Clinical Documentation: Beyond The Financials
Cheryll A. Rogers, RHIA, CDIP, CCDS, CCS
Senior Inpatient Consultant
3M™ HIS Consulting Services
Clinical Documentation: Beyond The Financials

Key Points of Discussion:

• Define and examine the influence “non-financial” initiatives have on Documentation Improvement Programs:
  – Hospital Acquired Conditions (HACs)
  – Patient Safety Indicators (PSIs)
  – Hierarchical Condition Categories (HCCs)
  – Risk of Mortality (ROM) profiling
Key Points of Discussion:

- Discuss challenges
- Discuss need for paradigm shift by focusing on getting the “right” documentation
The healthcare industry is evolving, with more emphasis on value and quality rather than volume and quantity.

- Quality is the new focus.
- CDI must evolve to include a broader spectrum, assuring accurate and complete documentation supports more than the traditional DRG assignment and CC/MCC capture.
Why Change Documentation Practices?

• Demonstrate the delivery of high quality medical care
• Assure the integrity of data for severity, predicted mortality and appropriate length of stay
• Withstand the scrutiny of outside reviews
• Improved internal compliance through regulatory understanding
Transition To Era Of Public Reporting

- Reporting Agencies
- 21st Century Consumers
- Team Approach for Improved Provider Documentation
- Healthcare Plans Regulatory Agencies
How is Quality Measured?

• Based on outcomes, reported conditions, morbidity, mortality, length of stay, and resource consumption
• Most quality tools utilize ICD diagnosis codes of reported conditions
• An accurate quality profile is the result of complete, accurate, and compliant documentation
• Physician documentation \textit{alone} determines:
  – DRG assignment
  – Hospital reimbursement
  – Physician billing
  – Profiling of hospital and physician
    • SOI
    • ROM profiling

• Therefore, physician documentation will drive quality reporting and metrics
Monitoring Quality

• Data Monitoring enables the facility to
  – Validate the data
  – Validate the quality of care provided/reflected
  – Improve outcomes through education of providers
  – Facilitate system improvements to impact the quality of care provided as well as the documentation that drives the data

• And this monitoring cycle must be repeated...
What is the Impact of the Focus on Quality?

- Quality scores are available publically with increasing consumer availability
- Pay for Performance Initiatives
  - Value Based Purchasing (VBP)
  - Patient Safety Indicators introduced into the VBP program
- Managed Care & Third Party Payor Contracts
  - Negotiated rates include performance outcomes measurement
- Financial losses due to Hospital Acquired Conditions (HAC)
What is Value Based Purchasing (VBP)?

• Pay for performance quality initiative in which providers receive incentive payments from Medicare based on their
  • Performance on Hospital Inpatient Quality Reporting measures
    OR
  • Performance improvement on each measure compared to their performance during a baseline period
• VBP authorized by the Affordable Care Act
• Next step in promoting higher quality care for Medicare beneficiaries
  – Pays for care that rewards better value, patient outcomes, and innovations, instead of just volume of services
• Funded by a 1.75% reduction from participating hospitals’ base operating Diagnosis-Related Group (DRG) payments for FY 2016
How Is Hospital Performance Measured?

- Based on an approved set of measures and dimensions, grouped into specific quality domains. Different domains applied during the FY 2013 – 2015

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Applicable Domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>Clinical Process of Care Domain</td>
</tr>
<tr>
<td></td>
<td>Patient Experience of Care Domain</td>
</tr>
<tr>
<td>2014</td>
<td>Clinical Process of Care Domain</td>
</tr>
<tr>
<td></td>
<td>Patient Experience of Care Domain</td>
</tr>
<tr>
<td></td>
<td>Outcome Domain</td>
</tr>
<tr>
<td>2015</td>
<td>Clinical Process of Care Domain</td>
</tr>
<tr>
<td></td>
<td>Patient Experience of Care Domain</td>
</tr>
<tr>
<td></td>
<td>Outcome Domain</td>
</tr>
<tr>
<td></td>
<td>Efficiency Domain</td>
</tr>
</tbody>
</table>
FY 2016 Domains and Measures/Dimensions

**Clinical Process of Care**
- AMI-7a
- IMM-2
- PN-6
- SCIP-Inf-2
- SCIP-Inf-3
- SCIP-Inf-9
- SCIP-Card-2
- SCIP-VTE-2

**Patient Experience of Care**
- HCAHPS
  - Communication with Nurses
  - Communication with Doctors
  - Responsiveness of Hospital Staff
  - Pain Management
  - Communications about Medicines
  - Cleanliness and Quietness of Hospital Environment
  - Discharge Information
  - Overall Rating of Hospital

**Outcome**
- MORT-30-AMI
- MORT-30-HF
- MORT-30-PN
- PSI-90
- CLABSI
- CAUTI
- SSI
  - Abdominal Hysterectomy
  - Colon Surgery

**Efficiency**
- MSPB

**Domain Weights**
- Efficiency 25%
- Clinical Process of Care 10%
- Patient Experience of Care 25%
- Outcome 40%
Domains and Measures/Dimensions Clinical Process of Care

AMI-7a: Fibrinolytic therapy received within 30 minutes of hospital arrival

IMM-2: Influenza Immunization

PN-6: Initial antibiotic selection for community-acquired pneumonia in immunocompetent patient

SCIP-Inf-2: Prophylactic antibiotic selection for surgery patients

SCIP-Inf-3: Prophylactic antibiotics discontinued within 24-hours after surgery end time

SCIP-Inf-9: Urinary catheter removed on post-operative day 1 or post-operative day 2

SCIP-Card-2: Surgical patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period

SCIP-VTE-2: Surgical patients who received appropriate venous thromboembolism prophylaxes within 24-Hours prior to surgery to 24-hours after surgery

Clinical Process of Care Weighting

- 10%

SCIP-VTE-1 – Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered, a FY14 measure, was removed from the FY 2015 program.
Domains and Measures/Dimensions Patient Experience of Care

Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) Dimensions

- Communication with Nurses
- Communication with Doctors
- Responsiveness of Hospital Staff
- Pain Management
- Communication About Medicines
- Cleanliness and Quietness of Hospital Environment
- Discharge Information
- Overall Rating of Hospital

Patient Experience of Care Weighting: 25%
Domains and Measures/Dimensions Outcome

30-Day Mortality Measures
- MORT-30-AMI
- MORT-30-HF
- MORT-30-PN

AHRQ Measure
- PSI-90 Composite

Healthcare Associated Infection (HAI) Measures
- CLABSI
- CAUTI
- SSI: Abdominal hysterectomy and Colon surgery

Outcome Weighting
- 40%
Domains and Measures/Dimensions
Outcome: Mortality Measures

Mortality Measures

Claims-Based Measures

Utilizes admissions for Medicare Fee-for-Service (FFS) beneficiaries aged ≥65 years discharged from subsection(d) and Maryland acute care hospitals having a principal discharge diagnosis of Acute Myocardial Infarction, Heart Failure, or Pneumonia, and meeting other measure inclusion criteria

Reported as survival rates

- **MORT-30-AMI:** Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
- **MORT-30-HF:** Heart Failure (HF) 30-Day Mortality Rate
- **MORT-30-PN:** Pneumonia (PN) 30-Mortality Rate
Domains and Measures/Dimensions

Outcome: AHRQ PSI-90

Agency for Healthcare Research and Quality (AHRQ) Measure

PSI-90 Composite

- Composite of 8 underlying component patient safety indicators (PSIs) which are sets of indicators on potential in-hospital complications and adverse events during surgeries and procedures.
- Claims-Based Measure

<table>
<thead>
<tr>
<th>PSI</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>03</td>
<td>Pressure Ulcer Rate</td>
</tr>
<tr>
<td>06</td>
<td>Iatrogenic Pneumothorax Rate</td>
</tr>
<tr>
<td>07</td>
<td>Central Venous Catheter-Related Bloodstream Infection Rate</td>
</tr>
<tr>
<td>08</td>
<td>Postoperative Hip Fracture Rate</td>
</tr>
<tr>
<td>12</td>
<td>Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate</td>
</tr>
<tr>
<td>13</td>
<td>Postoperative Sepsis Rate</td>
</tr>
<tr>
<td>14</td>
<td>Postoperative Wound Dehiscence Rate</td>
</tr>
<tr>
<td>15</td>
<td>Accidental Puncture or Laceration Rate</td>
</tr>
</tbody>
</table>
Domains and Measures/Dimensions

Outcome: HAI Measures

Healthcare-Associated Infections (HAI) Measures

**CLABSI:** Central line-associated blood stream infections among adult, pediatric and neonatal ICU patients

**CAUTI:** Catheter-associated urinary tract infections among adult and pediatric ICUs

**SSI:** Surgical site infections specific to Abdominal hysterectomy and Colon surgery
Domains and Measures/Dimensions

Efficiency: MSPB Measure

MPSB-1: Medicare Spending Per Beneficiary (MSPB)

Claims-Based Measure

Includes risk-adjusted and price-standardized payments for Part A and Part B services provided 3-days prior to hospital admission through 30-days after hospital discharge

Efficiency Weighting

25%
Present on Admission Indicators (POA)

• Required reporting to indicate whether the condition reported is a comorbidity (present at the time of admission) or a complication (developed during the hospital stay) in accordance with CMS definitions
Hospital Acquired Conditions (HACs)

• When a selected condition is acquired during hospitalization, the condition is excluded as CC/MCC if one of the following present on admission (POA) indicators is used:
  • N (not present at the time of admission)
  • U (insufficient documentation)
Hospital Acquired Conditions

- HAC are a group of reasonably preventable conditions that patients did not have upon admission to a hospital, but which developed during the hospital stay.
HAC List FY 2014

- Foreign Object Retained after Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcer Stages III and IV
- Falls and Trauma
  - Fracture
  - Dislocation
  - Intracranial Injury
  - Crushing Injury
  - Burn
  - Other Injuries
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Manifestations of Poor Glycemic Control

- Surgical Site Infection:
  - Mediastinitis Following Coronary Artery Bypass Graft (CABG)
  - Following Certain Orthopedic Procedures
  - Following Bariatric Surgery for Obesity
  - Following Cardiac Implantable Electronic Device (CIED) Procedures
- Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures
- Iatrogenic Pneumothorax with Venous Catheterization
• Query to clarify the POA status of secondary diagnoses to avoid being penalized for a HAC condition that WAS present at the time of admission
The Agency for Healthcare Research and Quality (AHRQ) developed a set of indicators that provide information on potential in-hospital complications and adverse events following surgeries, procedures, and childbirth.
How are PSIs Used?

• Help hospitals identify potential adverse events that might need further study
• Assess the incidence of adverse events and in hospital complications using administrative data found in the typical discharge record
• Include indicators for complications occurring in hospital that may represent patient safety events
• Indicators also have area level analogs designed to detect patient safety events on a regional level
Said Another Way.....PSI

- Used to help hospitals and health care organizations assess, monitor, track, and improve the safety of inpatient care
- Used for comparative public reporting and pay-for-performance initiatives
- Identifies potentially avoidable complications that result from a patient’s exposure to the health care system
- *Hospital-level* indicators detect potential safety problems that occur during a patient’s hospital stay
- *Area-level* indicators for potentially preventable adverse events that occur during a hospital stay to help assess total incidence within a region
Hospital Level PSIs

- Death in low-mortality DRGs (PSI 02)
- Pressure ulcer (PSI 03)
- Death among surgical inpatients with treatable serious complications (PSI 04)
- Foreign body left in during procedure (PSI 05)
- Iatrogenic pneumothorax (PSI 06)
- Central venous catheter-related bloodstream infections (PSI 07)
- Postoperative hip fracture (PSI 08)
Hospital Level PSIs

• Postoperative hemorrhage or hematoma (PSI 09)
• Postoperative physiologic and metabolic derangements (PSI 10)
• Postoperative respiratory failure (PSI 11)
• Postoperative pulmonary embolism or deep vein thrombosis (PSI 12)
• Postoperative sepsis (PSI 13)
• Postoperative wound dehiscence (PSI 14)
Hospital Level PSIs

• Accidental puncture or laceration (PSI 15)
• Transfusion reaction (PSI 16)
• Birth trauma— injury to neonate (PSI 17)
• Obstetric trauma— vaginal delivery with instrument (PSI 18)
• Obstetric trauma— vaginal delivery without instrument (PSI 19)
PSI 90: Composite of selected Indicators

- One of two new measures for the Outcome Domain in FY 2015
- A composite of eight underlying component indicators related to patient safety
PSI 90: A composite of selected Indicators

PSI 03  Pressure Ulcer Rate
PSI 06  Iatrogenic Pneumothorax Rate
PSI 07  Central Venous Catheter-Related Bloodstream Infection Rate
PSI 08  Postoperative Hip Fracture Rate
PSI 12  Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate
PSI 13  Postoperative Sepsis Rate
PSI 14  Postoperative Wound Dehiscence Rate
PSI 15  Accidental Puncture or Laceration Rate
Further Evolution: HAC Reduction Program

• HAC Reduction Program established by the 2010 Patient Protection & Affordable Care Act to encourage reduction in the occurrence of HAC conditions
HAC Reduction Program

- Effective FY 2015, the Secretary of Department of Health and Human Services is required to reduce payments to hospitals that rank in the quartile of hospitals with the highest Total HAC Scores by 1%
HAC Reduction Program

- Hospital performance is determined on a hospital’s total HAC Score, ranging from 1-10
- The higher the total HAC Score, the worse the hospital performed under the HAC Reduction Program
For FY 2016, the Total HAC Score is based on four quality measures grouped into two domains:

• Domain 1 – AHRQ Patient Safety Indicator PSI 90 Composite

• Domain 2 - National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) measures:
  – Central Line-Associated Bloodstream Infection (CLABSI)
  – Catheter-Associated Urinary Tract Infection (CAUTI)
  – Surgical Site Infection (SSI)
## Hierarchical Condition Categories or HCC

**CMS HCC**
- Developed by CMS for risk adjustment of the Medicare Advantage Program (Medicare Part C)
- CMS also developed a CMS RX HCC model for risk adjustment of Medicare Part D population
- Based on aged population (over 65)

**HHS HCC (Commercial HCC)**
- Developed by the Department of Health and Human Services (HHS)
- Designed for the commercial payer population
- Includes both medical and Rx component
- Includes all ages
CMS - Hierarchical Condition Categories

• Developed by CMS to adjust Medicare capitation payments to Medicare Advantage Plans (Medicare Part C) based on the health expenditure risk of their enrollees

• Current year data predictive of future year risk
CMS - Hierarchical Condition Categories

• Based on diagnoses patient on Medicare has accumulated over a year from data submitted from:
  – Principal and secondary diagnoses during hospital inpatient stays
  – Hospital outpatient diagnoses
  – Physician office diagnoses
  – Clinically-trained non-physician (psychologist or podiatrist) services

• CMS-HCC will be used in Value Based Purchasing to determine part of the risk adjustment score
Hierarchical Condition Categories HCC

- 79 Categories identified in FY 2014 – ICD-9 based
- Within each category, there are hierarchies that represent more advanced and costly conditions in a higher coefficient
- There is a formula to account for disease interaction and disabled status
- A risk score is assigned, where a risk score of 1.0 reflecting the Medicare-incurred expenditures of an average beneficiary
- Risk adjustment incorporates diagnostic and demographic data
- Demographic data includes, for example, age/sex group, Medicaid status, disability status and if living in an institution
Hierarchical Condition Categories HCC

HCC Category examples

– Infection
– Neoplasm
– Diabetes
– Metabolic
– Liver
– Gastrointestinal
– Musculoskeletal
– Blood
– Substance Abuse
– Psychiatric
HCC Classification System

- **ICD-9-CM Codes**: 14,000+ codes
- **ICD-10-CM Codes**: 70,000+ codes
- **Diagnostic Groups**: 805 groups
- **Condition Categories**: 189 categories
- **Hierarchical Condition Categories (HCC’s)**: 189 categories
- **CMS-HCC**: 79 categories used in payment model as of 2014
• Report all current diagnoses at the highest level of specificity based on physician documentation
• The more categories of diagnoses reported over a year creates a higher risk score
• Only one diagnosis per category is reported
  – For example, Angina is not reported as AMI is more severe condition in the category
• While all ICD-9 diagnosis codes fall within an HCC category, only 79 categories are included in the payment model
3M™ APR DRG Classification System

- Clinically coherent set of patient groups that include adjustments for severity of illness and risk of mortality
- Designed to describe the complete cross-section of patients treated in acute care hospitals
- Expands the precision of the basic DRG concept by adding four subclasses to each group for both severity of illness (SOI) and risk of mortality (ROM)
What is Severity of Illness and Risk of Mortality?

- SOI is the extent of physiologic decompensation, or organ system loss of function experienced by the patient.
- ROM is the likelihood of dying.
- SOI and ROM are distinct.
  - SOI is different from ROM, and therefore separate subclasses are assigned.
Severity of illness (SOI) and risk of mortality (ROM) are dependent on the patient’s underlying problem(s).

Patients with high severity of illness and risk of mortality are characterized by multiple serious diseases and the interaction among those diseases.
3M™ APR DRG Classification Data Elements

MDC (Major Diagnostic Category)

Base APR DRG
(316 base APR DRG categories)

Four Severity of Illness Subclasses*

<table>
<thead>
<tr>
<th>Subclass</th>
<th>Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Minor</td>
</tr>
<tr>
<td>2</td>
<td>Moderate</td>
</tr>
<tr>
<td>3</td>
<td>Major</td>
</tr>
<tr>
<td>4</td>
<td>Extreme</td>
</tr>
</tbody>
</table>

Four Risk of Mortality Subclasses

<table>
<thead>
<tr>
<th>Subclass</th>
<th>Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Minor</td>
</tr>
<tr>
<td>2</td>
<td>Moderate</td>
</tr>
<tr>
<td>3</td>
<td>Major</td>
</tr>
<tr>
<td>4</td>
<td>Extreme</td>
</tr>
</tbody>
</table>

* Severity subclasses have APR DRG weights for each subclass.
The assessment of the SOI or ROM is specific to the base APR DRG, i.e., disease-specific.

Significance attributed to secondary diagnosis/condition is dependent on the underlying problem. For example:

- Some infections are more significant in immunosuppressed patients than patients admitted with a fracture.

SOI and ROM determined by the interaction of multiple diseases.

- Patients with multiple secondary conditions affecting multiple organ systems represent difficult-to-treat patients who are more likely to have poor outcomes and require greater resources to treat.
Effective SOI/ROM Profile Assignment

It is imperative that all documented diagnoses that meet the UHDDS (Uniform Hospital Discharge Data Set) coding guidelines be reported for each patient

• Principal Diagnosis: The condition established after careful study to be chiefly responsible for occasioning the admission to the hospital

• Secondary Diagnoses: additional conditions that affect patient care in terms of requiring at least one of the following:
  • Clinical evaluation
  • Therapeutic treatment
  • Diagnostic procedures
  • Extended length of hospital stay
  • Increased nursing care and/or monitoring
What does all this mean for a CDI Program?

• Ensure complete and specific documentation of all conditions that meet reporting definitions
• Thorough review of alternative principal diagnosis options
• Concurrent review and querying to obtain documentation of all appropriate conditions, clarify complication diagnoses, POA status, etc.
• Early warning and notification of Core Measure cases and potential quality issues
Clinical Documentation Paradigm Shift

• Stagnant CMI
• Query types have not evolved
• Departments working in Silos?
  – Revenue Cycle
  – Quality
  – Case Management
  – Nursing
  – Clinical Documentation Improvement
Current Clinical Documentation Model

MS-DRG
APR-DRG

Assessment
Monitoring
Physician Education
Validation
Establish CDI Center of Excellence

Clinical Documentation *Integrity* Center of Excellence

- Goal is improving the overall quality and completeness of clinical documentation with adherence to industry best practice as well as corporate/regulatory compliance
  - Optimize coding accuracy for both quality metrics and reimbursement
  - Move to a more integrated, interdisciplinary model for education and best practice sharing to improve the validity of patient safety metrics as well as achieve appropriate reimbursement
Establish CDI Center of Excellence

- Balance quality, compliance and revenue integrity
  - Place more emphasis on capturing complete clinical data that can be shared throughout the care continuum
- Deliver consistent message to practitioners encompassing all concerns and initiatives
- Incorporate CDI metrics into physician profile reports and management reports related to quality and efficiency
- Monitor the proportion of high vs. low SOI cases for all patients and ROM scores for expired patients to measure improved capturing of co-morbid conditions
Establish CDI Center of Excellence

– Establish or modify second level review process to include quality concerns
– Share CDI benchmarks metrics with executive team including
  • 30-day readmission rates, stratified by APR DRG SOI for
    – pneumonia
    – heart failure
    – acute myocardial infarction
Paradigm Shift
Clinical Documentation Integrity

Quality
PSI, POA, HAC
CMI
Claims Denials
HHC
SOI/ROM Profiles

Assessment
Provider Education/Dashboards
CDI Center for Excellence
Validation
Monitoring
Clinical Documentation: Beyond The Financials

QUESTIONS
Resources

- [https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166](https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166)