of general engagement:** Unfamiliarity with process; lack of data provision.
- **Dataset limitations:** Dataset does not reflect clinical practise due to complexity of the clinical problem, operational procedure, etc; responsibility of care or team working; lack of accurate outpatient data
- **Coding process:** Poor quality of discharge summaries; coding staff not clinically trained/under-resourced; clinical staff not trained in data management , classifications uses and rules; general lack of confidence in coding accuracy
- **Allocation of activity- other data quality issues:** Activity allocated to the wrong consultant; poorly documented transfers of care, wrong allocated specialty

Source: Royal College of Physicians’ iLab (October 2006)- audit performed in England and Wales

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NMUH -clinical engagement strategies and coding data validation- how everything started

•Internal Audit (2008)- medical team and clinical coding (30 patients from specialty geriatric medicine

• Main Findings:

- different income attached to different medical terminology/diagnoses, for example Pneumonia/LRTI
- different Health Resource Group (HRG) and Income depending on the selection of primary diagnosis (complex case mix with a number of relevant diagnoses)
- Co-morbidities and/or secondary diagnoses (depth of coding) influencing income and final (HRG)

•PbR- Payment by Results and the financial impact as the main motivation for the engagement between clinicians and coders

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Coding and clinical engagement- main drivers- the NMUH experience

For the clinicians:
- Financial recognition of the clinical work performed
- Accuracy of the information sent to national databases and GPs
- Complexity of case mix recognition
- Assignation of the activity to be right
- Integral part of the job plan activity for consultants- appraisals

For the coding team:
- Accuracy of coding
- Correct reimbursement for the Trust
- Training and development of the coding team
- Improvement of the team productivity and efficiency

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Organizational changes facilitating coding (last 5 years)- the NMUH experience

New IT and Business Intelligence Solutions

•The development of new IT solutions and programs: clinical Information Program (CIP), NHS mail and Electronic discharge summaries

•Introduction of Qlikview – a new business intelligence reporting system

• The possibility of repeating and copying co-morbidities and secondary diagnoses electronically

Evolution of the Corporate Organizational Structure

•The clinical structure of the CBUs- clinical business units with clinical directors acting as first contact and champions of the clinical data improvements

•The corporate structure of the informatics, IT, finances, data quality and coding departments (working closely under the same management)

Further Investment in Training and Coding

•The investment in clinical coding resources and training (from 6 to 12 WTE coders, from 0 ACC staff to 8 staff with the accreditation, all the staff attending the clinical coding data standards course, specialty workshops, etc)

•*All the developments had coding department input*

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What we did at NMUH

-Development of a mixed coding model: centralised office for training/communication purposes with daily ward visitation and access to coding in the wards/units.

-Weekly meetings (5 per week) with geriatric medicine (complex case mix and longer LOS cases) consultants to validate all the coding data for current activity/ discharges and mortality coding

-Clinician engagement awareness sessions program: started in 2009, more than 40 clinical coding/ data quality presentations given across all the clinical specialties with presentations tailored to the case mix and the clinical specialty addressed

-Generic awareness sessions delivered twice per year to FY1 and FY2 and SHOs

-Monthly meetings to validate coded data for infections diseases and specialist medicine.

-Routinely weekly contact via E-mail with surgical specialties and T&O to clarify diagnosis and operational procedures

What we did at NMUH- continuation

-E-learning clinical coding induction for new clinical staff: consultant , registrars and junior doctors

-Co-morbidities leaflets and top 10 clinical coding tips leaflets available via Trust intranet for clinical staff and periodically delivered as hard copies to the clinicians meeting areas

-Monthly attendance of clinical coding staff to the mortality specialty reviews

-Awareness periodical communication via E-mail with the different clinical specialties in relation to Health Resource Groups and the use of co-morbidities and clinical data for existent and new appointed staff

-Training sessions (ad hoc) organised with the coding, finances , data quality and contracts team addressed to clinical staff

-Use of Qlikview data (patient and clinical coded data) with access for all the clinical staff with training provided by the Informatics department

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Future Challenges

• Use and development of new IT technologies for coding and communication with clinical staff- tablets, smart phones, patient electronic records.

•To increase the number of weekly meetings –to cover each specialty

•Attendance of the senior coding specialty leads to the monthly clinical audit specialty meetings

•To increase the number of audits performed with registrars and senior clinicians

Summary

- Get coders and clinicians talking. Drs DO want to get things right
- Use IT to facilitate change
- Get the team to the clinicians
- Empower coders to query and challenge
- Organise carefully the management structure: coding, information and data quality

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Putting people first

Thank you for listening

Dr. Maurice Cohen- Clinical Director