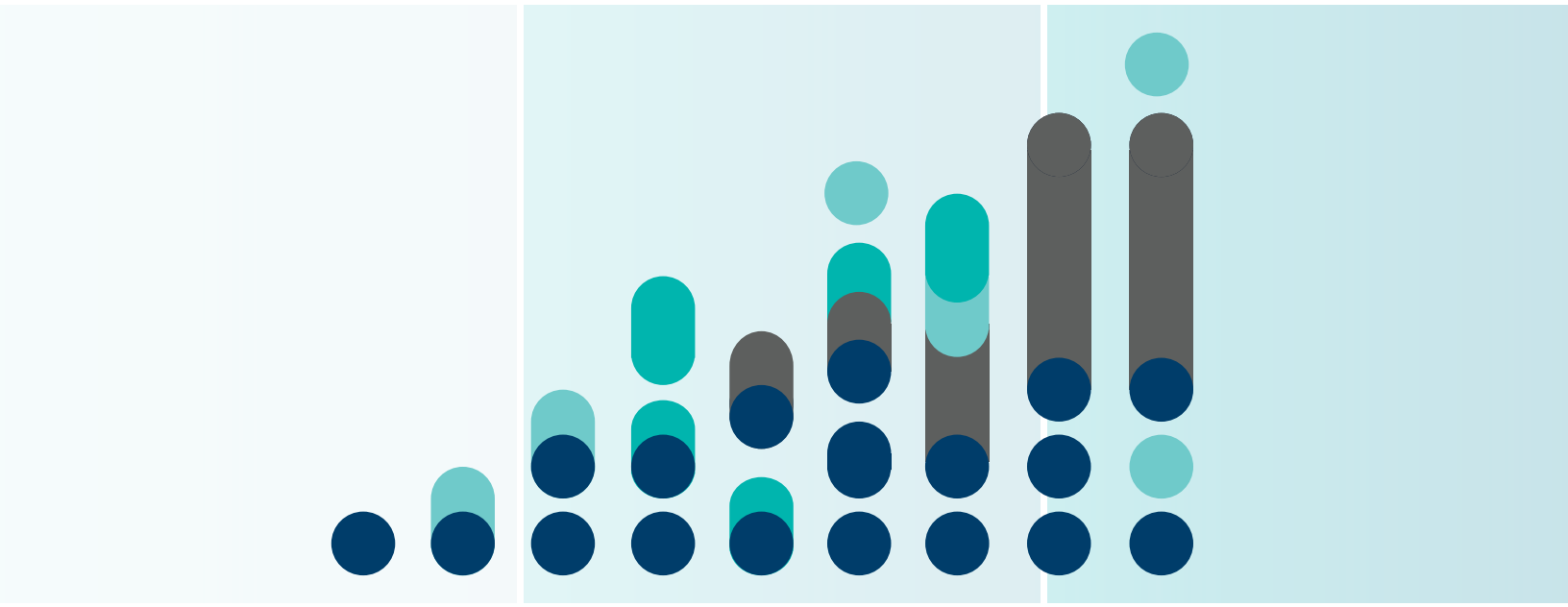
Insights on how to advance your quality rankings.



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Overview

Since the 2001 publication of the Institute of Medicine's *Crossing the Quality Chasm*, which critiqued the healthcare system and called for the creation of new performance standards and evidence-based practice, healthcare has been reinventing how it measures the quality of care.

In the decades since, changes to regulations and reimbursement structures have also prompted various ways of measuring and assessing quality. And consumer empowerment has created a demand for ways patients can have a more transparent view of medical services.

Today, several healthcare quality metrics and ratings can be found online. But the process of publicly measuring healthcare quality is still a complicated one. For example, because each rating system uses a different methodology, they do not come to the same conclusions. In an example reported by Chicago Booth, the Johns Hopkins Hospital was ranked in 2019 as the No. 3 hospital in the country by *U.S. News & World Report* and received a top-5-percent designation from Healthgrades. But it received a B in the fall from Leapfrog and only three stars from the Centers for Medicare and Medicaid Services (CMS).

The challenge for hospital executives is to understand their scores — and identify opportunities for improvement.

With so many different metrics and programs, healthcare organizations can be challenged to determine where they may be falling short. UASI can help organizations improve their quality rankings by providing experience based knowledge on the various quality programs, challenges, and best practices.

Stars, Letters, and Rankings: How Quality Scores Stack Up

There are a variety of organizations and approaches that assess healthcare quality through publicly reported data. Each entity has different methodologies, sources of data, and ways that it assesses a healthcare organization. For example:

CMS Hospital Compare uses a star rating system and assigns stars to hospitals. Hospitals report data through programs such as:

- Hospital Inpatient Quality Reporting (IQR) Program
- Hospital Readmission Reduction Program (HRRP)
- Hospital-Acquired Condition (HAC) Reduction Program
- Value-Based Purchasing (VBP) Program

There are 48 measures in five categories. CMS calculates a weighted average to combine the five group scores into a single hospital summary score.

Healthgrades analyzes Medicare patient care records (MedPAR data) for nearly 4,500 acute care hospitals nationwide. It assesses hospital performance relative to 32 common condi-

tions and procedures (called cohorts), plus two cohorts using all-payer data available for 16 states. Individual risk models are constructed for each of the 34 conditions or procedures relative to each specific outcome. "Star" ratings are assigned to providers, and patients may leave reviews.

Leapfrog Hospital Safety Grades are assigned to more than 2700 general acute-care hospitals across the nation. The Leapfrog Group uses up to 27 national performance measures from CMS, the Leapfrog Hospital Survey, and other supplemental data sources. Looking at both process/structural measures and outcomes, Leapfrog assigns a single letter grade to represent a hospital's overall performance relative to patient safety.

U.S. News & World Report releases its ranking of the best hospitals annually. Each hospital meeting the rating criteria is assigned to one of three overall performance categories: high performing, average, and below average. Its data sources include Medicare claims, Medicare Hospital Compare, publicly available clinical registries, and external designations. U.S. News uses the Elixhauser Comorbidity Index developed by AHRQ in its adjustment model for specialty rankings.

Why Quality Rankings Matter

Hospital ranking metrics are tied to reimbursement levels, where poor performance can lead to financial penalties and good performance can boost reimbursement or incentive payments from CMS. The rankings can have an impact on public perceptions, too, as consumers increasingly turn to reviews and rankings to make decisions about their care. In fact, we all know someone who looks at doctor reviews online as a first step when being referred. Even those over 70 years of age often rely on these reviews when seeking care.

The challenge for hospital executives is to understand their scores–and identify opportunities for improvement.

In many cases patient documentation can help tell the story, and one of the most valuable tools is clinical documentation integrity (CDI).

What is CDI?

The Association of Clinical Documentation Integrity Specialists defines CDI as the process of reviewing and making changes to clinical documentation in collaboration with clinicians to capture clinical severity to support the level of service rendered to patient populations, as well as evaluating how the health record translates into coded data and making sure missing, unclear, or conflicting documentation is clarified.

CDI specialists can help organizations find and correct missing or unclear documentation. This can support not only the quality reporting process but also provides a complete and accurate picture of a patient's health. CDI also supports reimbursement, research, education, and evaluating the appropriateness of patient care, according to the American Health Information Management Association.

"Where you shine the light is what you see."

Read our feature on page five to find out how one organization significatly improved its quality scores.

How Documentation Can Help: A Case Study

A close look at CDI and coding practices, along with a strong partnership between CDI and clinicians, can yield helpful results. For example:

UASI CDI auditors reviewed documentation specifically looking for an accurate and complete picture of expired patients to understand how the data was reflected in a hospital's Healthgrades reporting. They reviewed data on mortality for patients based on criteria such as:

- **Present on Admission (POA) Status**
- **Do Not Resuscitate (DNR) Status**
- **Admission Source**
- **Principal Diagnosis Selection**
- **Comprehensive and specific ICD-10-CM Codes**
- **Inclusion in the First 25 Diagnoses**
- **Review of Severity of Illness (SOI)/Risk of Mortality (ROM) Scores**
- **Any additional opportunities impacting Healthgrades**

Outcomes:
Seventy-five patient records and 1,000 POA indicators were reviewed. Of 70 POA opportunities, top topics included: DNR Status, Palliative Care, and Acute Respiratory Failure. They noted that 10 DNR statuses were not captured, and six cases had the opportunity for DNR to be captured. In addition, 70 ICD codes were not included in the first listed 25 diagnoses; in 20 cases, moving the ICD codes up would affect Healthgrades data. Further, there were 12 cases with a SOI/ROM score less than 4/4, suggesting opportunity for improvement in accurately representing patients' severity of illness and risk of mortality. Overall, UASI identified 150 opportunities for additional ICD codes that would affect Healthgrades data.

Best Practices for Unraveling the Web of Quality Scores

Unraveling the web of quality scores will take focus. Because each ranking system is slightly different, organizations should prioritize rather than try to accomplish everything at once. Which areas are the most important to address and what can be addressed first? Are there quick wins that can be gained or is a more systematic change needed?

Based on our experience, we recommend the following best practices:

Bolster your CDI program. CDI can be a helpful tool in identifying areas where documentation is lacking and developing new tools and templates to capture important data in a structured, consistent way.

Clarify focus and intent. Make an organizational commitment and structure to improve quality scores. Prioritize your areas of focus. Take a proactive, not a reactive, approach. (Read our feature on page five to find out how one organization significatly improved its quality scores.)

Collaborate. Create multidisciplinary teams to implement best practices. Involve all stakeholders to ensure collaboration and build better relationships between departments. Include the quality, CDI, health information management (HIM)/coding, and billing teams and end users (i.e., providers). Enlist champions to support and engage others in rolling out changes and educating colleagues on the need to recognize and document specific diagnoses.

Build evidence-based medicine (EBM) guidelines into CDI processes. Building EBM guidelines into documentation queries can help the process feel more

relevant to physicians. EBM can also be built into training for CDI specialists, coders, and physicians to support commonly queried diagnoses. A regular review of EBM guidelines can help keep documentation processes up to date.

Critical Steps to Improve Your Scores

Do not wait until a falling quality score causes a problem. To get a handle on and improve your quality scores, important steps include:

- **Find and understand your data. We provide a customized report for your organization to review.**
- **If your scores aren't as high as you'd like, perform a gap analysis to determine what to work on.**
- **Identify areas for improvement and actions to take to unravel the web.**
- **Develop a documentation template, pilot it, and work to build clinician support. Make regular coaching part of your best practices. This should be done based on the standards you want to measure.**

How One Health System Improved its Scores

"Where you shine the light is what you see."

Staff at a large state academic health system, comprising 16 hospitals and five institutes, addressed issues with their quality accountability scorecard. "We saw that our observed expected mortality rates for the neurology service line were in the lowest quartile of performance," said a staff representative. Looking closely at their expected mortality documentation, they found "we were missing things…and the answer is almost always documentation," a staff member said. "Because if you just give somebody a big blank sheet of paper, you're never going to get the same thing twice, right?"

A more structured approach to documentation was needed. Led by a cross-functional team, the organization went through a process of collaborating and improving processes to better understand its documentation issues and find solutions.

What they did:

Included a variety of stakeholders. The team included quality, CDI, HIM, and other stakeholders to design the template with input from users. "You have to have the people who are going to use it buying in," a staff member said.

Built a template. The team decided to create a multi-value tool that would capture many kinds of information they needed for multiple public reporting purposes.

Educated users. Looking through their documentation, staff found that other academic medical centers were diagnosing sepsis three times more often. Their own doctors were not coding sepsis unless it was a very severe case. The team educated their clinicians on when sepsis was appropriately coded.

Engaged champions. The team found physician champions who were already aware of quality measures to participate in testing and training and to spread the word among their leadership, teams, and fellows. These champions could tell the story of why the templates were necessary—to improve quality.

Set goals from the top down. The organization ensured that use of the templates was built into the medical staff incentive program for the year. Their goal was to ensure that the template usage was over 90 percent.

Built relationships across departments. Team members described this as an unforeseen benefit. “We had to really partner and make sure that we had good checks and balances,” one staff member said. “But it’s nice to have that relationship where we could try things out.”

Repeated the process as necessary. Different medical areas will need different templates and tools. The development, education, and engagement process could be repeated for as many quality measures as needed.

The organization is now scoring in the upper quartile of its performance measures.

To understand your scores and get insights on where you can improve, contact UASI.
Go to uasisolutions.com/quality-scores to request a free report with your quality scores.

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About UASI

UASI is a leading national provider of revenue cycle solutions that help healthcare organizations receive proper reimbursement for the care they provide. With nearly 40 years of experience in coding, clinical documentation integrity (CDI), and revenue integrity solutions, UASI staff members are the industry’s most experienced and credentialed professionals. UASI offers full-service consulting to identify inaccuracies and strategic solutions to drive coding and documentation quality improvements.

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