Learning Objectives

• At the completion of this educational activity, the learner will be able to:
  – Identify the impact of Potentially Preventable Complications (PPC) on quality scores and reimbursement
  – Differentiate PPCs from hospital-acquired conditions (HAC) and Patient Safety Indicators (PSI)
  – Understand basic methodology of PPCs
  – Identify key PPCs and challenges with improving SOI/ROM and reimbursement while ensuring accurate quality profiles

Steps for Attendees to View/Answer
POLLING QUESTIONS

1. Navigate to the event Agenda in the main menu
2. Tap the name of the current session to view the session details page
3. Tap Polls
4. Tap the name of the poll
5. Tap your answer choice and then tap Submit
Polling Question 1

• Our institution queries POA status of diagnoses when:
  A. It affects principal diagnosis selection
  B. It affects assignment of a condition as a hospital-acquired condition (HAC)
  C. When the condition would reflect negatively on the institution if it was not POA

  ➢ A only
  ➢ A and B only
  ➢ All of the above

The Quality Problem

• Hospitals are challenged in obtaining accurate and representative quality data
• Hospitals are challenged with documentation’s impact on profiles and quality metrics, higher than expected death rates, and violations of the two midnight rule
• Physicians, CDI specialists, HIM staff, and quality departments need training on documentation requirements for accurate capture of PSI, HAC, SOI, ROM, PPR, PPC, and PPP
• Health reform
• Shifting of care settings to outpatient, post-acute, home health, etc.
• Lower reimbursement
• Increased regulation
• Cutting of non-clinical headcount
• Public & business perception

How Is Quality Measured?

• Based on outcomes, reported conditions, morbidity, mortality, length of stay, and resource consumption
• Most quality tools utilize ICD-9-CM/ICD-10-CM/PCS codes to obtain list of reported conditions
• An accurate quality profile can only be obtained through complete, accurate, and compliant documentation
• Without monitoring, there is lost ability to maintain or improve quality
What Is the Impact?

• "Medicare Payment for Selected Adverse Events: Building the Business Case for Investing in Patient Safety":
  - Medicare pays hospitals for adverse events occurring during hospitalization; an estimate for the five types of adverse events accounted for 0.27 percent of the total Medicare hospital spending of $117 billion in 2002.

• 758 hospitals fined via HAC reduction program in the second year of the program with over 400 of those having been fined for the second consecutive year. In total, Medicare estimates the penalties will cost hospitals $364 million.

What Is the Impact?

Should it then be any surprise that commercial payers and state Medicaid regulatory agencies and will utilize similar criteria and metrics for assessing hospital performance and decreasing payments?

Comparison of Hospital-Acquired Conditions (HAC), Patient Safety Indicators (PSI), and Potentially Preventable Complications (PPC)
Hospital-Acquired Conditions

• Deficit Reduction Act of 2005 (DEFRA) was signed into law and stipulates:
  – Regulations that require a hospital to report a "present on admission" indicator for each secondary diagnosis reported
  – Conditions that are not present on admission can be targeted as hospital-acquired conditions (HAC)
  – Certain secondary diagnoses that develop after admission to the hospital are considered to be avoidable, and therefore there is no additional payment for a CC/MCC (HAC list)
  – Identified by POA indicator of
    • N for not present on admission
    • U for unable to determine whether present on admission

Hospital-Acquired Conditions

• Created by Medicare to promote increased quality and efficiency of care
• Objective: Facilities will not receive increased payment for certain potentially avoidable conditions acquired during the hospital stay
• Criteria to be considered a HAC:
  a) High cost and/or high volume
  b) Classified as a CC or MCC impacting the MS-DRG assignment
  c) Reasonably could have been prevented through the application of evidence-based guidelines
HAC List for FY 2016

- Foreign Object Retained after Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcers Stages III and IV
- Falls and Trauma
  - Fracture
  - Dislocation
  - Intracranial Injury
  - Crushed Injury
  - Burn
- Other Injuries
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Manifestations of Poor Glycemic Control
- Surgical Site Infection:
  - Surgical Site Infection, Mediastinitis Following Coronary Artery Bypass Graft (CABG)
  - Surgical Site Infection Following Certain Orthopedic Procedures
  - Surgical Site Infection Following Bariatric Surgery for Obesity
  - Surgical Site Infection Following Certain Orthopedic Procedures
- Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures
- Iatrogenic Pneumothorax with Venous Catheterization

Patient Safety Indicators

- The Patient Safety Indicators (PSIs) are a set of measures that screen for complications or adverse events that patients experience as a result of exposure to the healthcare system. These events are likely amenable to prevention by changes at the system or provider level.
- Originally released in March 2003, last updated March 2015 (Version 5.0)
- Developed by the Agency for Healthcare Research and Quality (AHRQ)
Patient Safety Indicators

- Provide a perspective on potential complications and errors resulting from a hospital admission
- Assist hospitals in assessing, monitoring, tracking, and improving the safety of inpatient care
- Can be used for comparative public reporting and pay-for-performance initiatives
- Identifies potentially avoidable complications

Patient Safety Indicators

- Current PSIs
  - Death Rate in Low-Mortality Diagnosis Related Groups (DRGs) (PSI 2)
  - Pressure Ulcer Rate (PSI 3)
  - Death Rate Among Surgical Inpatients with Serious Treatable Conditions (PSI 4)
  - Retained Surgical Item or Unretrieved Device Count (PSI 5)
  - Iatrogenic Pneumothorax Rate (PSI 6)
  - Central Venous Catheter-Related Blood Stream Infection Rate (PSI 7)
  - Postoperative Hip Fracture Rate (PSI 8)
  - Postoperative Hemorrhage or Hematoma Rate (PSI 9)
  - Postoperative Physiologic and Metabolic Derangement Rate (PSI 10)
  - Postoperative Respiratory Failure Rate (PSI 11)

Patient Safety Indicators

- Current PSIs (cont.)
  - Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate (PSI 12)
  - Postoperative Sepsis Rate (PSI 13)
  - Postoperative Wound Dehiscence Rate (PSI 14)
  - Accidental Puncture or Laceration Rate (PSI 15)
  - Transfusion Reaction Count (PSI 16)
  - Birth Trauma Rate - Injury to Neonate (PSI 17)
  - Obstetric Trauma Rate-Vaginal Delivery with Instrument (PSI 18)
  - Obstetric Trauma Rate-Vaginal Delivery without Instrument (PSI 19)
  - Retained Surgical Item or Unretrieved Device Fragment Rate (PSI 21)
  - Iatrogenic Pneumothorax Rate (PSI 22)
**Patient Safety Indicators**

- **Current PSIs Area Level**
  - Postoperative Wound Dehiscence Rate (PSI 24)
  - Accidental Puncture or Laceration Rate (PSI 25)
  - Transfusion Reaction Rate (PSI 26)
  - Postoperative Hemorrhage or Hematoma Rate (PSI 27)
  - Patient Safety for Selected Indicators (PSI 90)

**Potentially Preventable Complications (PPC)**

- UTI is a PPC when:
  - It is associated with a Foley catheter or other genitourinary device
  - It is not present on admission
  - It is not present on admission and there is no exclusion criteria
Potentially Preventable Complications

• Methodology developed by 3M and tested by Texas, California, and New York for relevance and appropriateness
• In use in Maryland and Texas with several other states moving to adoption as well

Potentially Preventable Complications

• Diagnoses that developed after admission to inpatient hospital beds
• Defined as harmful events or negative outcomes occurring during inpatient hospitalization that result from the processes of care and treatment rather than the natural progression of diseases
• Result in large expenditures for additional nursing time, pharmaceuticals, and tests before discharge is possible
• Although the frequency of complications is often low, the total additional expenditures can be large at the provider and systemwide levels

PPC Logic

1. Identify globally excluded admissions
2. Identify admissions with candidate complications
3. Assign PPCs after applying PPC exclusion and hierarchy exclusions
   ✓ Hierarchy exclusions are those in which multiple PPCs are in the same hierarchical family; use of hierarchy results in assignment of a single PPC instead of multiple ones that are clinically similar
PPC Methodology

- The full list of PPCs includes 64 mutually exclusive categories that were identified from ICD-9-CM codes for secondary diagnoses.
- Diagnoses are identified as clinical conditions that were not the principal causes of hospital admission.
- A number of diagnoses are excluded as non-preventable and include complications directly related to major or metastatic malignant diseases, multiple trauma, organ transplants, specific burns, and HIV-related disorders. Because of their unique characteristics, neonates are also excluded.

PPC Methodology

- Certain patients are excluded based on the admission APR-DRG or MDC (as based on the global exclusion criteria)
- Certain PPC assignment criteria require a minimum length of stay or require a certain number of days since procedure performed
- Certain procedures are utilized to create some of the complication groups
  - For example, intubation or mechanical ventilation occurring at least 4 days after admission
  - Blood transfusion when accompanied by hemorrhage or anemia

Criteria for Determining PPCs

- If a hospital or other healthcare facility has a statistically significant higher rate of a complication than comparable hospitals, reasonable clinicians would suggest further investigation for possible problems with quality of care
- The diagnosis:
  - Should not be redundant with the diagnosis that was the reason for admission (e.g., a stroke in a patient admitted with an ICH)
  - Should not be redundant with a secondary diagnosis determined to be considered POA and included in assignment of admission APR-DRG
  - Should not be an inevitable, natural, or expected consequence or manifestation of the reason for hospital admission (e.g., stroke in a patient with a brain malignancy)
  - Should be expected to have a significant impact on short- or long-term debility, mortality, patient suffering, or resource use
  - Should have a relatively narrow spectrum of manifestations, meaning that the impact of the diagnosis on the clinical course or on resource use must not be significant for some patients but trivial for others (e.g., iron deficiency anemia, atelectasis)
Exclusions

• Global exclusions by principal or secondary diagnosis code – not required to be present on admission
  – HIV
  – Certain malignancies
  – Transplant status or transplant complications

Exclusions

• Specific diagnoses, whether principal diagnosis or secondary diagnoses, are also used to define criteria for global exclusions
  – Examples of principal diagnosis as a global exclusion include:
    • Vertebral fracture with cord involvement
    • Femur fracture
    • Secondary neuroendocrine tumor of lymph, liver, bone

Exclusions

• Specific diagnoses, whether principal diagnosis or secondary diagnoses, are also used to define criteria for global exclusions
  – Examples of principal or secondary diagnosis codes present on admission as global exclusions include:
    • Anoxic brain damage
    • Ventricular fibrillation or flutter
    • Hepatic encephalopathy
    • Cardiac or respiratory arrest
Exclusions

- Malignancy codes POA (principal or secondary diagnoses) when reported in combination with certain secondary diagnoses are also global
  - Example of “pair” diagnoses
    - Malnutrition
    - Pancytopenia
    - Certain anemias
    - Thrombocytopenia
    - Neutropenia
    - Cachexia
    - Select pathological fractures

PPC Groups and Levels

PPC groups:
1. Extreme Complications
2. Cardiovascular-Respiratory Complications
3. Gastrointestinal Complications
4. Perioperative Complications
5. Infectious Complications
6. Malfunctions, Reactions, etc.
7. Obstetrical Complications
8. Other Medical and Surgical Complications

PPC levels:
1. Other
2. Major

List of PPCs

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<th>Description</th>
<th>Group</th>
<th>Level</th>
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<td>Stroke &amp; Intracranial Hemorrhage</td>
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<td>Major Liver Complications</td>
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<td>Genitourinary Complications except Urinary Tract Infection</td>
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<td>Renal Failure without Dialysis</td>
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<td>Renal Failure with Dialysis</td>
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<td>Diabetic Ketoacidosis &amp; Coma</td>
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<td>Poisonings due to Anesthesia</td>
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<td>Pressure Ulcer</td>
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<td>Transfusion Incompatibility Reaction</td>
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<td>Cellulitis</td>
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<td>Reopening Surgical Site</td>
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<td>Herpes Simplex</td>
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<td>Herpes Zoster &amp; Varicella</td>
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<td>Herpes Verruciformis</td>
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<td>Post-Procedural Substance Reaction &amp; Non-O.R. Procedure for Foreign Body</td>
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<td>Encephalopathy</td>
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<td>Other Complications of Medical Care</td>
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<td>Iatrogenic Pneumothorax</td>
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<td>Mechanical Complication of Device, Implant &amp; Graft</td>
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<td>51</td>
<td>Gastrointestinal Ostomy Complications</td>
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<td>Infection, Inflammation &amp; Other Complications of Devices, Implants or Grafts Except Vascular Infection</td>
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<td>Infection, Inflammation and Clotting Complications of Peripheral Vascular Catheters and Infusions</td>
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<td>Obstetrical Hemorrhage without Transfusion</td>
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<td>Obstetric Lacerations &amp; Other Trauma without Instrumentation</td>
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<td>Delivery with Puerperal Complications</td>
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<td>Post-Operative Respiratory Failure with Tracheostomy</td>
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<td>Other In-Hospital Adverse Events</td>
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<td>Urinary Tract Infection</td>
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<td>66</td>
<td>Catheter-Related Urinary Tract Infection</td>
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### Potentially Preventable Complications: Example Methodology and Case Examples

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PPC Example

- PPC 47 Encephalopathy
  - Includes encephalopathy NOS, encephalopathy NEC, metabolic encephalopathy, and toxic encephalopathy
  - Exclusions
    - Patient less than 18 years of age
    - Any diagnosis from one of the example exclusion groups is present on admission
      - Degenerative nervous system disorders, multiple sclerosis, and other demyelinating diseases
      - Bacterial, tuberculosis and non-bacterial infections of nervous system except viral meningitis
      - Severe non-traumatic brain injury, coma and encephalopathy
      - Brain contusion/laceration & complicated skull fracture with coma < 1 hour or no coma
      - Hepatic coma, other major acute liver disorders, alcoholic hepatitis and alcoholic ascites
      - Acute or chronic renal failure
      - Septicaemia and disseminated infections
      - Alzheimer’s disease and other dementias

PPC Case Example 1

- A 94-year-old female is admitted with AMS, pneumonia, and UTI. Additionally found to have pressure ulcer of coccyx per H/P. Length of stay 12 days.
  - CT on admission negative, and neurology consult ordered MRI which was performed two days after admission and found to have CVA. Case coded with POA N for pressure ulcer (PPC 31) and CVA (PPC 1).
  - Would have changed POA status of pressure ulcer. Any stage pressure ulcer with LOS greater than 4 days is a PPC.
  - Would have queried for POA status of CVA based on mental status and likelihood of POA status based on MRI results and common incidence of first CT being false negative.

PPC Case Example 2

- A 93-year-old female is admitted with CVA. Day after admission, patient suffers a cardiac arrest and is coded and intubated.
  - Cardiac arrest coded as POA Y
  - When correct POA status of cardiac arrest is documented, cardiac arrest is qualified as a PPC (PPC 14). Accurate reporting of POA status is essential.
  - Note that if patient had signs and symptoms of coma or persistent vegetative state, documentation of either of those diagnoses (regardless of POA status) would have excluded the cardiac arrest as a PPC.
PPC Case Example 3

• A 65-year-old male is admitted after a fall and found to have a fractured patella, which is repaired. Per ED documentation, patient was started on antibiotics for presumed UTI one day prior to admission. Discharge summary notes UTI was POA as well.
  – Case coded with POA of N for UTI, resulting in being flagged as a PPC (PPC 65)
  ➢ With proper identification of POA status, UTI would not be flagged as a PPC

PPC Case Example 4

• A 70-year-old male is admitted with acute onset of fever and AMS. ED documented RUL PNA, sepsis and hypoxia with temp 103.7, HR 89-101, RR 22-42, WBC 12.3 with 86% neutrophils. Day after admission, patient with decreasing respiratory status and is intubated and sedated with documented acute respiratory failure (PPC 04).
  – No further documentation of sepsis
  ➢ With clarification of and consistent documentation of sepsis, sepsis would be sequenced as principal diagnosis and acute respiratory failure would be excluded as a PPC

PPC Case Example 5

• A 66-year-old male presents with seizures x three with known seizure disorder. Troponins drawn on admission and second set positive with third set continuing to rise. Patient transferred to OSH for more definitive treatment for MI with documentation of MI day after admission.
  – AMI not POA is flagged as a PPC in this case (PPC 11)
  ➢ Clinically, the MI was likely POA so either:
    • POA status should be changed to Y
    • Clarification for POA status of MI should have been placed
**PPC Case Example 6**

- A 75-year-old male is admitted for elective CABG and AVR
  - Postoperatively, patient develops CVA, acute renal failure, acute blood loss anemia requiring transfusion and postoperative atrial fibrillation

> Although the acute blood anemia is a PPC (PPC 27), it meets exclusion criteria on the case and is not reported as a PPC.
> The CVA (PPC 01) and acute renal failure (PPC 24) meet criteria and are reported as PPCs.
> Atrial fibrillation not POA is not a PPC even though documented as postoperative. However, a clarification as to whether it is an expected outcome after heart surgery or a complication of the surgery would be appropriate to avoid reporting a complication that is noted in other quality metrics.

**Targeted Lessons Regarding Potentially Preventable Complications**

**Targeted Lessons Regarding PPCs**

- Consistent review and accurate coding of POA status of all diagnoses
- Clarification of diagnoses that clinically appear to be POA that might not be coded as such
- Standardization of definitions for common PPCs such as sepsis, acute respiratory failure, acute renal failure, etc.
- Begin review of clarification of PPC prior to government (federal/state), managed care, or commercial payers utilizing PPC methodology for quality assessment and payment adjustments
Targeted Lessons Regarding PPCs

- Ensure clinical significance of conditions being queried as they may be considered potentially preventable complications. For example:
  - ABLA only when resource consumptive and/or clinically significant
  - Diagnostic workup/evaluation or increased nursing care for encephalopathy with sustained alteration in mental status
  - Clinically significant alteration in BUN/Cr with definitive change in treatment plan prior to querying for diagnosis of acute renal failure

- Review for and capture of PPC exclusion conditions

Thank you. Questions?

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