Severity-Based Quality Ratings and Reimbursement

Frequently Asked Questions (Nurses)

Beginning in April 2024, Penn Highlands Healthcare will be expanding quality documentation efforts by enhancing our existing Quality Documentation Program. Claro Healthcare, a nationally recognized healthcare consulting firm specializing in hospital and physician services, will be helping us with these efforts. Below are frequently asked questions about the initiative.

Why do we care about physician and hospital quality ratings or peer comparisons?
Quality ratings and peer comparisons are utilized externally by the consumers, payors and employers to make decisions concerning healthcare. Appropriately reflecting the severity of our patients provides for accurate cost, length-of-stay and mortality statistics. Consumers can now gain access to hospital and physician profiles and ratings via the internet.

How does documentation impact quality ratings and peer comparisons?
Documentation in the medical record is the foundation for the coding and billing of the patient stay which is the basis for the data utilized in quality ratings. Nursing and ancillary department documentation provides hints and clues in the record for additional documentation from the physician that may indicate a higher patient acuity. Coding rules will not allow diagnoses and/or procedures to be coded from lab, x-ray, nursing notes, PA notes, etc. unless there is physician documentation of the corresponding diagnosis in the medical record; therefore, without physician documentation of all diagnoses and procedures, severity may be understated.

How will we ensure accurate depiction of severity of illness and quality of care?
Penn Highlands will have a Clinical Documentation Specialist (CDS) assist the medical staff. The Clinical Documentation Improvement (CDI) team and the Health Information Management (HIM) coding staff will receive extensive, nationally accredited education for accurately capturing the severity of illness and quality of care provided to our patients. The CDS will review the medical record during the patient stay and will assist us in identifying opportunities to clarify documentation on a concurrent basis, allowing us to confirm the profile of patient conditions and, therefore, the resulting DRG that best reflects the severity of the patient.

Why is nursing documentation important to this program?
Nursing department documentation can lead the CDS to seek additional documentation from the physician that may indicate a higher patient acuity. Because of the amount of time spent with the delivery of patient care, nursing documentation most often reflects additional hints and clues of other conditions being treated, monitored or evaluated. Documentation of patient conditions such as arrhythmias, respiratory status or any out of the norm assessment or responses to treatment often indicates a higher severity of illness level for a patient.

What is my role related to the program?
Nursing should continue providing the excellent hints and clues which support the documentation review process. Upon a patient's arrival, nursing should document all current patient conditions on assessment (onset of illness, all signs, and symptoms, etc.) and also document the patient's history, prior

treatments and home medications. In addition, it is pertinent that specimen collections and

procedures, including wound debridement (type, wound stage, instrumentation used and excisional/ non-excisional) are documented. Nursing can ensure that patient responses to interventions are also included in the medical record. Throughout the patient stay, nursing should continue to identify and coordinate discharge needs.

To learn more or if you have any questions, please contact one of the following:

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