Patient Safety Indicators and the Query Process

Patient Safety Indicators (PSI's) provide information on potentially avoidable safety events that represent opportunities for improvement in the delivery of care. More specifically, they focus on potential in-hospital complications and adverse events following surgeries, procedures, and childbirth. CMS assesses inpatient care quality in part through its analysis of inpatient claims utilizing Patient Safety Indicators. PSI reporting affects many reputational websites, such as CMS Hospital Star Ratings, Healthgrades, Leapfrog, and many others.

Key points:

1) Not all identified PSI's are actual reportable safety events.

2) Some PSI's are avoidable with proper documentation.

3) True PSI's help focus efforts to improve patient safety.

Some PSI Examples and Query Responses:

a) PSI-09: Perioperative Hematoma/Hemorrhage

A patient has postoperative bleeding leading to a second surgery to control the bleeding. Our comprehensive chart review may identify that the patient was on an anticoagulant prior to surgery that may have contributed to the bleeding, and we will ask this question to you in a query. If anticoagulation was documented and the query supports it, this is not considered a true PSI. However, if you feel the bleeding was not due to anticoagulation or antiplatelet agents, this should be documented, and it will be reported as a patient safety event.

b) PSI-03: Pressure Ulcer

If a sacral decubitus is present on admission (POA) then that pressure ulcer is not attributable to the hospital care and would not be considered a patient safety event. Please read the wound care nurses note and look for the POA status in that note. More importantly, look and care for the wound on day one of every patient who you expect to be in the hospital for an extended stay. Documenting the pressure ulcer on admission excludes this PSI. (Please remember that the wound care note can only document the stage and depth of the wound. Coding and documentation rules state that the site of the wound and whether the wound is POA can only be documented by the physician.)

c) PSI-12: Perioperative Pulmonary Embolism/Deep Vein Thrombosis

- CMS allows us to ask you through the query process if a condition was POA, and one of the responses you can choose is **"unable to clinically determine"** which by default codes the diagnosis as being POA. The most common example would be for a patient with a history of DVT who is taken off Eliquis for surgery, and subsequently develops a large DVT on day 2 after surgery while still in the hospital. Given the patients history and uncertainty surrounding the etiology of the DVT, a reasonable query response could be "unable to clinically determine" which would code the DVT as possibly present on admission. However, if your clinical judgement determines that it is unlikely that the

patient had a DVT on admission, this should be documented and will be reported as a patient safety event.

PSI Future Considerations:

Some patient safety indicator methodologies have changed recently.

1) No COVID positive patient will be entered into PSI reporting.

2) An important metric, PSI-4: Death Rate among Surgical Inpatients with Serious Treatable Complications has added **code Z66, Do Not Resuscitate**. If this order is obtained for your patient anytime during the admission, it will signify that your patient is more complex to care for and will favorably impact the risk adjustment assigned to the patient.

3) Documenting all your patients' chronic medical conditions (e.g. congestive heart failure, malnutrition, stroke, pulmonary hypertension, bleeding disorders, psychiatric disorders, etc.) in the chart is crucial to gaining credit for the difficulty of caring for that patient and will significantly impact the patient safety indicator scoring metrics.

Our team reviews all active PSI cases and will reach out with a query or a phone call for more information to accurately report the potential safety event. We are finding that many of these situations are not safety events reportable to the public. While we may be able to exclude a PSI via the query process, often the reportable event points us to where we need to improve a patient safety process. When we find PSI reportable events that are genuine quality issues, we have work teams prepared to execute on a plan to prevent future safety events. Please reach out if you would like to become involved to help us review cases and help us improve the care delivered to all our patients.

Please reach out to either Dr. Firman (russell.firman@sjhsyr.org) or Dr. Cummings (deann.cummings@sjhsyr.org) with questions on how to help improve PSI events at St. Joseph's Health.