Quality Measure Reporting Enhancing Coders' Value in Post-Acute Care

By Kellie Barranger, BSOM, RHIT

Effective healthcare transitions, new payment models, and quality outcomes are fast becoming a major focus for long-term care (LTC) providers as part of the new shift to value-based healthcare reform. The requirements are changing the concept of "value" from the best price for the service to the best quality experience.

A skilled nursing facility (SNF) has indicators of quality called "quality measures," which are driven by regulation with clinical outcomes tied to reimbursement and reputation much like acute care hospitals. The need for collecting and reporting clinical documentation has increased for SNFs because of the expanded focus on quality performance, sustaining patient outcomes across the healthcare spectrum, and participating in Bundled Payment Care Initiatives (BPCI).[1]

The myriad of changes with quality measures and BPCI requirements are beginning to impact the SNF administrators and executive nursing staff who, historically, have been responsible for monitoring quality outcomes in long-term care. For example, National Healthcare Corporation (NHC), a top-ranked provider of senior care, has made big changes to accommodate this increased focus on documentation-driven quality reporting. NHC has turned to health information management (HIM) professionals to help track, manage, and identify data needed to support positive outcomes.

Many of NHC's facilities in eastern Tennessee are preferred providers within several large care networks, and they participate in the health information exchange East Tennessee Health Information Network (etHIN) to enhance sharing of patient information during care transitions. Credentialed coding professionals are tasked with collecting and reporting patient data to various entities within these care networks.

With changes to reimbursement methods, such as BPCI, shorter lengths of stay are built into designed clinical care plans for specific diagnoses and surgical procedures. To demonstrate the provision of quality care for patients who only need short-term skilled nursing and rehabilitation services, the Centers for Medicare and Medicaid Services (CMS) recently added new measures which extend the scope of patient management beyond the facility discharge. SNFs are now scored, ranked, and reimbursed based on outcomes which occur during and after a patient's stay. Therefore, a successful facility's work is no longer finished when the patient goes home.

NHC Farragut, an LLC within the overall corporation of NHC and located in Knoxville, TN, is a SNF with the unique feature of being a high-volume skilled nursing and rehabilitation (rehab) facility with a small population of LTC patients. Uniqueness can be challenging in this setting because most of the measures used to calculate the quality ranking for a SNF are based solely on LTC patient outcomes. Quality measures are calculated using number of occurrences divided by total patients assessed in the period (i.e., two long-stay patients have a fall and there are only 12 long-stay patients, then 2/12 x 100 = 16.67 percent). Quality care is questioned when almost 17 percent of a facility's long-term patients suffer a fall. The measures outlined below are scored using documentation from patients with episodes greater than or equal to 101 days.

In the list below, quality care is shown by lower percentages on each measure except those indicated with an asterisk—for these measures, a higher percentage is better:[2]

- Percentage of residents experiencing one or more falls with major injury
- Percentage of residents who report moderate to severe pain
- Percentage of high-risk residents with pressure ulcers
- Percentage of residents with a urinary tract infection
- Percentage of residents with a catheter inserted and left in their bladder
- Percentage of residents who were physically restrained
- Percentage of residents whose need for help with daily activities increased

- Percentage of residents who received an antipsychotic medication
- Percentage of residents whose ability to move independently worsened
- Percentage of low-risk residents who lose control of their bowels or bladder
- Percentage of residents who lose too much weight
- Percentage of residents who have depressive symptoms
- Percentage of residents who received an anti-anxiety or hypnotic medication
- Percentage of residents assessed and appropriately given the seasonal influenza vaccine*
- Percentage of residents assessed and appropriately given the pneumococcal vaccine*

NHC Farragut has been working to expand the knowledge and understanding of quality measures beyond the nursing department. Developing systems to work with both short- and long-stay patients requires an interdisciplinary team approach both within and outside of the facility. NHC Farragut leadership has been forming collaborative partnerships with community physician groups and home health agencies to help with patient management post-discharge. Continued care coordination for short-stay patients encourages both patient and provider involvement to create positive outcomes. The HIM department plays a role in sharing patient stay information with case managers and physician offices to ensure timely follow up.

The measures outlined below are scored using documentation and claims data from patients with episodes less than or equal to 100 days. Quality care is shown by lower percentages on each measure except those indicated with an asterisk, where a higher percentage is better.[3]

- Percentage of residents who report moderate to severe pain
- Percentage of residents with pressure ulcers that are new or worsened
- Percentage of residents who newly received an antipsychotic medication
- Percentage of residents assessed and appropriately given the seasonal influenza vaccine*
- Percentage of residents assessed and appropriately given the pneumococcal vaccine*
- Percentage of residents who made improvements in function*
- Percentage of residents who were successfully discharged to the community*
- Percentage of residents who were re-hospitalized after a nursing home admission
- Percentage of residents who had an outpatient emergency department visit

It is challenging to engage front line clinical staff and non-clinical staff with facility measures because many have never been exposed to them and others run the opposite direction due to complex statistical mathematics involved in calculating them. NHC Farragut must monitor measures closely to keep a balance between effective care systems for a rehab patient discharging to home in seven to 10 days and a long-term patient of three years. Credentialed coders are part of the interdisciplinary team being educated on quality measures. Delving into the specifics of individual measures is creating an opportunity for clinical documentation improvement (CDI) from all disciplines involved in the circle of patient care.

As with acute care settings, SNF coding accuracy is linked to reimbursement. However, NHC Farragut is expanding the focus toward outcomes, which is increasing the value of data. Coders can utilize appropriate physician query when they understand certain diagnoses may include or exclude a patient from the calculation of a measure when documentation is unclear or unspecified. Coders involved with CDI programs can help train disciplines to locate documentation needed for a measure with a covariate (condition increasing risk of an outcome) attached to it.[4] In the September issue of the AHIMA e-newsletter *CodeWrite*, the Coding and Quality Measures Brief will be focused on the topic of long-term care, exploring details of individual measures mentioned above.

Sharing this information among coding professionals will enhance quality within the profession, as well as promote LTC quality improvement. Success in healthcare today relies on more than just being "in the black." The bottom line must also be bold and capitalized with quality. A service is provided to you, but an experience engages you. Providing a quality service will meet expectations—being accurate, timely, and cost-efficient—but a quality experience exceeds expectations by offering and sharing something personally. Utilizing coding and other HIM professionals in LTC to track and monitor quality measures enhances the care systems needed to sustain pathways of improved patient health and well-being, creating value for both patients and coders.

Notes

[1] Centers for Medicare and Medicaid Services. "Bundle Payments for Care Improvement (BPCI) Initiative: General Information."

[2] Centers for Medicare and Medicaid Services. "Long Term Care Facility Resident Assessment Instrument 3.0 User Manual." October 2016.

[3] Centers for Medicare and Medicaid Services. "Quality Measures."

[4] Centers for Medicare and Medicaid Services. "Long Term Care Facility Resident Assessment Instrument 3.0 User Manual."

References

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