Best Practice Strategies to Position your Organization for Value Base Purchasing

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The Changing Landscape
Best Practice Strategies to Position your Organization for Value Base Purchasing

- Gain increased understanding of the impact of quality data on organizational performance under new quality reporting programs and outcomes-based payment models
- Identify the potential for improvement in quality outcomes through the use of a Health system case study
- Review workflow for multi-disciplinary pre-bill quality control of PSI, HAC and mortality outcomes
- Improve collaboration with physicians, CDI staff and quality to ensure complete and accurate documentation Building upon success strategies to drive population health initiatives

Agenda

- What makes up a PSI – Diagnoses, Procedures alone?
- What is impact
  - Publicly reported data affects facility patient safety rating
  - Rankings in health care industry
  - Reflection of how care for patients
- Team approach to PSI’s
- Workflow
- Process – remove “noise” from data
  - Focus on patient care
  - Focus on Patient outcomes
What is Value Based Purchasing?

- The Hospital VBP Program is part of CMS’s effort to structure Medicare payments to improve healthcare quality, including hospital inpatient care.
- This is the fourth year of value-based purchasing for the largest share of Medicare spending, affecting payment for inpatient stays in over 3,000 hospitals across the country.
- CMS now pay hospitals for inpatient acute care services based on the quality of care, not just the quantity of services provided.
- CMS is increasing the program’s number of quality domains and measures used to evaluate performance.
VBP Goal and Quality Domains

CMS believes the program will result in improved patient outcomes, safety, and patients’ care experience, and includes a broader, richer set of measures over time and aligning with the National Quality Strategy (NQS). The quality domains for FY 2016 include:

- 10 percent: Clinical process of care
- 25 percent: Patient experience of care (HCAHPS survey)
- 40 percent: Outcome (hospital mortality measures for acute myocardial infarction, heart failure, and pneumonia, the central line-associated bloodstream infection measure, the catheter associated urinary tract infection measure, the surgical site infection strata, and the AHRQ PSI-90 Composite)
- 25 percent: Efficiency (Medicare Spending per Beneficiary measure)

Increasing Demand for High-Quality Documentation

- High-quality documentation provides more accurate clinical picture of quality of care provided
- Better clinical documentation promotes better patient care and more accurate capture of acuity, severity, and risk of mortality
  - Quality and performance reporting
  - Reimbursement
  - Severity-level profiles
  - Risk adjustment profiles
  - Provider profiles
  - Present on admission (POA) reporting
  - Hospital-acquired conditions (HACs)
  - PSI (Patient Safety Indicators)
Clinical Documentation Challenges

- Ensuring high-quality documentation without excessive administrative burden or levels of frustration, or encroaching on time spent on patient care
- Ensuring sufficient documentation to support code assignment while allowing providers to document in clinical, not coding, terms
- Need good clinical documentation – not a greater volume of documentation
- Requires collaboration between the provider, Quality, CDI, and Coding program leadership

Documentation Focus Areas for ICD-10-CM

- Disease type
- Disease acuity
- Disease stage
- Site specificity
- Laterality
- Missing combination code detail
- Changes in timeframes associated with familiar codes
Service mode changing

- Acute Care
- Well Care
- Population Health
- Chronic Care
Dramatic and Rapid Change

Inflection Point

Change is the Only Constant

Understanding Change

Kubler Ross Change Curve

Morale & Competence

Time

Shock, Numbness, Denial, Anger, Depression, Understanding, Acceptance, Moving on
### What’s a Provider to Do?

<table>
<thead>
<tr>
<th>Other Health Professionals</th>
<th>Transparency in Office Notes</th>
<th>Quality Metrics</th>
<th>Super and Cloud Computing</th>
<th>Algorithms Scorecards</th>
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</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

- Telemedicine
- Lack of Genomic Knowledge
- Patient Generated Data
- Reimbursement
- Retail-Based Clinics
- EHR Frustration

### Payment Structure

<table>
<thead>
<tr>
<th>Volume-Based</th>
<th>Value-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee-for-Service</td>
<td>Outcomes</td>
</tr>
<tr>
<td>Inefficient</td>
<td>Gain Efficiencies</td>
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</tbody>
</table>

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### What makes up a PSI?

- Quality
- Procedures
- Diagnoses

**Proposed 2015 PSI Targets**

<table>
<thead>
<tr>
<th>PSI</th>
<th>90th</th>
<th>50th</th>
<th>90th</th>
<th>50th</th>
<th>90th</th>
<th>50th</th>
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<tbody>
<tr>
<td>PS12</td>
<td>death in low mortality drgs</td>
<td>0.00</td>
<td>0.15</td>
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<td>PS13</td>
<td>pressure ulcer-prior 20074 decubitus ulcer</td>
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<td>0.00</td>
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<td>PS14</td>
<td>death among surgical-prior 20062 failure to rescue</td>
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<td>iatrogenic pneumothorax</td>
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<td>PS17</td>
<td>bloodstream infections-prior 20074 infection due to medical care</td>
<td>0.08</td>
<td>0.37</td>
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<td>0.00</td>
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<td>PS18</td>
<td>postoperative hip fracture</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>PS19</td>
<td>perioperative hemorrhage or hematoma</td>
<td>1.60</td>
<td>7.13</td>
<td>0.00</td>
<td>2.84</td>
<td>2.29</td>
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<td>PS20</td>
<td>postop physio metabol derangement</td>
<td>0.00</td>
<td>0.95</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>PS21</td>
<td>postop respiratory failure</td>
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<td>9.19</td>
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<td>4.83</td>
<td>0.46</td>
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<td>PS22</td>
<td>periopeative pe or dvt</td>
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<td>7.93</td>
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<td>2.62</td>
<td>1.40</td>
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<td>PS23</td>
<td>postoperative sepsis</td>
<td>3.89</td>
<td>10.86</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td>PS24</td>
<td>postoperative wound dehiscence</td>
<td>0.00</td>
<td>1.31</td>
<td>0.00</td>
<td>0.00</td>
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<td>PS25</td>
<td>accidental puncture or laceration</td>
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<td>1.85</td>
<td>0.00</td>
<td>0.87</td>
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<tr>
<td>PS26</td>
<td>ob trauma - vaginal with instrument</td>
<td>61.22</td>
<td>134.50</td>
<td>28.57</td>
<td>111.11</td>
<td>68.14</td>
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<tr>
<td>PS27</td>
<td>ob trauma - vaginal without instrument</td>
<td>5.92</td>
<td>16.05</td>
<td>6.09</td>
<td>16.70</td>
<td>11.26</td>
</tr>
</tbody>
</table>

**Edits used to stop cases with PSI**

- UHC AAMC
- UHC Community Hospitals Inpatient Discharges ≤
- UHC Community Hospitals Inpatient Discharges ≥
Patient Safety Indicator (PSI) Data Supports Intelligent Decision-Making

CAC and CDI system Assists With:
• Identifying Documentation Deficiencies
• Translating to Coded Data
• Accuracy of Reporting

Patient Care ➔ Medical Record Documentation ➔ Translation to Coded Data ➔ Reporting of Data ➔ Intelligent Decision-Making Based on Outcomes

**PSI 12 ICD-10 Consideration**

- Indicate the specific vein, such as femoral or iliac, along with laterality to indicate the actual side of the body involved
- Treatment of choice is a vena cava or Greenfield filter. Objective is to filter clots from blood and not restrict blood flow. The root operation is insertion, or “putting in a non-biological appliance that monitors, assists, performs, or prevents a physiologic function but does not physically take the place of a body part.” The filter is usually placed percutaneously in the inferior vena cava (IVC). The IVC is part of the “lower veins” body system with the body part specifically identified as the IVC. The ICD-10-PCS code used 06H03DZ:
  - 0, Medical and surgical
  - 6, Lower veins
  - H, Insertion
  - 0, Inferior vena
  - 3, Percutaneous
  - D, Intraluminal device
  - Z, No qualifier
Team Approach to PSI's

Clinical Documentation Improvement (CDI)
Coding
Quality
Physician
Clinical Staff

Opportunities

- What works?
- What doesn’t work?
- Where are the opportunities?
- Where can we become more efficient?
PSI Case Review

What are the:

- identified issues,
- opportunities for queries,
- and recommendations for documentation improvement

Examples of Good Physician Documentation

**Example A**
- "COMPLICATIONS Iatrogenic external iliac vein injury, which was repaired intraoperatively."

**Example B**
- "COMPLICATIONS Perforation and extravasation of the distal superficial femoral artery"

**Example C**
- "COMPLICATIONS Splenic injury requiring splenectomy."
Opportunity for Documentation Improvement

Inadvertent Perforation

Physician documentation supports this as it is not a complication, therefore it should not have been reported as a complication

Example of Physician Documentation:
"In the process of doing this, we made an inadvertent perforation into the small intestine close to the area where this intestine was stuck to the left side of the pelvis. We examined this area and again, there were thickened loops of bowel with an inflammatory rind."
Query Opportunities

Small Bowel Resection

Query is necessary to determine:

- Complication, or
- incidental/inherent

Example of Physician Documentation:

“Taking down the small bowel, I made an enterotomy; therefore, performed a limited small bowel resection, performing a side-to-side functional end-to-end anastomosis GIA-100 stapler.”

Reference AHA Coding Clinic® for supporting documentation

Coding Auditor: Patient presented for a lap colostomy due to her chronic constipation. However during the procedure it’s noted by the surgeon, “Taking down the small bowel, I made an Enterotomy; therefore, performed a limited small bowel resection, performing a side-to-side functional end-to-end anastomosis GIA-100 stapler.” Per CC 1Q 2010 pg. 11-12 this is not an incidental tear. On surgeon’s dictated report under “complications” he listed “None”. Following the procedure patient became hypotensive and d/t concerns for internal bleeding was brought back into the OR and found that there was bleeding at that small bowel resection site; additional small bowel was resected and repaired. Query opportunity for the physician on if this was a complication vs. incidental/inherent

MD Advisor agreed with Coding Auditor—Query opportunity for the physician -- it is not clear from the clinical documentation if the Enterotomy was a complication or if it was inherent/incidental to the procedure. If this Enterotomy was inherent/incidental, the surgeon’s clinical documentation should make it clear by including statements such as the Enterotomy was unavoidable, or expected -- demonstrating to the reader that based on the physical circumstances of the patient the Enterotomy was inherent and therefore not considered a complication. Physician education is needed.
Small Bowel Resection

Query is necessary to determine:
• Complication, or
• incidental/inherent

Example of Physician Documentation:
Per Op report, "then ran the small bowel and there was an enterotomy in the mid jejunum, which could not be repaired primarily, therefore, I resected this in the usual fashion using the GIA-100 stapler creating a functional side-to-side, functional end-to-end anastomosis, closing the mesenteric defect."

Serosa Tear

Query is necessary to determine:
• Complication, or
• incidental/inherent

Example of Physician Documentation:
“Unfortunately doing so, the peritoneum became very, very thin. It was the less than paper thin and ripped. I attempted to repair the tear in the peritoneum using 3-0 Vicryl sutures, but I was not able to complete the repair.”
Fistula of the Bladder

Query is necessary to determine:

• Complication, or
• incidental/inherent

Example of Physician Documentation:
“The fistula itself was down in the pelvis pressed against the bladder and upon mobilizing the small bowel, entered the bladder, making a 1.5 cm laceration in the dome of the bladder. All subfascial and interlooped planes were obliterated due to previous multiple surgeries. Upon mobilizing the small bowel distal to the fistula there was a small bowel enterotomy. The patient only had 20-25 inches of small bowel left. I therefore opted not to resect this, but to repair it primarily in a single layer closure with 3-0 Vicryl sutures.”

Exploratory Laparotomy of Abdomen

Query to determine if the diagnosis and the repair should be captured/reported

Example of Physician Documentation:
"There was a 0.75 cm injury to the lateral aspect of the colon, just before it was protruding through the stoma site. I therefore opted to repair this and not relocate the colostomy. ”
Bladder Repair

PSI was not correct
Query is necessary to determine the diagnosis

Example of Physician Documentation:
"There was a rent in the anterior dome of the bladder that was created during this dissection, but was completely unavoidable secondary to the severe dense inflammatory change in this region. The bladder was repaired with 2 layers of Vicryl suture. The first running, the second imbricating and then we inflated the bladder with 300 cc of saline and found it to be watertight. The bladder was then decompressed. Attention was turned back to the colon."

Cecal Perforation

Query is necessary to determine:
• Complication, or
• incidental/inherent

Example of Physician Documentation:
"There were dense adhesions of the omentum around the cecum and right colon. As these were taken down a perforation of the cecum was identified, with spillage of liquid green stool occurring"
Severe Protein Malnutrition

Query is necessary to determine:
- Complication, or
- incidental/inherent

Example of Physician Documentation:
"The dissection was initially difficult. It appears that the duodenum was densely adhered to the area infundibulum and while I am trying to tease off the duodenum, a hole was created in the duodenum. With that, I converted to an open procedure. Laparoscopic equipment was removed."..."The hole in the duodenum which was duodenum, which was about 3 cm in greatest diameter was closed with interrupted full-thickness 2-0 silks"
### Definition: PSI 15 Accidental Puncture/Laceration

- Diagnosis developed by AHRQ to help hospitals identify an unintended adverse event/complications despite best medical and surgical care
- Surgeons should review/be educated on information about clinical documentation that is consistent with PSI 15 and coding guidelines
- Not intended for conditions that are inherent, routinely expected, or intended

**Examples:**
- Serosal tears and enterotomy due to adhesions
- Deformation of anatomy
- Laceration or puncture required for the procedure

### Expected/Intentional/Inherent

- If a puncture, tear, laceration, enterotomy, colotomy, serosal “injury,” or other such event occurs due to (e.g., the nature of the adhesions, the inflammation, the abscess, the tumor, or other conditions present during the operation) believed to be routinely expected/inherent to the procedure, your documentation must clearly state that the event was inherent to the procedure to avoid the incorrect reporting of a complication.

- Also document reason(s) for describing an event as inherent (e.g., tumor disease encroaching on surrounding tissues, organs friable due to prior radiation treatment) to further clarify the documentation.

- Always respond, promptly and comprehensively, to query requests
Documentation Tips to Remember

<table>
<thead>
<tr>
<th>If you are thinking…</th>
<th>Consider this…</th>
</tr>
</thead>
<tbody>
<tr>
<td>…Iliac vein was lacerated in attempt to mobilize kidney</td>
<td>…Iliac had to be sacrificed in order to facilitate the removal of the large adherent tumor</td>
</tr>
<tr>
<td>During the resection of the bladder several small tear on the bowel was noted. A bowel resection had to be performed.</td>
<td>During the resection of the bladder it was seen that the tumor was adherent to the bowel. It was necessary to resect the bowel and anastomosis was performed.</td>
</tr>
</tbody>
</table>

Complication/Accidental/ Iatrogenic Injury

If you believe that an event is not routinely expected or is not inherent to the difficulty or nature of the procedure, thus qualifying as a complication of the procedure, explicitly document this in your operative note so that the complication can be properly coded, reported, and evaluated for future improvement opportunities.
Consider These Adjectives If Applicable:

<table>
<thead>
<tr>
<th>Accidental Puncture or Laceration</th>
<th>Non-Accidental Puncture or Laceration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terms that are indicative of an accidental laceration:</td>
<td>Terms that suggest non-accidental puncture or laceration:</td>
</tr>
<tr>
<td>• Inadvertent/inadvertently</td>
<td>• To facilitate</td>
</tr>
<tr>
<td>• Complication/complicated by</td>
<td>• Necessary</td>
</tr>
<tr>
<td>• Accidental/accidentally</td>
<td>• Required</td>
</tr>
<tr>
<td>• Unintended/unintentional</td>
<td>• Intentional/intended</td>
</tr>
<tr>
<td>• Iatrogenic</td>
<td>• Inherent</td>
</tr>
<tr>
<td></td>
<td>• Integral</td>
</tr>
<tr>
<td></td>
<td>• Routinely expected</td>
</tr>
</tbody>
</table>

CDI and Coders

**CDI & Coders should query the provider for clarification:**

- If the provider’s op/procedure notes do not clearly describe the circumstances of the puncture or laceration, whether it is routinely expected or inherent to the procedure or whether it is a complication
- If the postop/procedure note conflicts with the op/procedure report
Complication Coding

- Code assignment is based on the provider’s documentation of the relationship between the condition and the care or procedure. The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications.
- There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication.
- Query the provider for clarification, if the complication is not clearly documented.

Final Points

- Educate CDI, Coders, and Physicians on PSI’s
- Increase/implement concurrent review of these cases by collaboration with CDI, Physicians, & Quality teams.
- Involve Chief Quality Officer and CMO in cases identified as a PSI
- Re-educate Coders on Complication Coding Guidelines
- Incorporate a Pre-bill review of cases identified as a PSI
- Provide feedback on findings to CDI, Coders and Physicians.
Questions