

Quality Rankings and Documentation Accuracy: Finding Objectivity in Subjective Ratings

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Executive Summary

Healthcare organizations expend significant resources ensuring that they provide safe, efficient, and equitable care to their consumers. The measurement used to assess and compare the quality of that care is taken from the documentation in medical records and reported to the public through a handful of quality ratings organizations, each with their own analytics frameworks for quality assessment. These consistently published lists have thrust healthcare decision-making into the public consciousness, and consumers of care have become increasingly knowledgeable regarding variability in the quality and cost of care. As a result, consumers are utilizing these reports to make healthcare decisions causing healthcare leaders to become increasingly concerned regarding the accuracy of the data that measures the quality of care being provided.

In a perfect world, the quality of care provided during a patient encounter would never be questioned. But too often, the medical record documentation—that becomes the platform for measurement of the metrics that contribute to these published quality ratings and rankings—lacks specificity and clarity. This can negatively impact healthcare organizations by causing appearances of poor performance in these publications. Budgetary constraints, logistical hurdles, human error, and most importantly, documentation inaccuracies contribute to inaccurate measurement of the quality of care being provided and underreport the positive outcomes patients are achieving.

Healthcare scrutiny and evaluations—while necessary—contribute to the problem as there is no “gold standard” for quality. Therefore, organizations are forced to satisfy multiple quality ratings systems at once, each with its unique rating formula. According to an article featured by the American Hospital Association, this can “offer conflicting results, which may mislead stakeholders relying on the ratings to identify top-performing hospitals.”¹

Additionally, the ratings systems may be flawed. In fact, according to an NEJM Catalyst report, none of the major ratings systems earned an ‘A.’ Each of the ratings systems had a deficiency that could cause inaccuracies in the reporting of a healthcare organization’s performance.²

To address poor performance in these reports, healthcare organizations should first understand the most common root causes of inaccuracies by ensuring that the documentation of care provided is consistently accurate. Indeed, many organizations have attempted to solve the appearance of poor quality of care by implementing clinical documentation integrity programs.

However, it’s difficult to know whether there are real quality of care issues within the organization or if there is a problem with documentation integrity because there is no standard metric available today that can reflect the accuracy of documentation. So, how does an organization know when the documentation will translate into an accurate picture of the quality of care being provided?

There is no quick and easy answer...yet. But technological advancements in the measurement of accuracy are on the horizon. In the meantime, understanding how documentation accuracy can help improve a healthcare organization holistically is paramount. If we look at the state of documentation accuracy today, we can better understand the impact and why it will be important to measure going forward.

1. <https://www.aha.org/news/headline/2019-08-15-study-hospital-quality-rating-systems-need-improvement>

2. <https://www.hpnonline.com/patient-satisfaction/article/21092979/inaccuracies-revealed-in-hospital-quality-rating-systems>



The State of Documentation Integrity Today

In a 2020 Iodine Software study of CDI queries from July 2019 to December 2019 across nearly 500 U.S. hospitals, Iodine found that 84 percent of medical conditions with a high level of clinical evidence were not included in final reported code sets. Iodine was able to identify that the root cause of this leakage was caused by breaks in the documentation integrity process. This would be expected to result in a high rate of poor quality reporting even when patients are experiencing positive outcomes. For healthcare organizations, these results are palpable and unacceptable.

The effects of inaccurate or incomplete clinical documentation on quality metrics swings both in favor and against hospitals. Documentation that is reported in the final code set but is not supported with clinical evidence can result in falsely inflating quality ratings and significantly increases the risk of denial. While this problem exists, the more common concern for organizations is when care and resources are provided for specific conditions but those conditions are not clearly articulated in the medical record, reflecting high levels of care being provided to less acutely ill patients.

A recent and troublesome example is the uptick in patients being treated at the highest levels of severity. From 2014 to 2019, there was a 20 percent increase in the number of patients staying in the most resource intensive, “high severity” level of care. This is especially noteworthy because patient activity decreased in all other levels of acuity. Additionally, of the most severe cases, one in three patient stays were more than 20 percent shorter than the associated geometric mean length of stay (GMLOS) for the final reported DRG. This caused stakeholders to wonder if these cases were appropriately diagnosed and billed or if they were subject to inappropriate billing practices, such as upcoding.³

An example of the discrepancy that can occur between care and documentation can be demonstrated with this case; a patient who is admitted with a urinary catheter in place and then subsequently develops a urinary tract infection (UTI). When this occurs during the patient admission, it is considered a “hospital acquired

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3. <https://acdis.org/articles/note-acdis-director-latest-oig-report%E2%80%94alarm-bells-or-much-ado-about-nothing>



condition” negatively impacting quality scores. However, if the patient was admitted with the UTI and the condition is documented as present on admission, then it is reflected as a pre-existing condition and it *does not* negatively impact the quality score. This is a simple example, but it exhibits the impact of documentation [in]accuracy on quality metrics.

The reality is that when a patient enters a healthcare organization, they assume they are going to get the best care possible (as they should). This means that all decisions should be made with adequate knowledge and supportive clinical evidence and then appropriately documented in the medical record. While there will always be some negative and adverse outcomes, even in the best organizations, these should be documented accurately and reported appropriately. Documentation integrity can reveal clinical improvement opportunities and improve communication and clinical processes that will ultimately be reflected in improved patient outcomes and quality metrics.



Focus on Documentation Accuracy

As reimbursement models evolve from fee-for-service to value based care, the importance of clinical documentation accuracy becomes increasingly evident. Documentation should reflect an accurate picture of the services and procedures provided and resources expended in the patient's care. It should also support accurate and complete final coding that can yield measurable, actionable benefits for healthcare organizations:

- **Quality Measure Accuracy:** Documentation accuracy should translate to accurate quality scores and reports, regardless of quality criteria, and be reflected in positive patient outcomes. Healthcare systems should strive to achieve quality scores that are grounded in reality based upon clinical evidence and accurate documentation.
- **Insights for Improvement:** Proper documentation provides a litmus test for an organization. Where can patient experiences and outcomes be improved? This could help uncover the root cause of low-quality scores and provide insights into how to address the problem at the source.
- **Financial Improvement:** Improper documentation leads to improper coding and can cost healthcare organizations millions of dollars in lost revenue. Accurate reimbursement also results in appropriate resource allocation.
- **Growth Strategies:** Identifying areas where the organization excels can support institutional growth strategy in the way of improved payer negotiations and risk-based contracting opportunities.

Unfortunately, for most organizations, documentation accuracy is lacking—resulting in underachievement in quality scores and rankings.

Poor documentation accuracy and improper coding are the inevitable side effects of outdated review processes and overworked CDIS and coding staff. Adding staff might help, but in times of budgetary constraint and limited resources, it is not a realistic solution. Nor are there enough qualified applicants who can quickly jump in and make a difference.

However, documentation accuracy can be improved with the use of technology that streamlines workflows by focusing efforts on the right medical records. In doing so, such technology effectively creates the time needed for adequate investigation and clarification of the documentation.

Attributes to look for in a technology solution include:

- Ability to prioritize cases with opportunity to **best utilize CDISs time**
- Ability to **easily compare documentation** to relevant, supportive clinical evidence
- Ability to **identify all documentation issues**, regardless of perceived impact



Capturing Documentation Accuracy

Understanding the value and impact of documentation accuracy is key to determining whether your quality metrics are an accurate representation of the care your team is providing. This requires a complete and automated documentation integrity solution.

Iodine offers a solution that streamlines the documentation integrity process from admission to final coding. We've pioneered an innovative application of artificial intelligence and machine learning called **Cognitive Emulation**. This approach uses proprietary AI technology and machine learning algorithms to emulate clinical judgment and identify records with the highest likelihood of a discrepancy between the clinical evidence and the documentation in the medical record. Unlike alternative technologies in the CDI space, Iodine's software does not merely support efficient documentation review. Instead, Iodine's systems are also able to identify *missing* documentation, which can be a huge source of documentation inaccuracies.

Iodine's Cognitive Emulation combines NLP and Machine Learning to evaluate complex medical data similar to a physician's approach to diagnosing and treating patients. Because of this, Iodine is able to focus CDIS teams on those records that are most likely to have material documentation discrepancies and therefore benefit from review and possible intervention to capture documentation accuracy. The resulting increase in documentation accuracy improves reporting of the comorbid conditions that contribute to external quality scoring methodologies. A truer depiction of the actual quality of care provided is the net result.

This is all made possible by Iodine's unique approach which combines the strengths of machine learning, artificial intelligence, and natural language processing to automate tasks that require clinical judgment. Running 24/7, it frees up clinical teams from sifting through medical record to find documentation discrepancies and allows them to focus on the right cases to more efficiently support documentation accuracy, limiting unnecessary nudges and queries to providers. More effectively managing the documentation process allows providers of care to spend more time providing quality care, and less time laboring over those arduous documentation tasks that have been shown to cause burnout.

In summary, accuracy of documentation is vital to the measurement of quality of care. Accurate depiction of the conditions being monitored and treated during care delivery leads to accurate reporting of the quality metrics by which our health systems are measured. Finally, documentation accuracy can also effect positive change in care delivery by providing a clarity of the true quality of care which is necessary for identifying areas of focus for care improvement.



About the Author



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Fran Jurcak is an accomplished senior executive with over 30 years of success in healthcare practice, education, consulting and technology. As a healthcare consultant, Fran leveraged her clinical and coding knowledge to support process improvement in the mid-revenue cycle, particularly in the clinical documentation integrity space. These process improvements allowed her clients to successfully minimize mid-cycle leakage and accurately report outcomes of care. She is currently the Chief Clinical Strategist at Iodine Software, where she has worked to bring artificial intelligence and machine learning technology to concurrent CDI workflow. Fran is active in ACDIS, received the 2017 ACDIS award for Professional Achievement, and is the author of the CCDS Study Guide. She is recognized as a national speaker and author for ACDIS and AHIMA and is currently serving a 3-year term on NAHRI's advisory board.

