Quality and Productivity Commission

33rd Annual Productivity and Quality Awards Program

"Empowering Innovative Solutions"

2019 APPLICATION

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):

NAME OF PROJECT: CLINICAL DOCUMENTATION IMPROVEMENT FOR DHS

DATE OF IMPLEMENTATION/ADOPTION: DECEMBER 2017

(Must have been **fully** implemented **for a minimum of** at least one year - on or before July 1, 2018)

PROJECT STATUS: X Ongoing _____ One-time only

HAS YOUR DEPARTMENT PREVIOUSLY SUBMITTED THIS PROJECT? _____ Yes X No

EXECUTIVE SUMMARY: Describe the project in 15 lines or less using Arial 12 point font. State clearly and concisely what difference the project has made.

1 Healthcare revenue depends heavily on how accurately our clinicians document in the
2 medical record to reflect how sick our patient population is. Payors, regulators, and
3 publicly reported data all competitively compare performance across institutions using
4 metrics that depend on precise documentation of level of illness. DHS has had limited
5 focus on optimizing clinical documentation, so our publicly reported data and Medicare
6 revenue have been suboptimal. We implemented a Clinical Documentation
7 Improvement initiative at all 4 DHS hospitals in late 2017, with a goal of reducing our
8 publicly reported mortality rates, reducing our adjusted length of stay, and increasing
9 our Case Mix Index which is the principle driver of Medicare revenue, all by improving
10 the accuracy of recording patient diagnoses in the medical record. The result of the
11 program was that the 2018 DHS-wide inpatient mortality rates fell to a rate below the
12 expected rate (less deaths than expected based on our patients' sickness) for the first
13 time in its history due to marked improvement in clinical documentation. In addition, the
14 Medicare Case Mix Index improved by >5%, which should translate into $12-14 million
15 in increased Medicare revenue to the system.

BENEFITS TO THE COUNTY

(1) ACTUAL/ESTIMATED **ANNUAL** COST AVOIDANCE	(2) ACTUAL/ESTIMATED **ANNUAL** COST SAVINGS	(3) ACTUAL/ESTIMATED **ANNUAL** REVENUE	(1) + (2) + (3) = TOTAL **ANNUAL** ACTUAL/ESTIMATED BENEFIT	SERVICE ENHANCEMENT PROJECT
$	$	$ >12 million	$ >$12 MILLION	X

ANNUAL = 12 MONTHS ONLY

SUBMITTING DEPARTMENT NAME AND COMPLETE ADDRESS		TELEPHONE NUMBER
LAC+USC Medical Center 2051 Marengo St. Los Angeles, CA 90033		323-409-1000
PROGRAM MANAGER'S NAME Brad Spellberg, MD **SIGNATURE ON FILE**		**TELEPHONE NUMBER** 323-409-6734 **EMAIL** bspellberg@dhs.lacounty.gov
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE (PLEASE CALL (213) 893-0322 IF YOU DO NOT KNOW YOUR PRODUCTIVITY MANAGER'S NAME) Connie Salgado-Sanchez **SIGNATURE ON FILE**	**DATE** 6/25/19	**TELEPHONE NUMBER** 213-288-8483 **EMAIL** cosanchez@dhs.lacounty.gov
DEPARTMENT HEAD'S NAME AND SIGNATURE Christina R. Ghaly, M.D. **SIGNATURE ON FILE**	**DATE** 6/25/2019	**TELEPHONE NUMBER** 213-288-8050

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):

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1st FACT SHEET – LIMITED UP TO 3 PAGES ONLY: Describe the **challenge(s), solution(s), and benefit(s)** of the project **to the County**. What quality and/or productivity-related outcome(s) has the project achieved? Provide measures of success **and specify assessment time frame**. Use Arial 12 point font.

The public perception of the quality of care that is provided in the inpatient settings at the 4 DHS hospitals depends heavily on the accuracy of documentation in the medical record. A variety of payor, regulator, and public data sources (e.g., Leapfrog, CMS) compare performance across healthcare systems using quality metrics. They depend on the diagnoses entered into the medical record in order to compare how sick patients are at each facility. For example, because it would not be fair to compare death rates at hospitals caring for very different levels of patient complexity (e.g., a trauma center vs. a small community hospital), the observed mortality at each institution is normalized to the "expected" mortality in order to create an index. An index of <1 implies that the hospital is saving lives. An index >1 implies the hospital is harming patients. Thus the index depends very much on having an accurate "expected mortality", and the expected mortality depends very much on accurate documentation.

Another factor impacted by accurate documentation is Medicare reimbursement. Medicare pays for inpatient care with a "bundled"/lump sum payment. The amount of that payment depends heavily on the diagnoses entered into the computer when the patient is discharged. The hospital's "Case Mix Index" is the marker that describes for Medicare how sick the patients are, and allows calculation of much of the Medicare payment for the care of the patients.

As such, both public perceptions of quality of care and actual hard revenue depend very much on having providers accurately document in the medical record. However, many public hospitals, including those at DHS, have been historically insulated from the need to focus on documentation. Our patients have not historically had choices for where they could go for care. As such, we have not focused on publicly reported data, as we did not worry about losing patients, or having the public lose confidence in our care. Furthermore, our revenue was largely independent of quality of care or documentation. As such, training, education, and monitoring the thoroughness of the documentation of diagnoses in the medical record was never before a priority.

All of that has changed because of Medi-Cal expansion under the Affordable Care Act, which allows our patients to have options about where they receive their care. Furthermore, we have experienced a doubling of Medicare rates in the inpatient setting likely due to an aging population. As such, more of our revenue now depends on thoroughly and accurately documenting how sick our patients really are.

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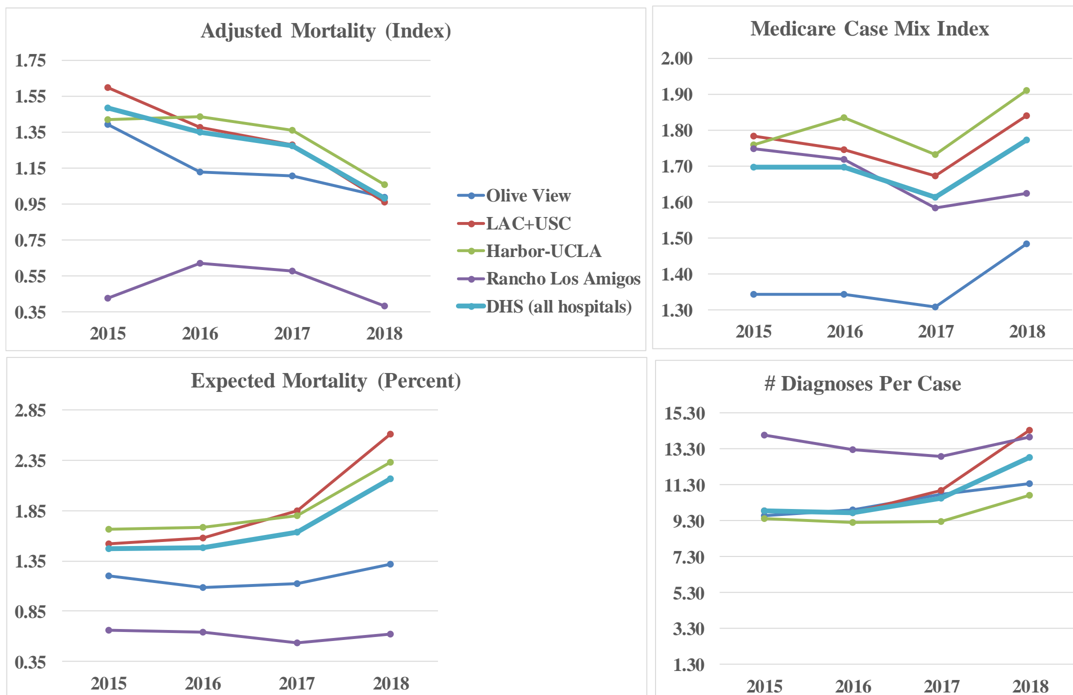
Use Arial 12 point font.

We implemented training to inpatient providers and reinforced that training with a formal Clinical Documentation Improvement (CDI) program. The CDI program is staffed by nurses who have been specially trained around medical documentation. They work in concert with our Health Information Maintenance (HIM) Coders, who are the official transcribers of the medical record for the purpose of assigning diagnostic codes. The CDI nurses and HIM Coders work cooperatively to identify opportunities for more accurate and thorough documentation reflecting how sick our patients are. If they find such opportunities, they contact the healthcare providers to ask if clarification can be made in the medical record. This enables a more accurate reflection of the severity of our patients' illnesses when the charts are coded. The outcome metrics we focus on included:

1) Mortality Index (target <1; achieved 0.98)—exceeded this goal
2) Expected Mortality (targeted 10%, achieved 50%)—exceeded this goal
3) Case Mix Index (target 3% increase, achieved 5%)—exceeded this goal
4) # diagnoses/patient (target 5% increase, achieved 30%)—exceeded this goal

The hospitals rolled out CDI from 12/17 to 6/18. As a result, the DHS-wide mortality index fell by an astounding 50%, to below 1 in 2018, and Medicare Case Mix Index rose by 5%, which should translate to >$12 million in revenue.



We Support Plain Language

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):
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Linkage to the County Strategic Plan – 1 page only. Which County Strategic Plan goal(s) does this project address? Explain how. Use Arial 12 point font.

This project addressed County Strategic Plan Goal III. Realize Tomorrow's Government Today, specifically by "pursuing operational effectiveness and fiscal accountability" and goal III.3.1 Maximize Revenue.

Prior to this program, the Department was not realizing the full reimbursements available based on the patients' level of illness. The county hospitals see some of the sickest patients in the nation. Furthermore, the county runs 2 of the largest trauma centers on the west coast. In the past, <5% of these patients were Medicare patients, so the reimbursements available were low compared to the efforts to implement a comprehensive clinical documentation program. This all changed after the Affordable Care Act. DHS hospitals now admit up to 17% of patients with Medicare coverage. Having a program that maximizes revenue capture for this population has a significantly positive affect on the overall revenue for the Department of Health Services, estimated at an increase of >$12 million annually. This was accomplished with an investment of $1.8M in salaries of new nurses trained in clinical documentation. This revenue increase will continue and be maintained or increased as our Medicare population increases.

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COST AVOIDANCE, COST SAVINGS, AND REVENUE GENERATED (ESTIMATED BENEFITS TO THE COUNTY): If you are claiming cost benefits, include a calculation on this page. Please indicate whether these benefits apply in total or on a per unit basis, e.g., per capita, per transaction, per case, etc. You must include an explanation of the County cost savings, cost avoidance or new revenue that matches the numbers in the box. Remember to keep your supporting documentation. Use Arial 12 point font

Cost Avoidance: Costs that are eliminated or not incurred as a result of program outcomes. Please indicate whether these are costs to the County or to other entities.

Cost Savings: A reduction or lessening of expenditures as a result of program outcomes. Please indicate whether these were expenditures by the County or by other entities.

Revenue: Increases in existing revenue streams or new revenue sources to the County as a result of program outcomes.

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$	$	$ 12 MILLION	$ 12 MILLION	☐

ANNUAL= 12 MONTHS ONLY

We estimate the annual revenue increase to the county of > $12M. Medicare payment for inpatient care are linearly related to the Medicare Case Mix Index. Payments are equivalent to the hospital base Medicare rate multiplied by the Case Mix Index and multiplied by the number of patients. DHS hospitals have base Medicare rates of approximately $11,000. Comparing projected Medicare revenue from 2015 to 2018:

2015: $11,000 * 6,540 * 1.69 = $122 million

2018: $11,000 * 7,012 * 1.77 = $136.5 million

Costs: 11 nurses SAEB: estimated $1.8 million

Net = $14.5 million - $1.8 million = $12.7 million

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FOR COLLABORATING DEPARTMENTS ONLY

(For single department submissions, do not include this page)

DEPARTMENT NO. 2 NAME AND COMPLETE ADDRESS	
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE EMAIL:______________________	DEPARTMENT HEAD'S NAME AND SIGNATURE EMAIL:______________________
DEPARTMENT NO. 3 NAME AND COMPLETE ADDRESS	
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE EMAIL:______________________	DEPARTMENT HEAD'S NAME AND SIGNATURE EMAIL:______________________
DEPARTMENT NO. 4 NAME AND COMPLETE ADDRESS	
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE EMAIL:______________________	DEPARTMENT HEAD'S NAME AND SIGNATURE EMAIL:______________________
DEPARTMENT NO. 5 NAME AND COMPLETE ADDRESS	
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE EMAIL:______________________	DEPARTMENT HEAD'S NAME AND SIGNATURE EMAIL:______________________
DEPARTMENT NO. 6 NAME AND COMPLETE ADDRESS	
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE EMAIL:______________________	DEPARTMENT HEAD'S NAME AND SIGNATURE EMAIL:______________________
DEPARTMENT NO. 7 NAME AND COMPLETE ADDRESS	
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE EMAIL:______________________	DEPARTMENT HEAD'S NAME AND SIGNATURE EMAIL:______________________