MEDINFO23

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Reducing preventable harm to patients using a digital platform: A tool for clinicians and coders

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Let's talk about Hospital Acquired Complications (HACs)

- Reducing preventable harm is critical in delivering high quality healthcare
- This is linked to accuracy of clinically coding; relevant and timely clinical information
- Clinical governance for HACs is a high priority area
- However, what if the coded data underpinning HACs is not reliable?

Question:

How confident are you in the accuracy of your reported HACs?

HAC classification, coding & adjustment

"A patient complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring" (ACSQHC)

- Coding of HACs specified by IHACPA
- Public reporting of HACs
- Risk adjustment model for HAC funding

Question:
What do you think is the average additional cost of Falls resulting in fracture or other intracranial injury?

1. Pressure injury	5. Unplanned intensive care unit admissions	9. Gastrointestinal bleeding	13. Endocrine complications
2. Falls resulting in fracture or other intracranial injury	6. Respiratory Complications	10. Medication complications	14. Cardiac complications
3. Healthcare associated infection	7. Venous thromboembolism	11. Delirium	15. Third and fourth degree perineal laceration during delivery
4. Surgical Complications (unplanned return to theatre)	8. Renal Failure	12. Incontinence	16. Neonatal birth trauma

A:

$17,173

*Average additional cost of Falls resulting in fracture or other intracranial injury**

Hospital complications cost more than $4billion a year for public hospitals and more than $1billion for privates**

*Fernando-Canavan Liam et al (2021) Measuring the economic impact of hospital-acquired complications on an acute health service. *Australian Health Review* **45**, 135-142.

** Grattan Institute 2018. Safer care saves money: How to improve patient care and save public money at the same time

Challenges for clinicians & coders

- Lack of trust in the coded data
- Lack of clinician engagement in HAC management
- Multiple sources of HAC data
- Lack of timeliness in HAC reporting
- Incomplete clinical documentation impacting on the assignment of condition onset flag and code assignment specificity

Consider:

How can we ensure that HAC data that is reported is accurate and will ultimately improve the quality of care and patient safety? What systems and processes do you have in place to manage and report on your HACs?

Using SaaS to correct and measure HACs

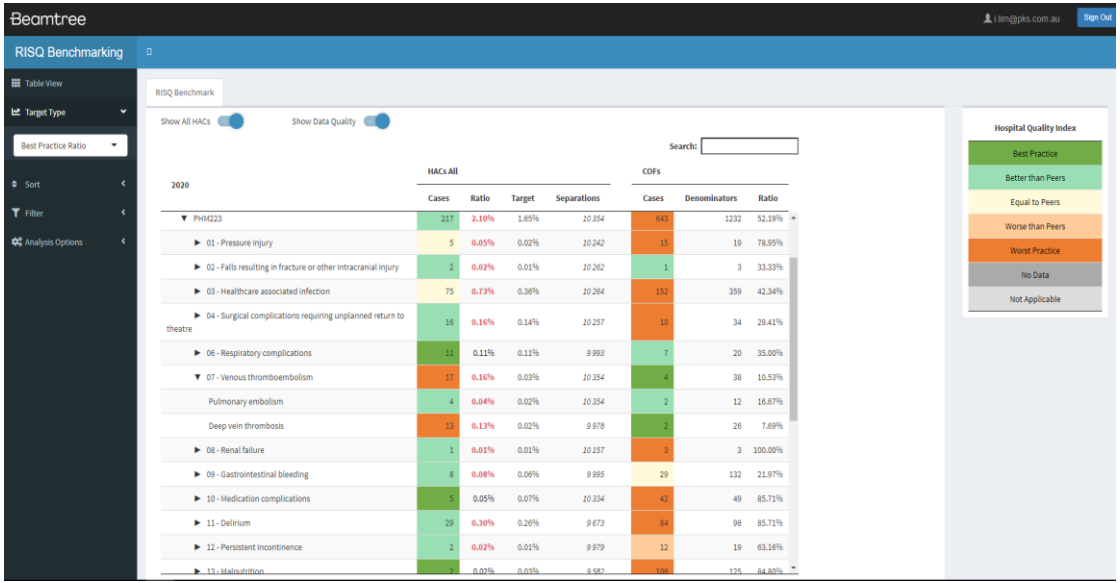
Identifies focus areas and set targets, allowing health services to monitor improvements over time

Measures data quality with a focus on reducing HACs error rates and to reduce financial penalties

Compares performance with industry best practice

Monitors HAC rates, drill down into clinical specialities or select records for review with detailed source information from the medical record

RISQ™ drives data and patient safety improvements



- Benchmarking with Peers
- Workflow for Coders & Clinicians
- National Standards Measurement

Case study 1: Central Adelaide LHN

≈140k annual separations

5 sites (2 largest sites: Royal Adelaide Hospital, The Queen Elizabeth Hospital)

Pre RISQ:

- ✕ NO Formalised HAC Management workflow
- ✕ NO Rigorous HAC auditing process
- ✕ NO Clinician trust in HAC

Case study 1: CALHN - RISQ

RISQ - went live early 2022

New workflows & HAC governance implemented:

- Each clinical unit has their own access to RISQ portal
- HAC review panels established and meet regularly
- HAC queries are escalated back to the Documentation Improvement Manager

44

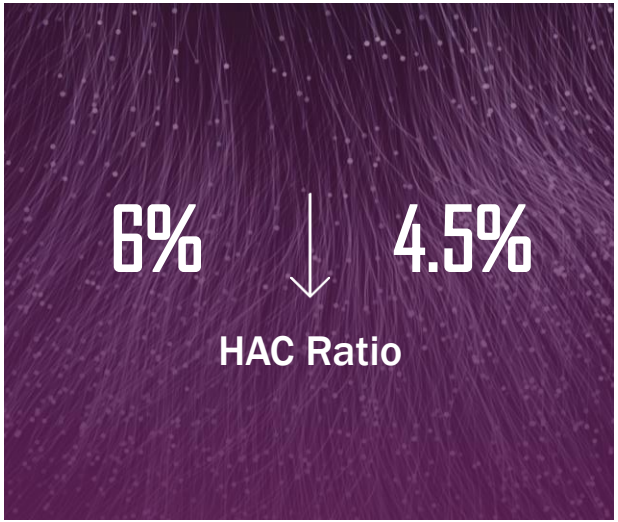
HACs coded incorrectly within the first week of implementation

- ✓ New HAC reduction infection controls
- ✓ In-house clinical programs developed on HAC rates
- ✓ Improved education on coding rules

Case study 1: Central Adelaide LHN - IMPACT

- Stringent HAC Management workflow
- All HACs justified and reviewed
- Trust in data

> *"Higher data quality, Clinical access to reviewed HAC data without having to come to Clinical Coding Team for audits, individual coder education, ability to audit output and review coder understanding of HACs and documentation."*
>
> CALHN



Case study 2: St Vincent's Health Australia

Why RISQ?

- SVHA Board directive in 2019 to reduce HAC rate by 10% (15% in subsequent years)
- Wanted to be leaders in minimising potentially avoidable harm – HACs
- Needed transparency of data, confidence in accuracy of data, including automated data collection, integrated workflows and more robust reporting
- Improved internal and external benchmarking

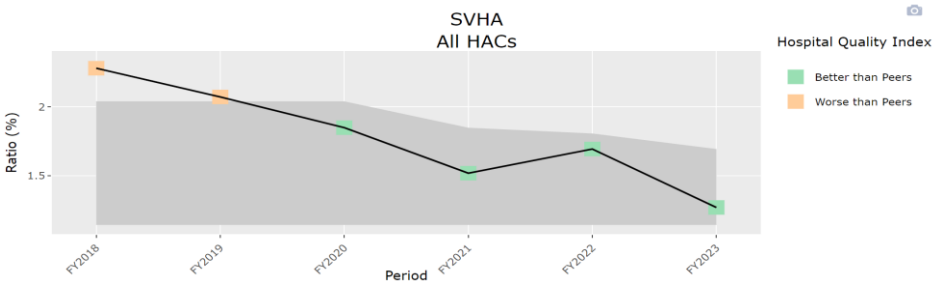
A network of 10 Private Hospitals across 3 states

- 1693 beds incl. 55 ICU beds
- 75 Operating Rooms
- 9 Cardiac Cath Labs

Case study 2: SVHA – new workflows

- RISQ was implemented in 2020 as the tool to manage and govern HAC data across SVHA private hospitals.
- Establishment of **Multidisciplinary Quality & Safety, Clinicians and Coders HAC Working Parties** to:
  - Identify the Priority HACs due to high rates/ outliers/ harm
  - Review clinical practices to ensure compliance with state and national standards
  - Review quality of clinical documentation and coding
- Coder workflow and clinician workflows developed in collaboration with Beamtree to ensure almost real time automated HACs review

Case study 2: SVHA– Results



Period		Ratio	Target
FY2018		2.281%	2.040%
FY2019		2.073%	2.040%
FY2020		1.849%	2.040%
FY2021		1.518%	1.849%
FY2022		1.694%	1.807%
FY2023		1.269%	1.694%

Nb. 2022 – HACs V3.1: new HAC Surgical Complications & URTT saw slight increase in HACs – industry review in progress

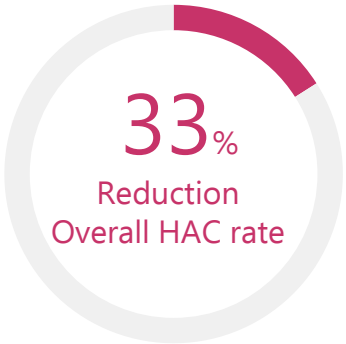
Case study 2: SVHA– What helped to achieve the reduction?

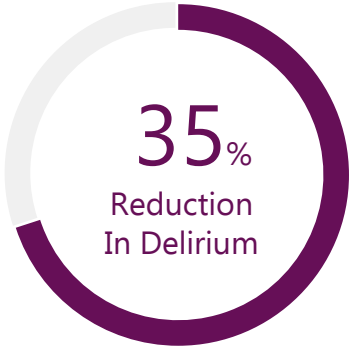
- ✓ Ongoing Board directive to improve & CEO accountability
- ✓ Private hospitals collaborative approach, led by an enthusiastic Clinical Governance Manager and Clinical and HIS teams!
- ✓ Regular benchmarking reports using RISQ Portal
- ✓ Committed multidisciplinary HAC working parties who meet regularly to maintain and sustain the improvements
- ✓ Deep dives into the data in response to identified gaps
- ✓ Close working relationship with Beamtree.

Case study 3: Uniting Care (Private Hospital Group)

"If coding of HACs does not accurately reflect trust incidents rate, mistrust in the data can build with clinical governance programs then focusing on querying the data rather than preventing the HAC"

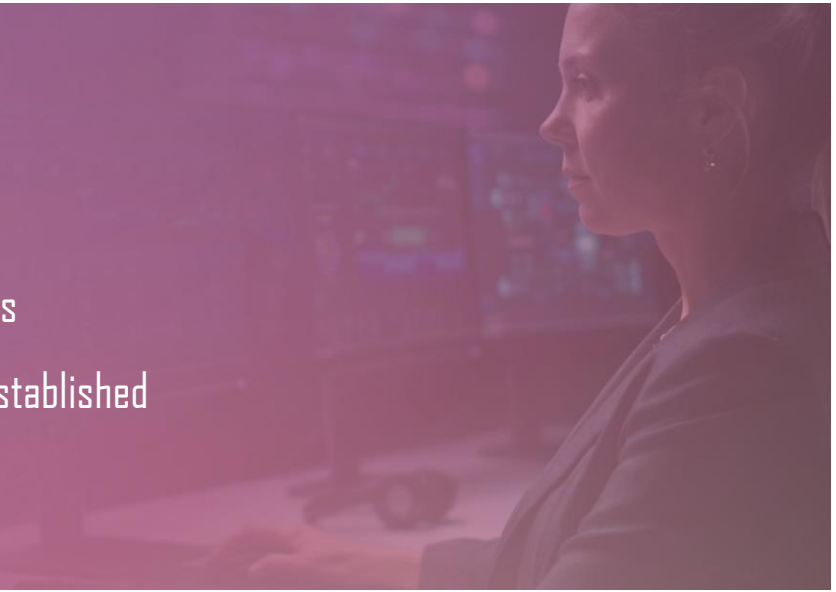
"The Beamtree HAC solution implemented by us have driven many improvements in health information, data management and the delivery of clinical care. The partnership with our clinical coder and clinicians is one of collaboration."





Key takeaways:

1. Coding education is important
2. Incomplete documentation needs to be addressed
3. Embed coding HAC review process into daily workflows
4. Collaboration between clinician and coders must be established
5. HAC governance should be clear



Thank you

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