HAC, PSI, and PDI: Incorporating Reviews Into Daily CDI Workflow

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Learning Objectives

• At the completion of this educational activity, the learner will be able to:
  – Define hospital acquired conditions, patient safety indicators, pediatric quality indicators, and inclusion and exclusion criteria for these measures.
  – Implement measures to incorporate HAC, PSI, and PDI reviews into daily workflow.
  – Identify strategies for collaboration between CDI, coding, quality, and physicians to accurately capture adverse events.
  – Explore how CDI staff can have a positive impact on value-based purchasing.
  – Recall information provided to review cases examples and complete an informal quiz.
Definitions

• Hospital Acquired Condition—an undesirable situation or condition that affects a patient and that arose during a stay in a hospital or medical facility. It is a designation used by Medicare/Medicaid in the US for determining MS-DRG reimbursement.

• Patient Safety Indicator—a set of indicators providing information on potential in hospital complications and adverse events following surgeries, procedures, and childbirth.

• Pediatric Quality Indicators—set of measures that can be used with hospital inpatient discharge data to provide a perspective on the quality of pediatric healthcare. Specifically, PDIs screen for problems that pediatric patients experience as a result of exposure to the healthcare system and that may be amenable to prevention by changes at the system or provider level.
Hospital Acquired Conditions

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcer Stages III & IV
- Falls and Trauma:
  - Fracture
  - Dislocation
  - Intracranial Injury
  - Crushing Injury
  - Burn
  - Other Injuries
- Catheter-Associated Urinary Tract Infection (CAUTI)
  - No UC=No CAUTI
  - >100,000 bacteria count needed to meet CDC criteria, yeast is excluded.
- Vascular Catheter-Associated Infection
  - (CLABSI)
- Manifestations of Poor Glycemic Control
  - DKA, nonketotic hyperosmolar coma, and hypoglycemic coma
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)
- Surgical Site Infection Following Certain Orthopedic Procedures
  - Spine, neck, elbow, shoulder
- Surgical Site Infection Following Bariatric Surgery for Obesity
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
- Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures
  - Total knee and total hip replacements
- Iatrogenic Pneumothorax with Venous Catheterization
Patient Safety Indicators

• **PSI 3: Pressure ulcers in medical and surgical DRGs**
  - Stage 3, 4, and unstageable pressure ulcers. Unstageable pressure ulcers are not a HAC, but they are a PSI. Watch for further staging of unstageable ulcers as debridement may allow for further specification of the stage.

• **PSI 6: Iatrogenic pneumothorax in medical and surgical DRGs**
  - Excludes cases with chest trauma, thoracic surgery, pleural effusion, lung or pleural biopsy, diaphragmatic repair, and some cardiac procedures. Pleural effusion must be clinically significant to pick up an exclusion.

• **PSI 8: In-hospital fall with hip fracture**
  - All hip fractures from inpatient falls, not just post-op falls. Excludes cases that are susceptible to falls (seizures, syncope, stroke, coma, arrest, some cancers)

• **PSI 9: Perioperative hemorrhage and hematoma in surgical DRGs**
  - There must be a procedure to control the hemorrhage or remove the hematoma to qualify. Coagulation disorders such as thrombocytopenia, DIC, Von Willebrands disease can exclude patient from this PSI.

• **PSI 10: Post op acute kidney injury in elective surgical DRGs**
  - Patient must receive peritoneal dialysis or urinary filtration single or multiple times to qualify for this PSI. Watch for progression of CKD to ESRD for possible exclusion.
Patient Safety Indicators cont.

• **PSI 11: Post-op respiratory failure following an elective surgery**
  – MDC 4 & 5 are excluded. Do not enter as post-op or post-procedural unless the MD documents that way. Acute respiratory failure requiring re-intubation may qualify for this PSI.

• **PSI 12: Peri-op DVT/PE in surgical DRGs**
  – PE on surgical DRGs or DVT below the waist on surgical DRGs (upper extremity DVTs are not reported). Look for diagnoses preventing the patient from being anti-coagulated such as head bleed, acute brain injury, or spinal injury as these diagnoses may exclude patient from this PSI.

• **PSI 13: Post-op sepsis in elective surgical DRGs**
  – Excludes cases with an infectious diagnosis POA.

• **PSI 14: Post-op abdominal wound dehiscence in surgical DRGs**
  – There has to be a repair of the abdominal wound to qualify for this PSI. SPCM excludes this PSI.

• **PSI 15: Unrecognized abdominopelvic accidental puncture or laceration in surgical DRGs**
  – This PSI now requires a second trip back to the OR one or more days after the original surgery. Query to clarify if the puncture/laceration/tear was integral or a true complication of the procedure.
Pediatric Quality Indicators

- **PDI 1: Accidental puncture or laceration**
  - Excludes cases with a spinal surgery.

- **PDI 2: Pressure ulcer**
  - Includes pressure ulcers stage 3, 4, or unstageable that are not POA.

- **PDI 5: Iatrogenic pneumothorax**
  - Excludes cases with chest trauma, pleural effusion that is clinically significant, lung or pleural biopsy, or diaphragmatic surgery repair.

- **PDI 8: Peri-operative hemorrhage or hematoma**
  - Excludes cases with a diagnosis of coagulation disorder. Has to be a control of hemorrhage or drainage of hematoma procedure to qualify.

- **PDI 9: Post-operative respiratory failure**
  - Excludes cases with chest trauma, pleural effusion that is clinically significant, lung or pleural biopsy, or diaphragmatic surgery repair.

- **PDI 10: Post-operative sepsis**
  - Excludes cases with infectious diagnosis that was POA such as abscess, PNA.

- **PDI 11: Post-operative wound dehiscence rate**
  - Excludes newborn cases with gastroschisis or umbilical hernia repair prior to abdominal wall reclosure.
Wake Forest Baptist Medical Center

- Located in the beautiful piedmont region of North Carolina serving 19 surrounding counties
  - Total licensed beds: 885
  - Level 1 Trauma Center, Brenner Children’s Hospital and the Childress Institute for Pediatric Trauma
  - Emergency department visits: 110,602
  - Inpatient admissions (FY 2017) 40,810
  - Registered nurses: 3,075
  - Total medical center workforce: 14,271
  - Currently 3 smaller community hospitals are part of Wake Forest Baptist with a fourth onboarding in July 2018.

- Magnet designation
Our Patient and Family Promise

• We will ...
  – Keep you safe
  – Care for you
  – Involve you and your family
  – Respect you and your time
Clinical Documentation Excellence

- Program has been in existence for 19 years
- All registered nurses, BSN prepared
- Service base approach
- Cover all payors when possible, goal of 90% coverage rate
- Currently inpatient and outpatient areas are covered
Wake Forest Baptist Health CDI team was awarded the The Summit Award for Clinical Documentation Improvement at the 2016 3M Client Summit.
ACDIS Survey on CDI Prioritization

• An ACDIS survey from 2016 revealed that nearly 38% of CDI programs feel that reviewing for quality measures hinders their productivity.

• July 2017 ACDIS survey supported by 3M Health Information Systems, polled 263 hospital and health system CDI leaders and ACDIS members.

• 16% of participants prioritize follow-up cases by using the working DRG to identify cases that might have a quality indicator (PSI, HAC, or readmission)
Incorporation of Quality Measures Into Concurrent Review Process

• Reviewing the chart is more than just finding CC and MCC opportunities
• Education is provided to review inclusion and exclusion criteria. Reference materials are provided
• Feedback is provided based on second-level review with education provided when needed
• Use of software tools reinforced
• Designated CDI specialist that focuses on quality measures
Concurrent Review Process

• Clinical documentation nurse reviews chart concurrently
  – Look for buzz words such as injury, bleeding after procedure, fall, complication, skin breakdown, respiratory failure, catheter-related infection.

• Diagnoses and procedures are entered into software
  – Software tools are utilized to alert CDI nurse to a possible HAC/PSI/PDI.

• CDI queries provider if needed for POA status, clarification of possible adverse event
Review Process cont.

• CDI places information in chapter in software for second level review.
• Second-level review completed looking for possible exclusions, clarity of documentation, any further query opportunities.
• Chart final coded and coder sends any possible adverse event for second level review by coding supervisor/auditor.
• Dialog between CDI and coding if any further clarification is needed. This should occur before bill drop to accurately capture adverse events and avoid re-bills.
CDS
Focuses on documentation improvement across all care settings.

Coding
Apply consistent coding guidelines.

Physicians
Provide education and support with other providers.

Quality
Ensure best clinical practices are met and monitor patient outcomes and reported adverse events post-DC.
Collaboration Between CDI, Coding, Quality, and Physicians

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HAC/PSI/PDI reported post-DC</td>
</tr>
<tr>
<td>2</td>
<td>Second-level review by CDI, coding, and quality for opportunities.</td>
</tr>
<tr>
<td>3</td>
<td>Physician champion reviews case if needed/provides feedback.</td>
</tr>
</tbody>
</table>
Collaboration Between CDI, Coding, and Quality

4. Query sent to provider if further clarification needed. Include brief education with query on HAC/PSI/PDI.

5. Coding reviews query response and rebill sent if needed.

6. Quality monitors reporting to validate that HAC/PSI/PDI has been reversed. Cases are discussed at monthly multidisciplinary meeting.
Value Based Purchasing

- Hospital VBP (“HVBP”) is required by the Affordable Care Act. VBP focuses on lowering healthcare costs and improving outcomes.
- VBP rewards acute care hospitals with incentive payments for quality of care provided to patients with Medicare.
- VBP program encourages hospitals to improve quality and safety of patients by eliminating or reducing adverse events, adopting evidence-based care standards and protocols that create the best outcomes for the most patients.
- Today’s data drives tomorrow’s reimbursement.
How Can CDI Impact VBP?

• Review for presence of any exclusions.
• Clarify POA status of possible HAC/PSI/PDI diagnoses when needed.
• Ensure that documentation accurately captures the SOI and ROM of the patient. Chart needs to match patient lying in the bed.
• Utilize software tools to capture events concurrently, allowing for concurrent clarification.
• Understand the role they play in patient safety.
• Educate providers on adverse events.
<table>
<thead>
<tr>
<th>Patient Safety Indicators</th>
<th>Nov-17</th>
<th>Dec-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSI 03 Pressure Ulcer</td>
<td>5</td>
<td>1</td>
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<tr>
<td>PSI 06 Iatrogenic Pneumothorax</td>
<td>2</td>
<td>1</td>
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<tr>
<td>PSI 09 Perioperative Hemorrhage or Hematoma</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>PSI 11 Postoperative Respiratory Failure</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>PSI 12 Perioperative PE or DVT</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>PSI 13 Postoperative Sepsis</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>PSI 14 Post op wound dehiscence</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>PSI 15 Accidental puncture and laceration</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>PDI 10 Postoperative Sepsis</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Hospital Acquired Conditions</td>
<td>Nov-17</td>
<td>Dec-17</td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
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</tr>
<tr>
<td>CAUTI</td>
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<td>2</td>
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<tr>
<td>DVT/PE after certain ortho procedures</td>
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<td>1</td>
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<tr>
<td>Falls and trauma</td>
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<td>2</td>
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<tr>
<td>Pneumothorax following venous catheterization</td>
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<td>0</td>
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<tr>
<td>Surgical site infection following certain ortho procedures</td>
<td>1</td>
<td>0</td>
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<tr>
<td>Manifestations of poor glycemic control</td>
<td>2</td>
<td>0</td>
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<tr>
<td>Stage 3 &amp; 4 pressure ulcers</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>CLABSI</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
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Quiz

- Patient is admitted with a STEMI and goes for a cardiac cath. Day after procedure, patient develops a groin hematoma at cath site. No intervention for the hematoma was performed other than a sandbag and ongoing monitoring. Is this a PSI 9?
- Diabetic patient is admitted for pneumonia. Has periods of hypo and hyperglycemia after admission. Is this a HAC for manifestation of poor glycemic control?
- Patient has abdominal surgery and dehisces wound 3 days after surgery. Goes back to OR for repair of abdominal wall. Which degree of malnutrition will exclude this patient from PSI 14?
Several One Things

Always look for the present on admission status of any possible HAC, PSI, PDI. Always look for that one diagnosis that may exclude patient from a PSI or PDI. If your institution is able to reverse one HAC/PSI/PDI it is totally worth it. If we can make one patient safer through our efforts we have achieved success.
Thank you. Questions?

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