

Clinical Documentation & Coding

A Team Approach to Improving Data, Quality Outcomes & Reimbursement in the Hospital Setting

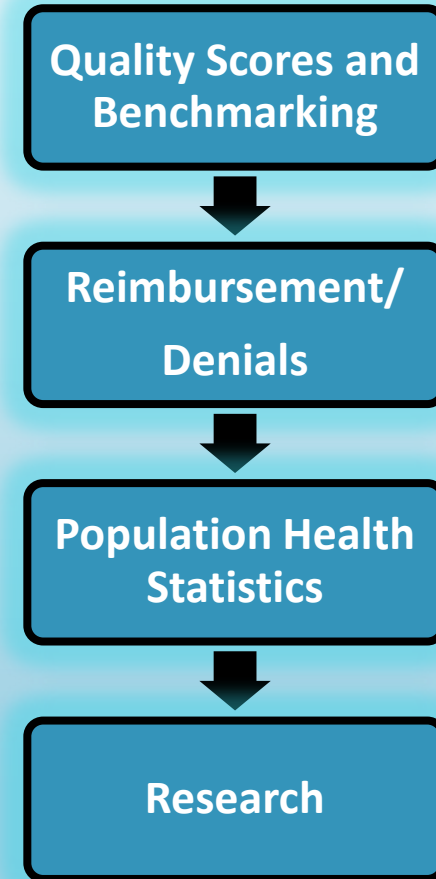
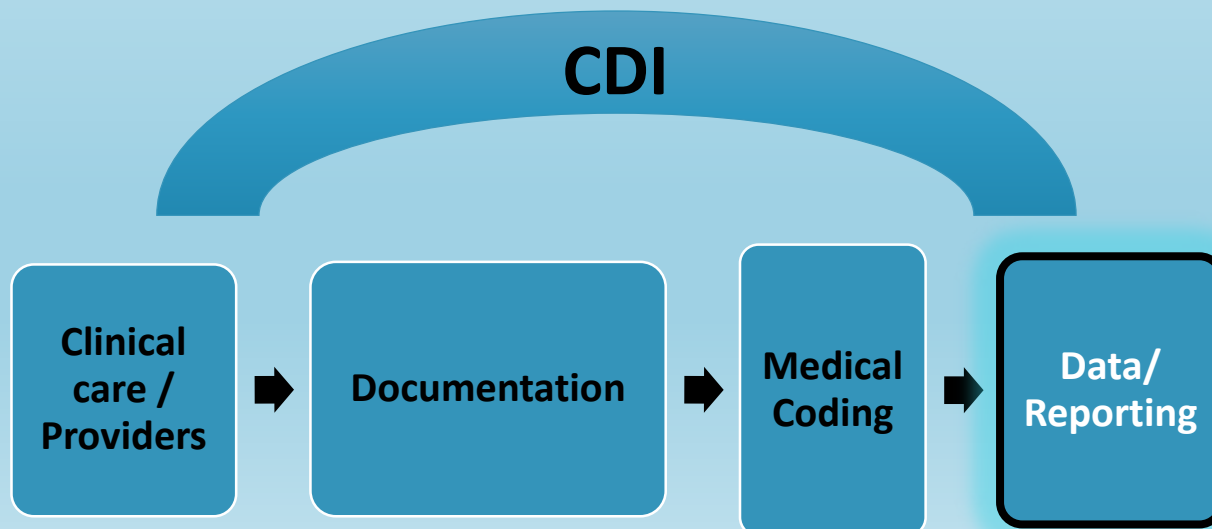


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LIHMA Presentation
April 10, 2019

DOCUMENTATION = DATA

The **coding / billing statements** created from the review of the provider's **documentation** becomes the **data** that ultimately drives many processes.

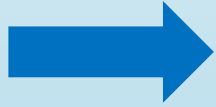
CDI's job is to ensure that the **clinical acuity** and the **effectiveness of the care provided** are **accurately documented** in order to be **coded**.



CHANGES IN THE ROLE OF THE CDI SPECIALIST

As healthcare reimbursement methodologies are changing:

Fee for Service



Pay for Performance/Value Based Purchasing

The role of the certified Clinical Documentation Specialist is also changing:

MCC/ CC capture for reimbursement



Clinical oversight of administrative billing data to ensure accurate publically reported data for both hospitals and physicians.

HOW DID THIS HAPPEN?

NATIONAL HEALTHCARE QUALITY STRATEGY

Established by the Affordable Care Act to **improve the delivery of health care services, patient health outcomes, and population health.**

LONG TERM GOALS

*Reduce preventable hospital admissions and readmissions.

(Readmissions Reductions Program)

*Reduce the incidence of adverse health care-associated conditions

(HAC Reduction Program)

*Reduce harm from inappropriate or unnecessary care

(Value-Based Purchasing / Pay 4 Performance)

Medicare

*Improve quality at same cost
(lower quality organizations
subsidize those with improved
quality. "Budget Neutral")*

Commercial payers

Additional payments for high quality

****All of these programs can result in a hospital payment penalty
Documentation is critical***

AS PART OF THE VALUE BASED PURCHASING / PAY FOR PERFORMANCE INITIATIVE,
HOSPITALS ARE EVALUATED ON:

HIGH QUALITY	LOW COST
Outcomes	Efficiency
Readmission rates Length of stay (O/E) Mortality Index (O/E) HAC'S (Hospital Acquired Conditions) PSI'S (Patient Safety Indicators) SSI'S (Surgical Site Infections)	Correct Admission status (Inpatient vs. Outpatient / Observation) Correct level of care Length of Stay Utilization & Resources (Labs, Tests)

****The metrics in red are influenced by DOCUMENTATION → CODED DATA****

OUR "TEAM APPROACH" AT STONY BROOK HOSPITAL

Clinical Documentation

Coding

Reviews chart / Queries as needed
(Notes in CDIS)

Patient Discharged

Codes chart

Queries based on coder suggestion or gives clinical explanation (no query necessary)

Suggests possible query opportunity

If query sent, adds code for query response

OR

Reconciles coded chart (Coding summary vs their notes)

If no query opportunity, saves on draft for CDI

Assesses for risk adjustment diagnoses (queries/adds documented diagnosis*)

Final decision/ Final coding

The final coding summary is a collaboration between Coding & CDI

This team approach between Coding & CDI

- Eliminates determination of “who did what”
- Enhances a positive, collaborative working environment
- Ensures accurate coding which captures:
 - Acuity of the patient
 - Proper risk adjustment

How do we know what diagnoses are important?

How exactly are we are measured?

How can we tell we make an impact?

THE BASICS

OBSERVED / EXPECTED (O/E)

- Many Quality metrics are based on ***OBSERVED*** vs ***EXPECTED*** outcomes.
- The goal is to have the **OBSERVED** outcomes meet or exceed the **EXPECTED** outcomes set forth by CMS or other Benchmarking entities.
- ***GOAL = O/E ratio be ≤ 1***
- This can only be accomplished accurately capturing the patient's acuity/complexity through clear and concise **documentation** throughout the medical encounter, and then have these diagnoses **coded**.

CLINICAL SCENARIO

69 yo M w/hx of Parkinsons, requiring nocturnal CPAP.

Presents to ED after episode of muscle spasms, tachypnea, lethargy following food intake.

O2 sats upon arrival=84%. Placed on 4 L NC, then 100% NRB, then BIPAP.

Nutrition assessment states “Meets criteria for severe protein-calorie malnutrition”

Patient’s LOS was 4 days.

QUERIES sent for acute respiratory failure (MCC/ SOI), Severe PC Malnutrition (MCC/ SOI) & type of PNA (SOI)

	BEFORE	AFTER adding acute resp fail (MCC)	AFTER adding TYPE of PNA (“likely Aspiration PNA”)	
DRG	195: Simple Pneumonia & Pleurisy w/o CC/MCC	193: Simple Pneumonia & Pleurisy w/MCC	177: Respiratory Infections & Inflammations w/MCC	
SOI/ROM	2/1	4/4	4/4	Higher risk adjustment
LOS	3.3 O/E = 1.21 (Goal ≤ 1): Did not meet	5.7 O/E = 0.70 (Goal ≤ 1): better LOS O/E	7.1 O/E = 0.56 (Goal ≤ 1): Excellent LOS O/E	Increased LOS
RW	0.7028 (\$7,028*)	1.3860 (\$13,860*)	1.8509 (\$18,509*)	Increased revenue

+\$11,481* not actual reimbursement

Assess your impact by monitoring:

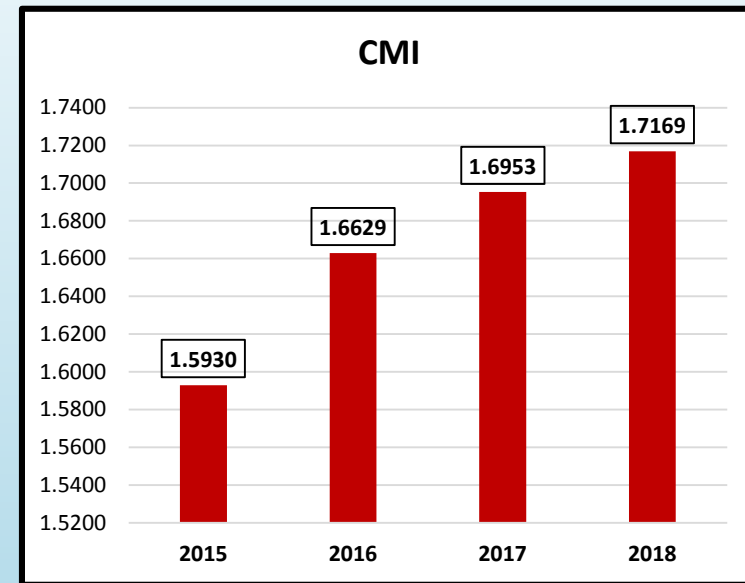
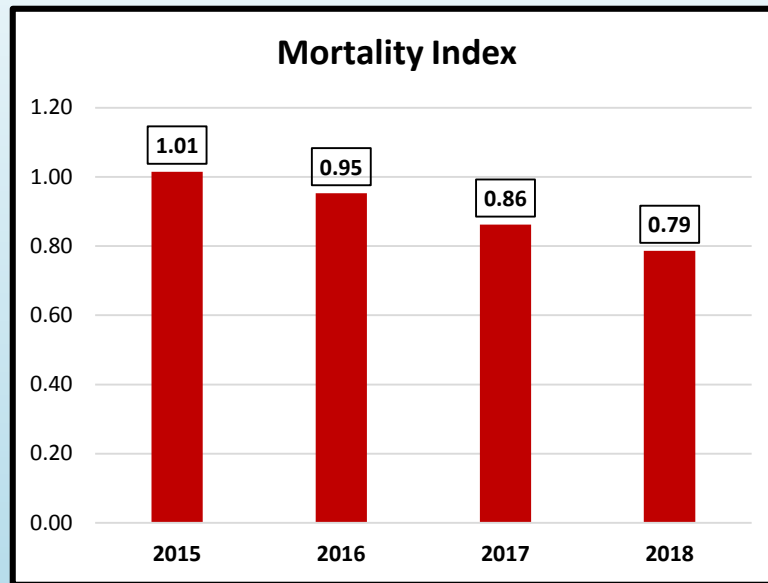
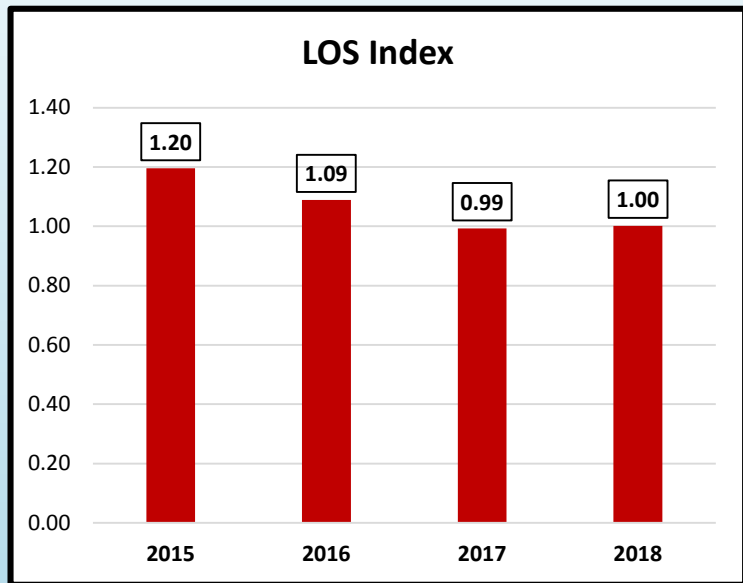
CMI (Case Mix Index)

LOS (Length of Stay)

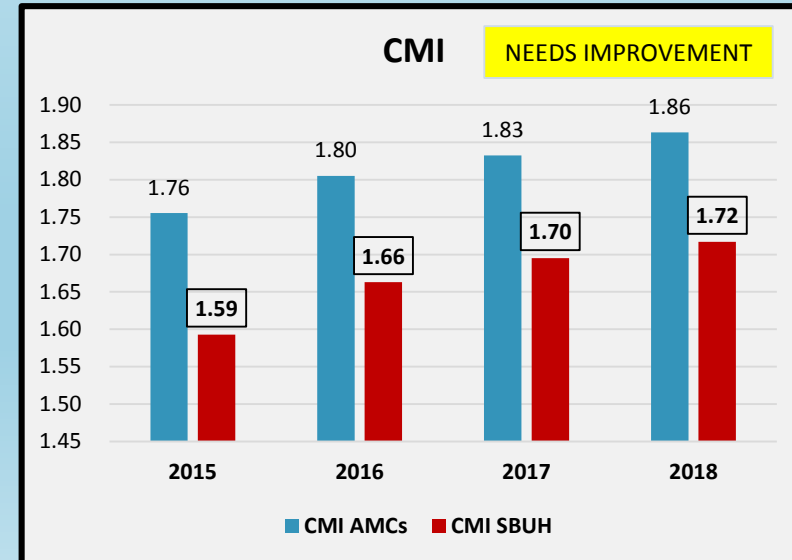
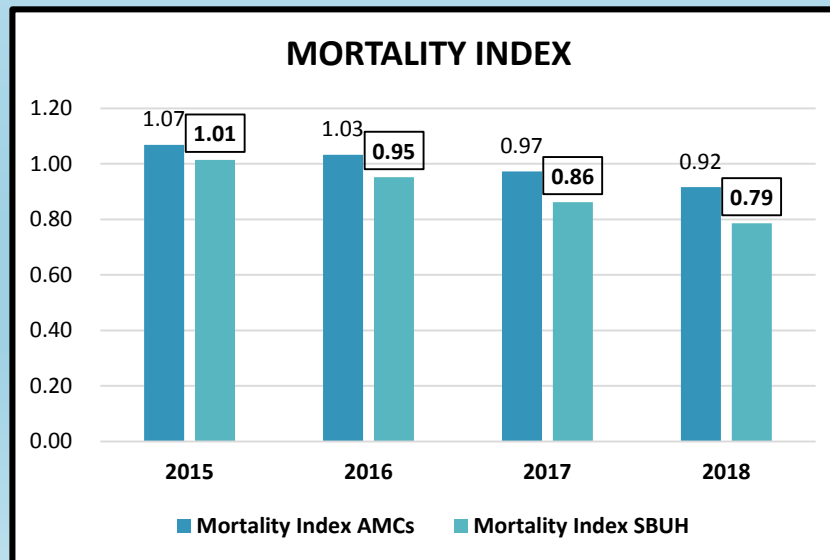
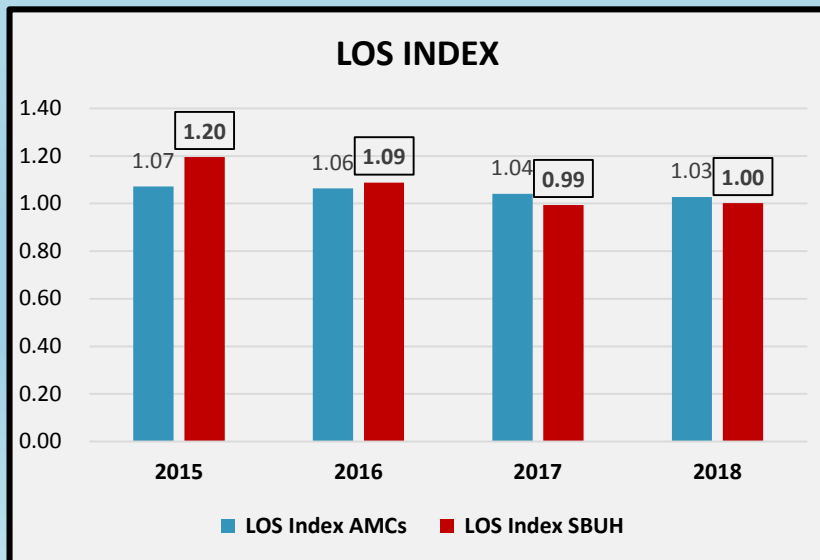
Mortality Index

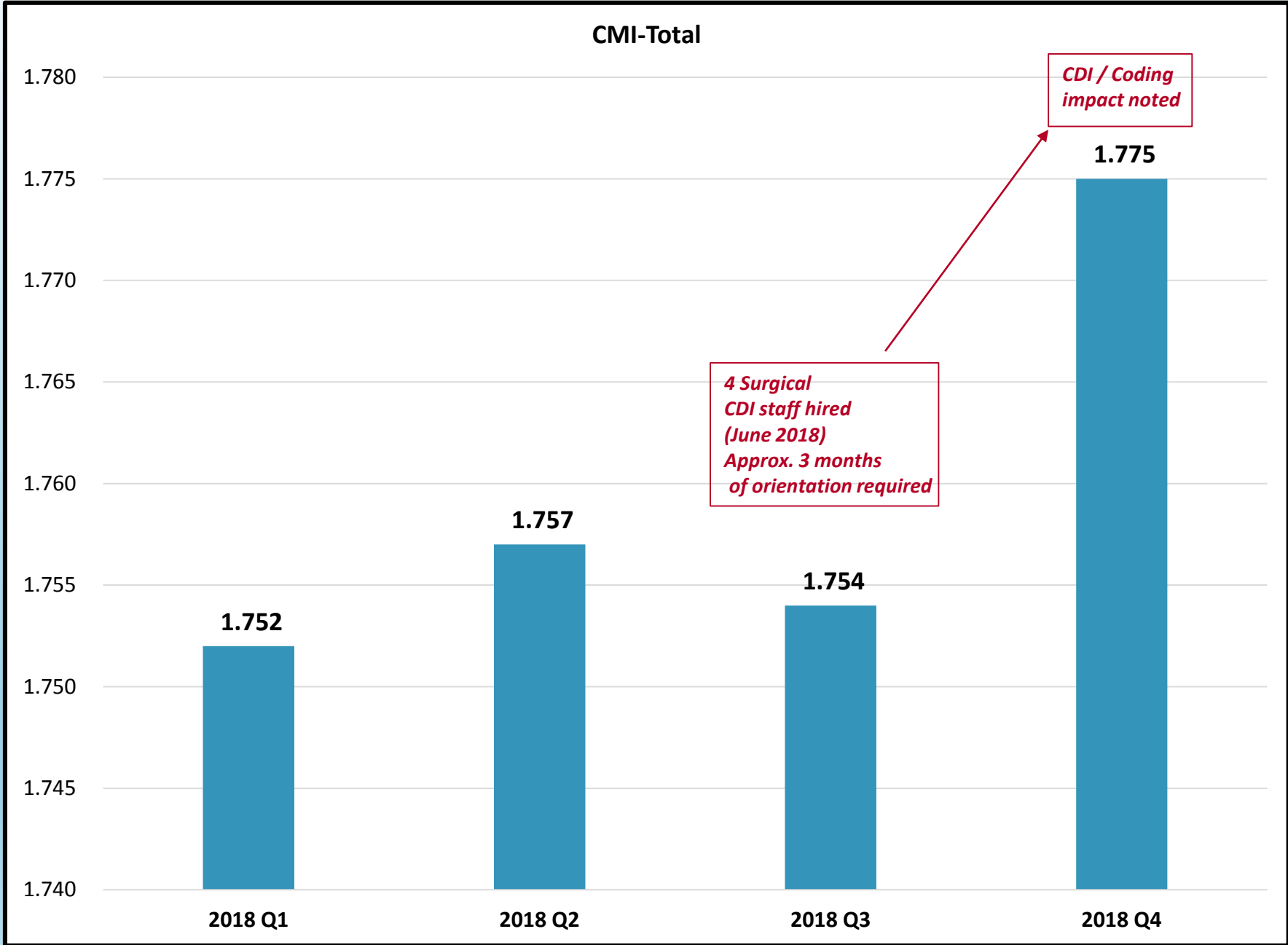
HOW DO WE COMPARE?

Stony Brook Hospital Yearly Comparison



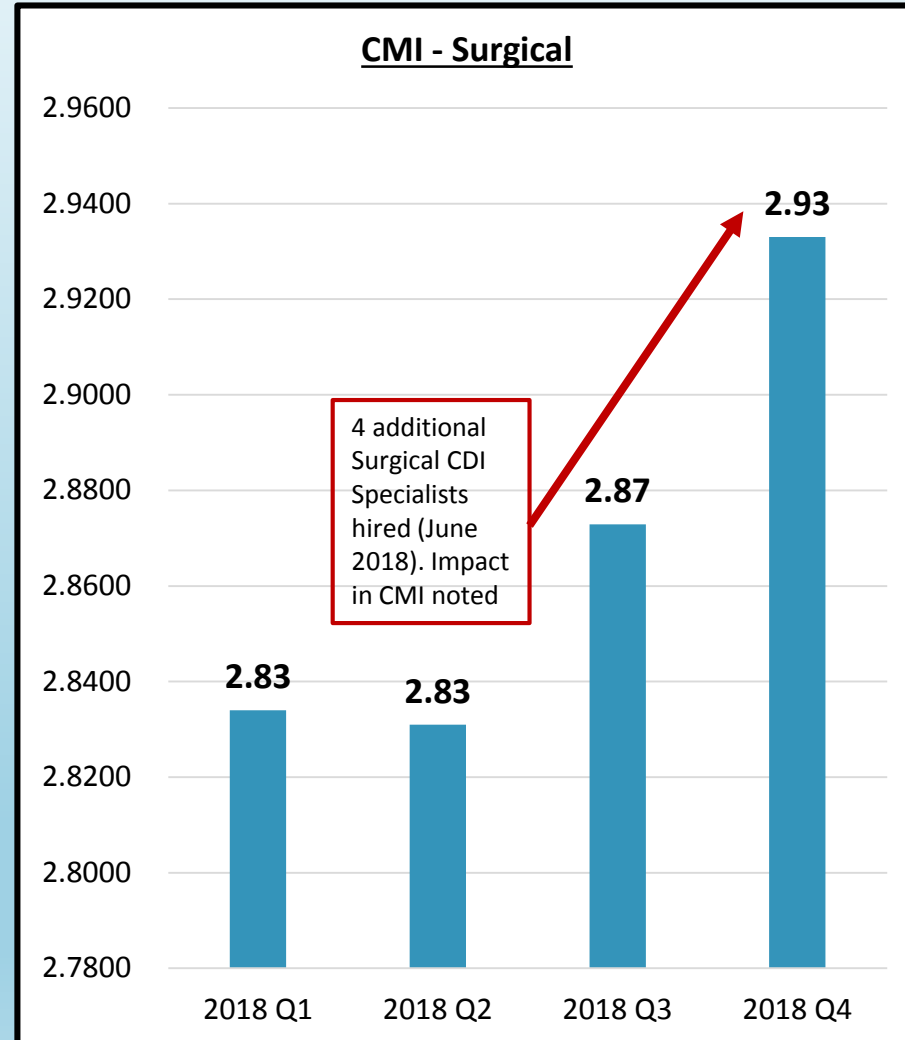
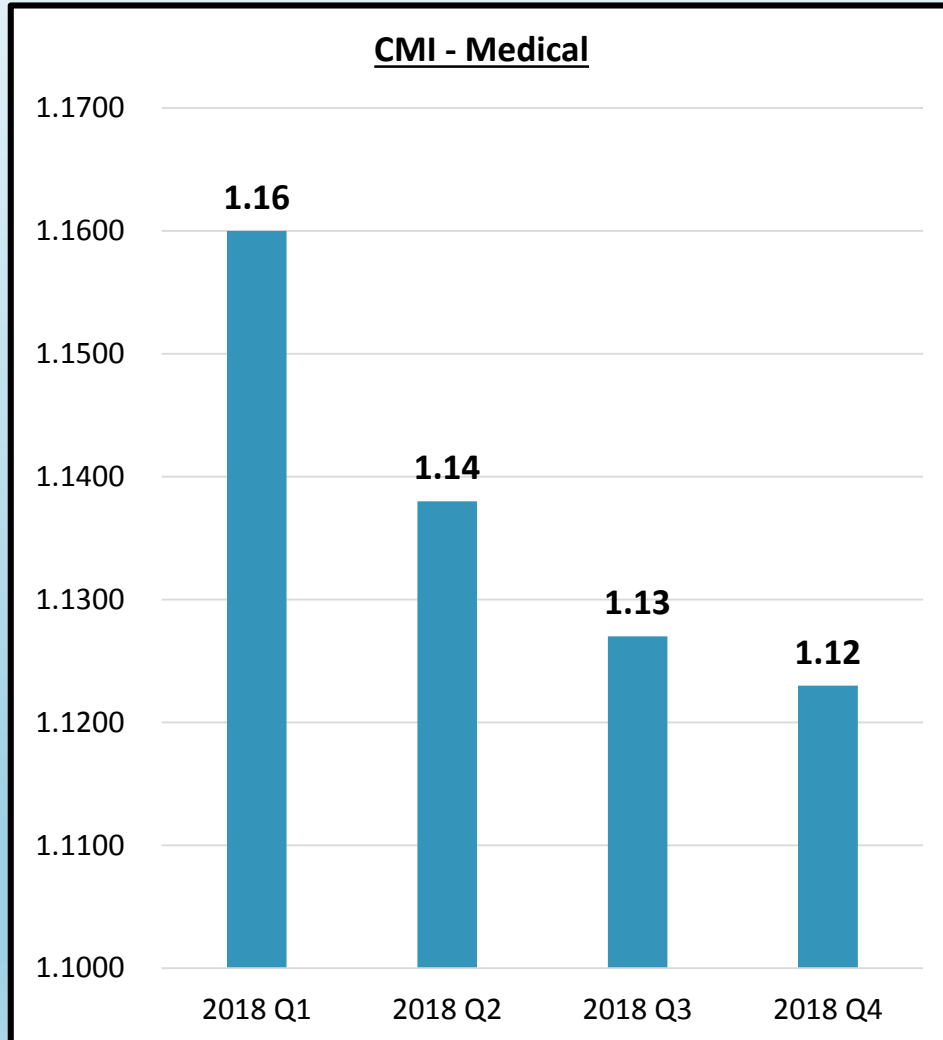
Stony Brook Hospital compared to other Academic Medical Centers





WHERE CAN WE IMPROVE?

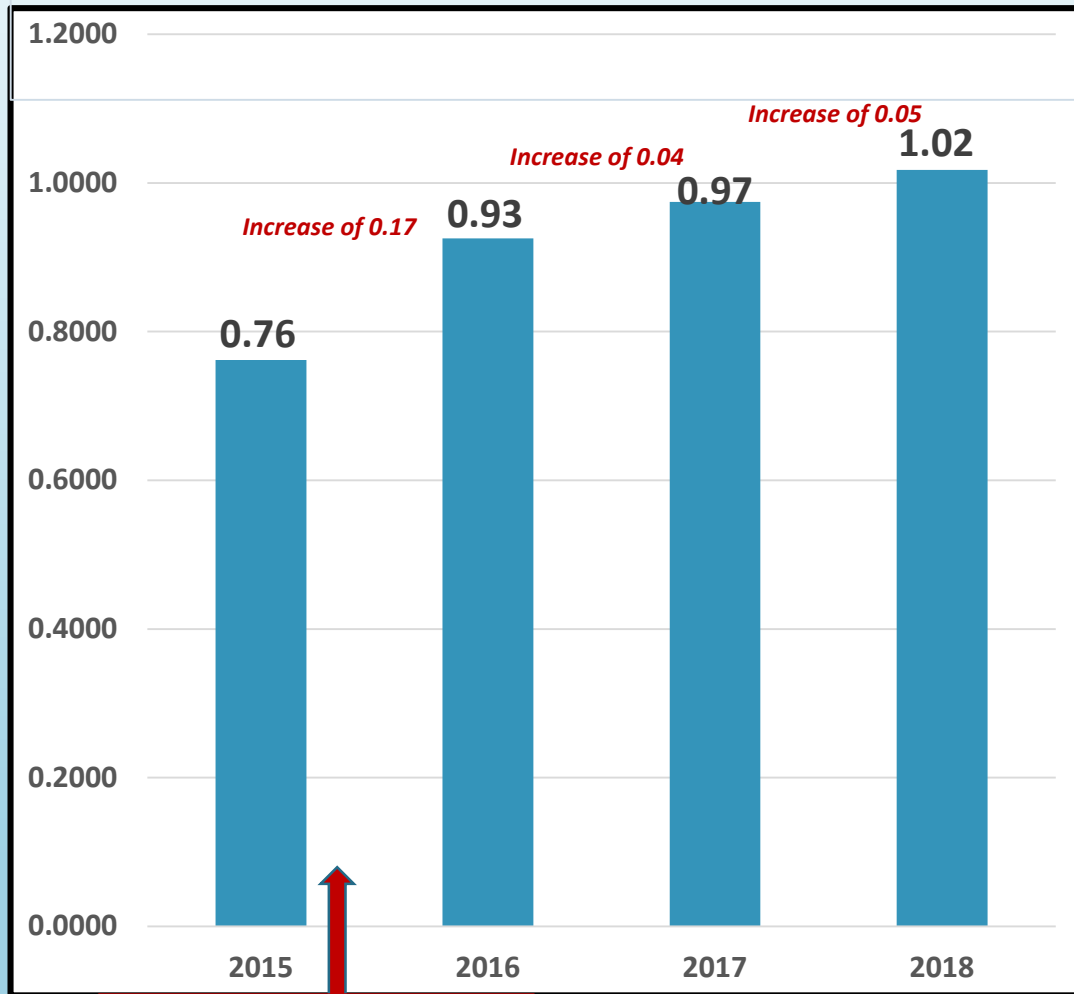
DRILL DOWN



***Analysis supports the need for more CDI coverage in Medicine**

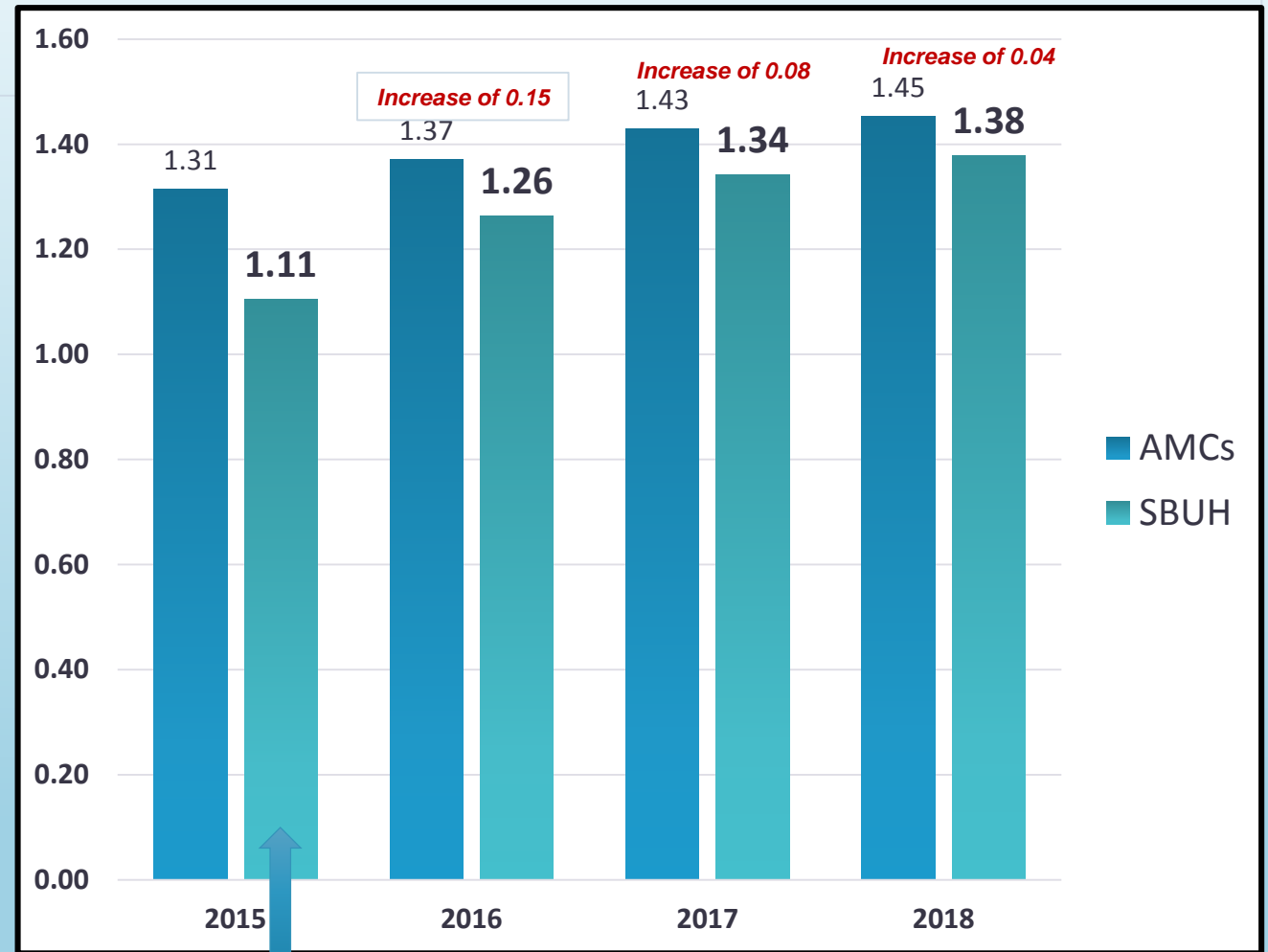
CDI & Coding's impact on PEDIATRICS

CMI: Pediatric Hospitalists (Discharge Physician)



CDI coverage begins

CMI Overall comparison for Pediatrics



CDI coverage begins

*Data from Vizient, INC.
2014 – 2015 used Risk Model 2016
2016-2018 used Risk Model 2017

DATABASES USED FOR BENCHMARKING

- **VIZIENT** (converts all payers into standard MS-DRGs)
- **CMS: Hospital Compare, Physician Compare** (mainly Medicare data)
- **Leap Frog**
- **NSQIP** (National Surgical Quality Improvement Program)
- **Service specific Databases** (STS-Adult Cardiac Surgery, HQIP-National Vascular Registry, etc.)

VIZIENT

- Compares Academic Medical Centers to allow for benchmarking
- Community Hospitals have recently been allowed to submit data for their own comparison
- Service lines are defined by set DRGs (Diagnosis-Related Groups)

***In 2016, SBUH's Overall rank = 73, Overall Score = 57.72%**

Significant efforts made between CDI, Physicians & Coding to ensure accurate documentation was present in order to be coded. This resulted in a tremendous increase in our ranking in Vizient.

2017 AMC Quality and Accountability Performance Scorecard



Stony Brook University Medical Center

Star rating	Overall rank	Overall score	Top performers
★ ★ ★	36	59.07%	MAYOCLINIC_MN 80.88%

Domain performance

CDI & CODING IMPACT:
Review 100% Mortalities

Mortality
20.92% of 26.25%

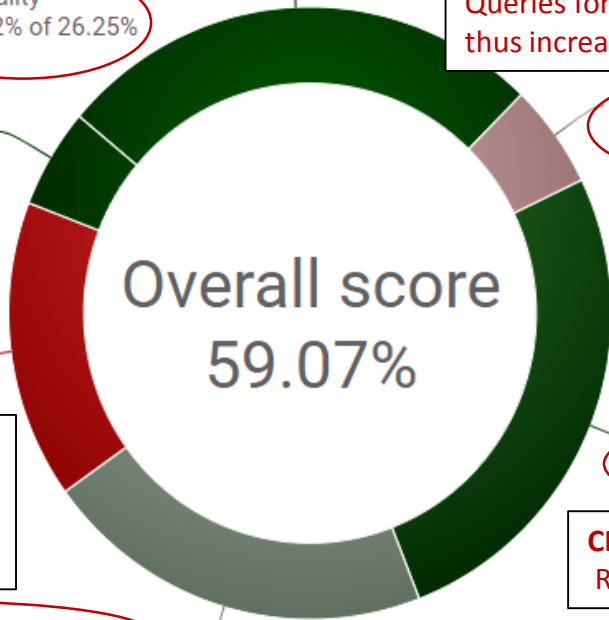
CDI & CODING IMPACT: LOS
Queries for CC/MCC to change DRG
thus increasing allowed LOS

Efficiency
2.57% of 5.50%

Equity
5.25% of 5.25%

Patient centeredness
3.58% of 15.75%

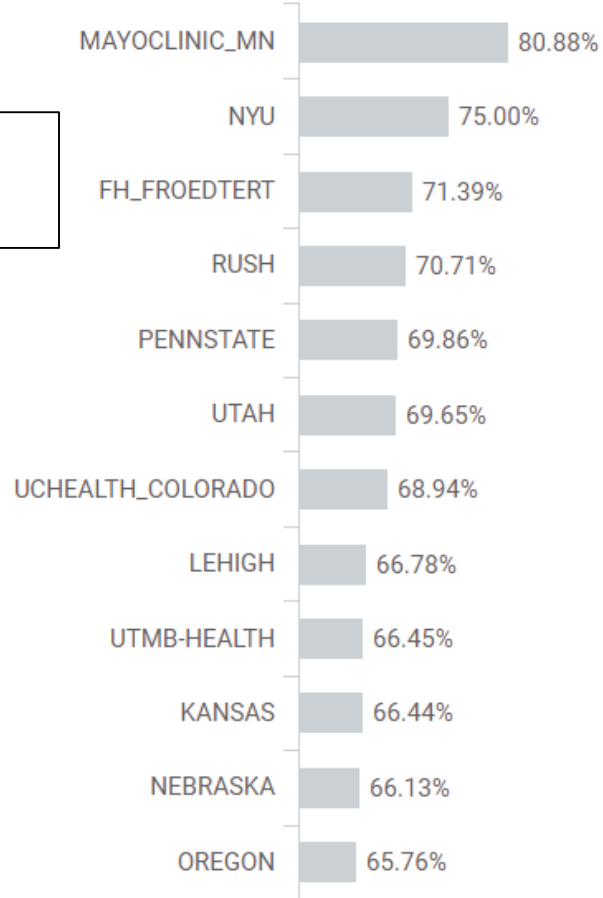
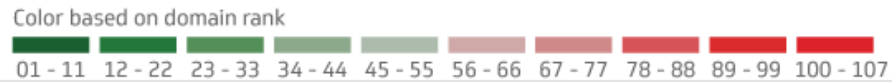
CDI & CODING IMPACT:
Ensure documentation supports planned
readmissions, core measures, admit source,
discharge disposition



Safety
16.29% of 26.25%

CDI & CODING IMPACT:
Review 100% PSI's

Effectiveness 10.47% of 21.00%



Mortality Risk Calculator for DRG 194

Simple pneumonia & pleurisy w CC

AMC Hospitals: Risk Modeling Summary for CDB 2017

Outcome: Mortality

Model Group: 66 ← Select model group from drop-down list

Simple pneumonia & pleurisy w MCC (MSDRG 193), Simple pneumonia & pleurisy w CC (MSDRG 194), Simple pneumonia & pleurisy w/o CC/MCC (MSDRG 195)

Explanatory Variables	Value	Coefficient
Intercept	1	-6.396
Metastatic Cancer		1.808
Liver Failure		1.388
Leukemia		1.347
Respiratory Failure		1.310
CMV		1.144
Myelodysplasia		1.097
Non-Invasive Mechanical Ventilation on Admission Day		1.051
Respiratory Condition due to External Agent		0.917
Female, Age >= 85		0.903
Lymphoma		0.877
Admit Source = Transf From Skilled Nursing/Long Term Care		0.814
Altered Mental State w/o Coma		0.759
Male, Age >= 85		0.747
Other Pulmonary Conditions		0.737
Malnutrition		0.731
Debility		0.701
Pancytopenia/Aplasia		0.693
Primary GI Cancer		0.691
Admit Source = Transf From Acute		0.639
Dementia		0.568
Male, 80 <= Age < 85		0.559
Encephalopathy		0.473
Acute Renal Failure		0.437
Fluid & Electrolyte Disorders		0.417
Cardiac Arrhythmia		0.414
Cardiomyopathy		0.387
CHF		0.244
Male, 31 <= Age < 51		-0.767

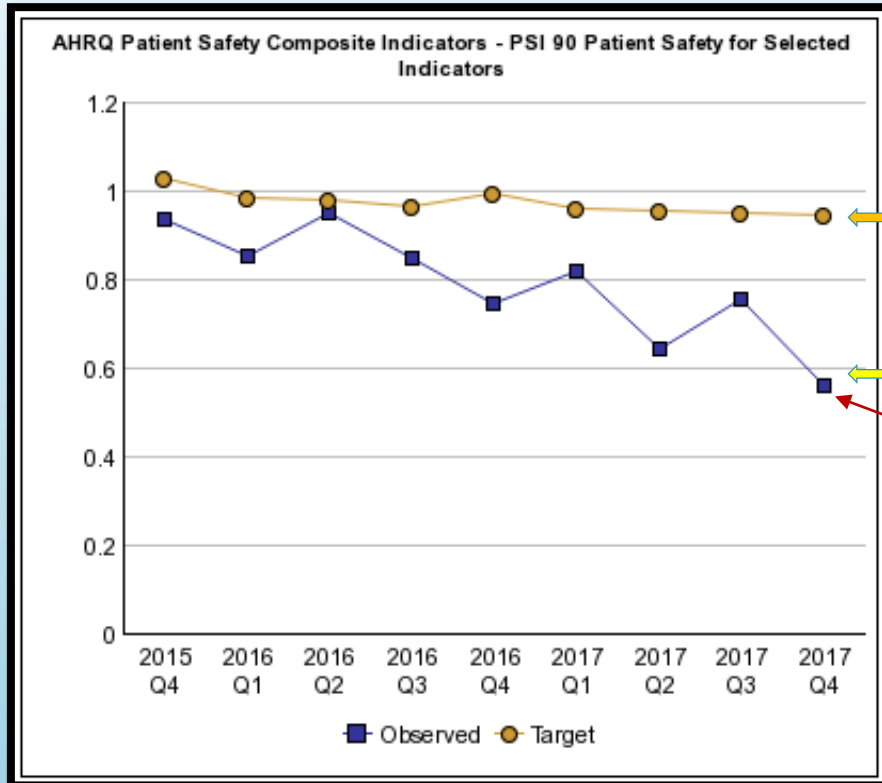
Expected Mortality	
Mean Expected Mortality	0.014
Expected Mortality for this patient	0.002
Expected Mortality relative to model group	0.116

EXPECTED

OBSERVED

- Behind each of these variables can be many diagnoses
- Only 1 can be submitted for each variable
- Each variable must be *present on admission*
- The variables combine to make up the **OBSERVED** in the O/E calculation
(goal is to be higher than the EXPECTED)

PSI 90 Improvement



TARGET (Vizient): 0.95

TOP DECILE: 0.59

STONY BROOK MEDICINE: 0.56
****TOP DECILE RANKING****

Lower is better
We ranked 7th out of 151 Hospitals for Q4 2017

Oct - Dec 2017 (Q4)						
Relative Performance		Denom (n)	Observed	Target	Rank	
Current Quarter			0.56	0.95	7/151	
Population						
Observed	Value	10th	25th	50th	75th	90th
	0.56	0.59	0.67	0.81	0.95	1.03
						Mean 0.82

***STONY BROOK MEDICINE**
 (lower is better)

TOP DECILE

CMS

HOSPITAL COMPARE / PHYSICIAN COMPARE

- The overall rating shows how well each hospital performed, on average, compared to other hospitals in the U.S.
- The most common overall rating is 3 stars.
- Data is reported to CMS through the Hospital Inpatient Quality Reporting Program (IQR)
- The overall rating summarizes up to **57 quality measures**.
- Hospitals may perform more complex services or procedures *not reflected* in the measures on Hospital Compare.



CMS: HOSPITAL COMPARE Quality Metrics

Mortality (7)	Death rate for heart attack patients
	Death rate for coronary artery bypass graft (CABG) surgery patients
	Death rate for chronic obstructive pulmonary disease (COPD) patients
	Death rate for heart failure patients
	Death rate for pneumonia patients
	Death rate for stroke patients
	Deaths among patients with serious treatable complications after surgery
Safety of Care (8)	Central line-associated bloodstream infections (CLABSI)
	Catheter-associated urinary tract infections (CAUTI)
	Surgical site infections from colon surgery (SSI: Colon)
	Surgical site infections from abdominal hysterectomy (SSI: Hysterectomy)
	Methicillin-resistant Staphylococcus Aureus (MRSA) Blood Laboratory-identified Events (Bloodstream infections)
	<i>Clostridium difficile</i> (C.diff.) Laboratory-identified Events (Intestinal infections)
	Rate of complications for hip/knee replacement patients
	Serious complications

Readmission (9)	Hospital Return Days for heart attack patients
	Rate of unplanned readmission for coronary artery bypass graft (CABG) surgery patients
	Rate of unplanned readmission for chronic obstructive pulmonary disease (COPD) patients
	Hospital return days for heart failure patients
	Rate of unplanned readmission after hip/knee surgery
	Rate of unplanned readmission for pneumonia patients
	Rate of unplanned readmission for stroke patients
	Rate of unplanned readmission after discharge from hospital (hospital-wide)
	Rate of unplanned hospital visits after an outpatient colonoscopy
Patient Experience (11)	Patients who reported that their nurses communicated well
	Patients who reported that their doctors communicated well
	Patients who reported that they received help as soon as they wanted
	Patients who reported that their pain was well controlled
	Patients who reported that staff explained about medicines before giving it to them
	Patients who reported that their room and bathroom were clean
	Patients who reported that the area around their room was quiet at night
	Patients who reported that they were given information about what to do during their recovery at home
	Patients who understood their care when they left the hospital
	Patients who gave their hospital a rating on a scale from 0 (lowest) to 10 (highest)
	Patients who would recommend the hospital to their friends and family

CMS: HOSPITAL COMPARE

www.medicare.gov/hospitalcompare

- | | |
|------------------------------------|---------|
| • NYU | 4 stars |
| • New York-Presbyterian Hospital | 4 stars |
| • Stony Brook Medicine | 3 stars |
| • St. Charles Hospital | 3 stars |
| • John T. Mather Memorial Hospital | 3 stars |
| • Huntington Hospital | 3 stars |
| • NYU Winthrop Hospital | 3 stars |
| • St. Catherine of Siena Hospital | 2 stars |
| • North Shore University Hospital | 2 stars |
| • Brookhaven Memorial Hospital | 2 stars |
| • Southside Hospital | 2 stars |
| • Peconic Bay Medical Center | 2 stars |
| • Good Samaritan Hospital | 1 stars |

*Some of the measures used to calculate the overall rating are based only on data from **Medicare patients** and some are based on data from all patients. The claims-based measures, which include the mortality, readmission, complications, PSI-90, imaging efficiency, and unplanned hospital visits measures, are calculated using Medicare fee-for-service (FFS) hospital claims data only. The process of care, healthcare-associated infection (HAI), and HCAHPS Survey measures include data from all payers.*

LEAP FROG

<http://www.hospitalsafetygrade.org>

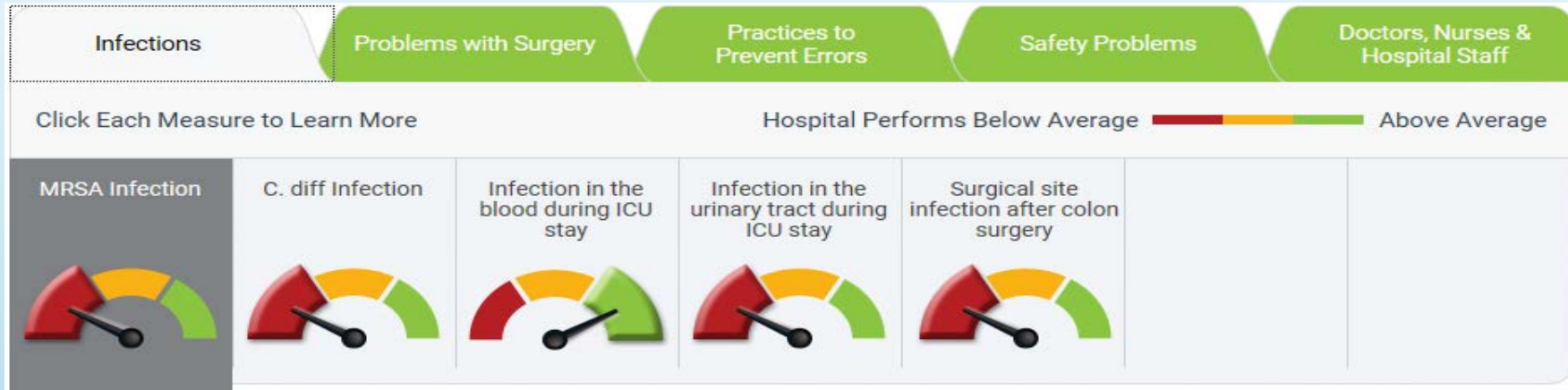


- **HOSPITAL SURVEY:** Hospitals **voluntarily** submit data by completing the Leapfrog Hospital Survey.
- **HOSPITAL SAFETY GRADE:** Hospitals with available data are given grades **regardless of participation in the Survey.** The Safety Grade includes data from CMS, the Survey if available, and the American Hospital Association.

LEAP FROG

LEAPFROG
HOSPITAL
SAFETY GRADE

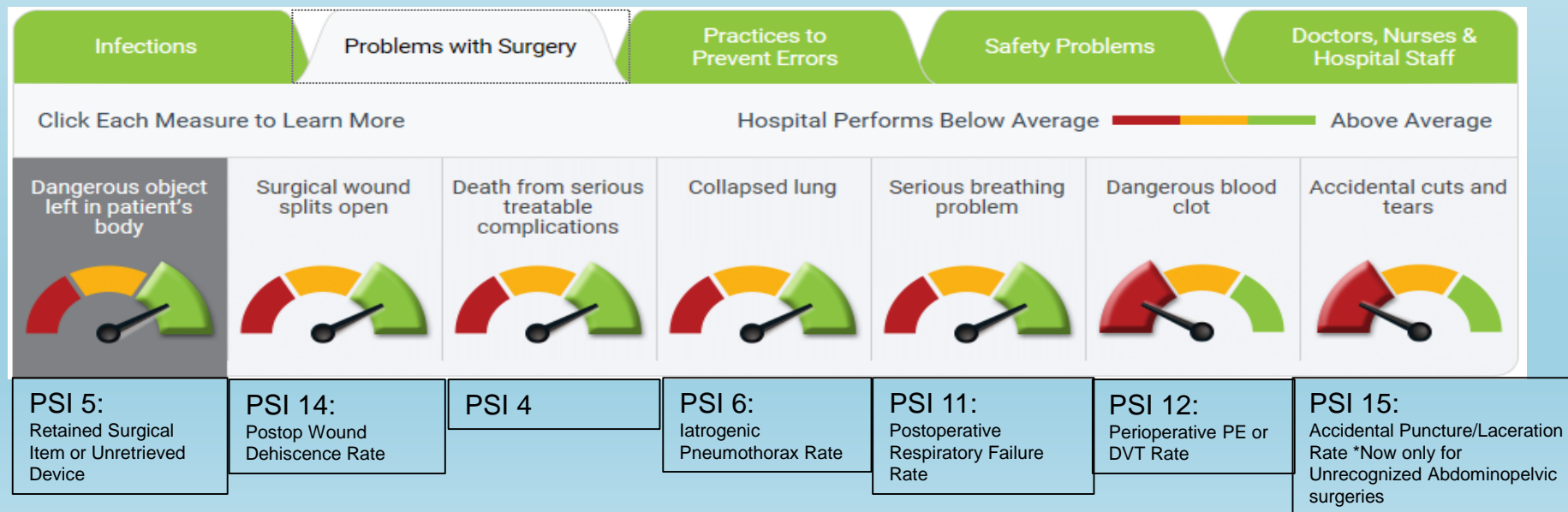
OUTCOME MEASURES (15)	
Measure Name	Primary Data Source
Foreign Object Retained	Data.cms.gov
Air Embolism	Data.cms.gov
Falls and Trauma	Data.cms.gov
CLABSI	2016 Leapfrog Hospital Survey
CAUTI	2016 Leapfrog Hospital Survey
SSI: Colon	2017 Leapfrog Hospital Survey
MRSA	2017 Leapfrog Hospital Survey
C. Diff.	2017 Leapfrog Hospital Survey
PSI 3: Pressure Ulcer	CMS Hospital Compare
PSI 4: Death Among Surgical Inpatients	CMS Hospital Compare
PSI 6: Iatrogenic Pneumothorax	CMS Hospital Compare
PSI 11: Postoperative Respiratory Failure	Data.cms.gov
PSI 12: Postoperative PE/DVT	CMS Hospital Compare
PSI 14: Postoperative Wound Dehiscence	CMS Hospital Compare
PSI 15: Accidental Puncture or Laceration	CMS Hospital Compare



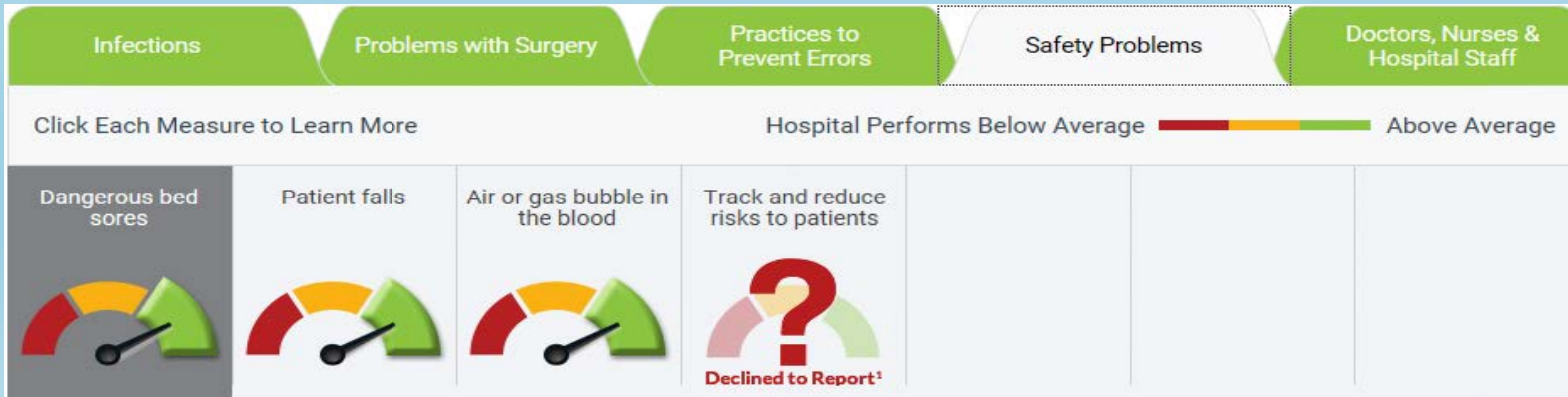
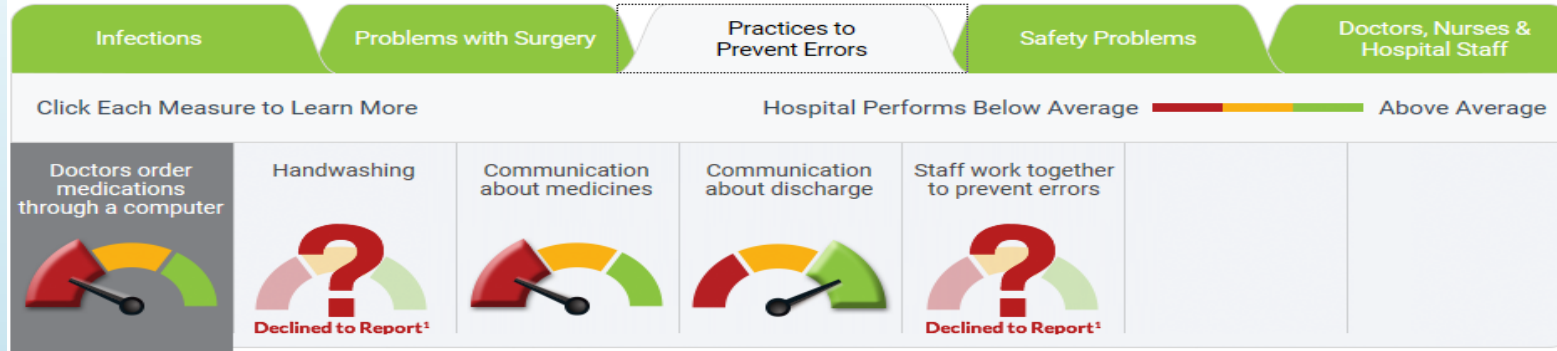
CLABSI

CAUTI

SSI



LEAPFROG HOSPITAL SAFETY GRADE



Collaboration between Physicians/Providers Clinical Documentation Specialists & Coders is Critical to Success

- Clinical documentation & accurate Coding has long been recognized as a key opportunity for **improving reimbursement capture** and **safeguarding operating margins**.
- With increasing **public reporting** and **integration of performance metrics** into provider reimbursement, the quality risks of poor documentation have become further magnified.

Quality Documentation Supports Your Quality of Care

Improved
Quality Outcomes



Improved Hospital &
Physician
Performance Statistics

QUESTIONS?