

VALUE-BASED PURCHASING

NON-PAYMENT FOR HOSPITAL-ACQUIRED CONDITIONS

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Medicare's current payment systems reward quantity, rather than quality of care, and provide neither incentive nor support to improve quality of care. Value-based purchasing (VBP), which links payment more directly to the quality of care provided, is a strategy that can help to transform the current payment system by rewarding providers for delivering high quality, efficient clinical care.¹

HAC payment adjustment provision synonyms:

- POA
- HAC-POA law
- HAC-POA policy
- HAC-POA provision
- POA/MS-DRG provision
- Hospital-Acquired Condition provision

One major thrust of healthcare reform has been Value-Based Purchasing (VBP). Consistent with the history of other major shifts in approaches to healthcare reimbursement in the U.S., the country's largest payer — Centers for Medicare & Medicaid Services (CMS) — is leading the way with changes to the Medicare program. Authorized by Congress in the Deficit Reduction Act of 2005, CMS has been building upon the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program, which provided differential payments to hospitals reporting their performance according to a defined set of quality measures (core measures), to put in place a new program beginning in FY 2009 that includes both public reporting and financial incentives for better performance. The intent is to use the combination of transparency and financial incentives to drive improvements in clinical quality, patient-centeredness and efficiency. This is part of the larger CMS initiative to alter reimbursement regulations for hospitals, including the Recovery Audit Contractor (RAC) program, Medicare Severity-DRGs (MS-DRGs), and Medicare rate increases pegged to performance on core measures.

“Some say that every system is perfectly designed to get the results it gets, and right now our healthcare system is not designed to produce reliably high quality care. Value-based purchasing is potential rocket fuel to get us there.”²

— Carolyn Clancy, Director of the Agency for Healthcare Research

For hospitals, VBP presents many challenges. The major one, of course, is to achieve high levels of performance on the clinical measures and patient satisfaction surveys used by CMS to gauge quality. However, even assembling the necessary patient-specific information to determine affected patients and whether or not they have received the appropriate care is difficult and labor-intensive.³

This paper focuses on another component of VBP: the *Hospital Acquired Condition (HAC) payment adjustment provision*,⁴ which: a) provides a different kind of financial incentive (or, more appropriately, disincentive) by decreasing reimbursement, and b) requires that hospitals code claims to indicate primary and secondary diagnoses (including potential HACs) that are and are not present on admission (POA).

The 2009 implementation of HAC payment adjustment is just the beginning of using non-payment to drive improvements in patient safety. CMS is already proposing and considering adding conditions to the current “selected HACs” in 2010 and subsequent years, risk and/or rate-based HAC payment adjustments, and other changes. In addition, similar programs are being piloted or are in some stage of planning by commercial and Medicaid payers, state hospital associations, and employer- and community-interest groups.

The addition of HAC reimbursement adjustment to CMS VBP presents new challenges for hospitals. This white paper provides an overview of how it works, what is required of hospitals and how they are responding.

“So we’re working to transform the Medicare program from simply being a passive payer to being a more active purchaser of higher quality more efficient healthcare.”⁵

— Tom Valuck, MD, JD, Medical Officer and Senior Advisor, CMS

CMS HAC Payment Adjustment — How Does it Work?

This section describes how the HAC payment adjustment provision is designed to work.

“Selected” HACs

For the first year, CMS selected a subset of HACs for payment adjustment that have been under scrutiny for some time. They were selected because they are:

- high-cost, high-volume, or both, as determined by CMS;
- coded in ICD-9-CM as “complicating conditions” (CCs) or “major complicating conditions” (MCCs) that, when present as secondary diagnoses on claims, result in a higher-paying MS-DRG; and
- reasonably preventable.

CMS designated (“selected”) 10 HACs for FY 2009 payment adjustment and added three never events in January that also apply to all Medicare claims filed during the year.

An HAC is a reasonably preventable condition which was not present or identifiable at the time of hospital admission, but was present during discharge.⁶

Hospital-Acquired Conditions (HAC) Selected for FY 2009	
1. Foreign Object Retained After Surgery*	
2. Air Embolism*	
3. Blood Incompatibility*	
4. Stage III and IV Pressure Ulcers*	
5. Falls and Trauma*	Fractures Intracranial Injuries Crushing Injuries Burns Dislocations Electric Shock
6. Manifestations of Poor Glycemic Control*	Diabetic Ketoacidosis Nonketotic Hyperosmolar Coma Hypoglycemic Coma Secondary Diabetes with Ketoacidosis Secondary Diabetes with Hyperosmolarity
7. Catheter-Associated Urinary Tract Infection	
8. Vascular Catheter-Associated Infection	

Hospital-Acquired Conditions (HAC) Selected for FY 2009 (cont'd)

9. Surgical Site Infection Following Specified Procedures	Coronary Artery Bypass Graft (CABG) – Mediastinitis Bariatric Surgery: <ul style="list-style-type: none"> • Laparoscopic Gastric Bypass • Gastroenterostomy • Laparoscopic Gastric Restrictive Surgery Orthopedic Procedures: <ul style="list-style-type: none"> • Spine • Neck • Shoulder • Elbow
10. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)	Total Knee Replacement Hip Replacement
*Also designated by the National Quality Forum as Never Events ⁷	

NDCs Added as Never Event HACs During FY 2009

1. Wrong Surgical or Other Invasive Procedure Performed on a Patient	
2. Surgical or Other Invasive Procedure Performed on the Wrong Body Part	
3. Surgical or Other Invasive Procedure Performed on the Wrong Patient	

HACs were published in August, 2008;⁸ NDCs were announced and became effective on January 15, 2009.⁹ Note that HAC selection criteria are similar to those used by the National Quality Forum (NQF) to designate “never events,” and that in fact, the HAC list overlaps the NQF list of 28 never events.¹⁰ More information about HAC selection is published in the Federal Register, Tuesday, August 19, 2008, (<http://edocket.access.gpo.gov/2008/pdf/E8-17914.pdf>).

HACs Under Consideration for Future Selection for FY2010 (as of March 31, 2009)

1. Delirium
2. Ventilator-Associated Pneumonia (VAP)
3. Staphylococcus aureus Septicemia
4. Clostridium difficile-Associated Disease (CDAD)
5. Legionnaire’s Disease
6. Iatrogenic Pneumothorax
7. Methicillin-Resistant Staphylococcus aureus (MRSA)

Hospital Claims Reporting Requirements

On all Medicare claims for October 1, 2007 and subsequent discharges, most non-government acute care hospitals have had to include a POA indicator code with each primary and secondary diagnosis. Beginning with January 1, 2008 discharges, CMS notified hospitals when indicator codes were lacking; for April 1, 2008 and subsequent discharges, claims lacking this documentation were returned.

Types of Hospitals Exempt from Mandatory CMS Claims POA Reporting¹¹

- Critical access hospitals
- Long-term care hospitals
- Maryland waiver hospitals
- Cancer hospitals
- Children's inpatient facilities
- Rural health clinics
- Federally qualified health centers
- Religious non-medical healthcare institutions
- Inpatient psychiatric hospitals
- Inpatient rehabilitation facilities
- Veterans Administration and Department of Defense hospitals

As the name suggests, POA indicator codes report whether secondary diagnoses were present when the patient was admitted. Generally speaking, POA conditions are those present at the time the admission order was written. They also must be confirmed by patient medical record documentation, which must be completed by a provider who cares for or treats the patient — when that “provider” is “a physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis.”¹²

Present on Admission Indicator Codes

- Y Yes, present at the time of the admission order
- N No, not present at the time of the admission order
- U Unknown (insufficient documentation)
- W Clinically undetermined (clinician unable to clinically determine)

HAC Payment Adjustment Rules

On claims for discharges on and after October 1, 2008, CMS automatically makes reimbursement adjustments when one or more of the selected HACs listed as a secondary diagnosis on the claim is not designated as POA and the HAC(s) is the only secondary diagnosis listed.¹³

The mechanics for HAC payment adjustments are based on a further evolution of DRGs known as MS-DRGs, which provide lower reimbursements for the same condition without CC — complications or comorbidities — or MCC — major complications or comorbidities. (DRGs — Diagnostic Related Groups — are codes that classify hospital cases in terms of similar hospital resource use, and are used by CMS and many other payers in determining reimbursement rates for inpatient care.) Payment adjustment is achieved by assigning the MS-DRG code without MCC or CC (and results in a lower payment). Basically, the result is that the hospital receives reimbursement as though the HAC secondary diagnosis, or never event, was not present.¹⁴

“Effective for acute care inpatient PPS discharges on or after October 1, 2008, the Secretary [HHS] cannot assign cases with these conditions to a higher paying DRG unless they were present on admission.”¹⁵

“This provision will apply only when the Hospital-Acquired Condition is the only CC or MCC present on the Claim. If any other CC or MCC, not subject to the Hospital-Acquired Condition Provision, is present, the case will be assigned to the higher-paying MS-DRG.”¹⁶

HAC Payment Adjustment – How are Hospitals Responding?

HAC payment adjustment provision compliance poses a number of challenges to hospitals:

1. Improve Care Processes: Both redouble HAC and never event prevention efforts and reliably identify pre-existing conditions at the time of admission. Both are critical not only to the hospital's bottom line, but also to improve the real and perceived quality of care at the hospital.
2. Ensure Clinical Documentation Substantiates POA: Be sure providers clearly document the presence of HACs upon admission.
3. Manage POA Coding: That is, ensure that Medicare (and other participating insurer) claims include justifiable POA indicator codes with each primary and secondary diagnosis.

How hospitals are addressing these challenges is reviewed below.

Care Process Changes

CMS-selected HACs have been the subject of hospital quality improvement efforts for a long time; in the case of patient falls and pressure ulcers for decades. Not a single targeted item is new. What is new — the direct tie between their occurrence and eventual reimbursement — just adds to the long list of reasons for devoting significant hospital resources and improvement efforts to eliminating these conditions whenever possible.

Survey Responses – Care Process Questions ¹⁷	
Changed admission procedures or processes	58%
Limited screening to one or two conditions	67%
Added admission screening for pressure ulcers	92%
Add admission screening for pressure ulcers and UTIs	42%

Different interventions are used to address different types of HACs, and hospitals continue to make advances in the tactics employed. For pressure ulcers, for example, one fairly recent intervention is use of skin/wound assessment teams (or SWATs) to reinforce the work of nurses and others in applying guidelines for assessment and treatment. In an increasing number of hospitals, surgical teams are being aided by post-surgical kit inventories of Radio Frequency Identification (RFID)-tagged items used during surgery. Most hospitals have made significant progress on HACs and never events that can occur during or following surgery, applying guidelines developed by the American College of Surgeons, the Institute for Healthcare Improvement and other groups.

One of the concerns among caregivers involved with managing these HACs and never events is how much more prevention can be expected in some of these areas. For example, patient falls are commonly associated with elderly patients who try to get up and around without recommended assistance; and it is unrealistic to implement 24x7 monitoring in every case. This is one of the reasons hospitals are encouraging CMS to consider risk- and/or rate-based payment adjustments for some conditions.

In their direct responses to the HAC payment adjustment provision, hospitals have been paying particular attention to the admission process to ensure that HACs present at the time of admission are detected as soon as possible. Although much of the screening has already been routine practice, when expansions or investments in new technology are being considered, improvement teams in hospitals must carefully weigh the costs and the yields.

Patient profiling is widely reported to target the most at-risk patients. For example, patients transferred from nursing homes and other facilities are at far greater risk for pressure ulcers and certain types of infections. Other typical cases receiving particular attention are patients admitted with Foley or intravascular catheters, who are routinely screened for bloodstream and/or urinary tract infections (UTIs).

Ensure that Clinical Documentation Substantiates POA

Clinical documentation in most hospitals today is a combination of paper-based processes (handwritten or dictated and transcribed) and some electronically captured notes and data elements as hospitals incrementally implement inpatient electronic health records (EHR). Added to that complexity, CMS has specified that physicians (or other providers legally authorized to provide information to substantiate diagnoses) must complete POA documentation. These complexities and demands lead to several challenges:

- Documentation templates and other tools available in EHRs are the ideal vehicles for ensuring that needed information is captured. The reality though is that physician documentation is slated as one of the last EHR modules to be rolled out (years from now at most hospitals).
- Other aspects of VBP — core measures and MS-DRGs in particular — have already placed increased demands on clinician documentation, and all of this work must be coordinated.
- Physicians completing the needed documentation are not always the original source of the information. For example, nurses may well be the first to discover (and document the presence of) pressure ulcers at admission. Thus the documentation task requires coordinated teamwork to be efficient.
- Doing a good job documenting POA for purposes of the HAC payment adjustment requires recording not only what is present, but also what is not present and what might be present (e.g., suspected). This type of documentation — also needed for core measures and other quality indicators¹⁸ — is counterintuitive to clinicians and a major effort is required to manage change.

Summary of POA Coding and Documentation Rules (from “ICD-9-CM Official Guidelines for Coding and Reporting”)¹⁹

- Conditions explicitly documented by providers at the time of admission
- Conditions that were diagnosed prior to admission (e.g. asthma, diabetes, hypertension)
- Conditions that were “clearly present on admission” but not diagnosed until after admission occurred. Provisos: one of the following must be documented at the time of admission:
 - Suspected
 - Possible
 - Rule out
 - Symptom later determined to be related/caused by
- Conditions that develop during prior outpatient encounters, including:
 - Emergency department visits
 - Observation
 - Outpatient surgery
- Chronic conditions. Provisos:
 - Even if not diagnosed until after admission
 - If a combination code used to diagnose the condition only identifies the chronic condition (and not the acute exacerbation)
 - However, not POA if the combination code includes acute exacerbation (e.g. asthma with asthmaticus) and exacerbation was not POA
- Conditions documented as possible, suspected, rule out or probable at the time of discharge. Provisos;
 - Must be documented as suspected at time of admission, or
 - Symptoms or clinical findings associated with the condition are documented as present on admission

One CMS documentation guideline that is not clear is how soon after admission the condition must be documented as POA. Prevailing opinion at hospitals is that, although CMS will accept “clarifications” to documentation any time during the patient stay, some evidence or suspicion of the condition must be documented at the time of admission. This can be in the form of “rule-out” diagnoses, symptoms or suspected problems. Once again, the challenge is that most physicians are not accustomed to documenting this way and need instruction and immediate feedback to incorporate changes into their documentation processes at the point of care.

“If you’re sloppy with documentation and POA reporting, you’re going to get hammered by reduced MCC and CC reimbursements.”

– Anonymous contact

Hospitals are using a variety of strategies to improve documentation, most of them in concert with ongoing efforts to improve quality reporting and discharge coding. In fact much of the RAC program audit is focused on whether documentation adequately justifies billing. Now the scope of RAC audits includes POA.

Survey Responses – Education Questions ²⁰	
Education or training for MDs and RNs on POA screening/documentation	92%
Specific training for billing/coding staff	75%

Because documentation must be done by a physician, one constant theme is continuing physician education. Efforts focus on both the “whys” – explanations about why POA documentation is important, as well as the “specifics.” At one hospital interviewed for this paper, for example, staff are developing and distributing specific guidelines about how to distinguish (in the patient record) between catheter-based UTI and bloodstream infections from other sources. Most of the standard delivery modes are used to reach physicians, including brown-bag lunch meetings, scheduled sessions, newsletter articles and one-on-one meetings with champions, department chiefs and other key providers.

Education is reinforced with changes to the documentation process, including new forms and more coordinated teamwork. Some hospitals are bringing in outside assistance to help address documentation gaps for POA, core measures and other uses. Some changes are as simple as asking clinicians to write “POA” next to the appropriate diagnoses. Specially designed forms – especially for a critical piece of documentation, the physician history and physical – are often being employed to remind the physician to look for POA HACs and provide appropriate documentation. Hospitals in which physicians are using an EHR are at a great advantage because data and order entry modules can be configured to automatically build in special templates and/or “pop-up” reminders for physicians to include the information. In advance of the EHR, hospitals are employing paper templates and checklists attached to the patient chart or incorporated into the packet of admission forms.

Survey Responses – Documentation Questions ²¹	
New staff have been hired to help with POA assessment and documentation	8%
New protocols require nurses to take and file pressure ulcer photographs in patient chart	17%

Many hospitals already use additional staff — often nurses — to track patients of interest and interact with clinicians to address any gaps in care or documentation they identify. For the most part, this role has been focused on information needed for billing (coding, especially of secondary diagnoses) and/or quality management and reporting. In essence, a new process has emerged that ensures that reimbursement needs, such as POA identification, are incorporated into clinical documentation. In some cases, this has even resulted in the hiring additional staff. For example, one hospital reported, “ ... three dedicated case managers/documentation specialists have been hired specifically to review new admissions and check for adequate documentation.”²²

The specific titles and job responsibilities of the new supporting roles vary (there are some role crossovers), and some hospitals employ multiple roles. However, we generally see the following roles evolving as an adjunct to point-of-care documentation:

- **Coders:** The primary additional responsibility for coders is to assign POA indicators to primary and secondary diagnosis codes submitted with Medicare claims. However, some hospitals are also asking coders to review documentation to ensure POA statuses are substantiated, look for indicators in the patient chart that the condition is or may be POA, and ask providers to clarify documentation when questions arise. Training coders is clearly important at hospitals that assign coders with this additional responsibility, and some hospitals also insist that coders work closely with clinical documentation specialists.
- **Case Managers:** Case managers have traditionally focused on insurance authorizations and patient discharge. To manage POA, hospitals have assigned case managers to work with providers during the admission process — to review and ensure that both appropriate pre-admission screenings are performed and documentation accurately reflects POA and “not POA” statuses. In addition to working directly with physicians, they may work with clinical documentation specialists to understand hospital documentation guidelines and provide feedback to documentation specialists about what providers do and do not understand. They may also work closely with coders to be sure that potential POA conditions are not falling through the cracks and that coders understand documentation conventions.
- **Clinical Documentation Specialists:** The emergence of clinical documentation specialists (registered nurses who are specially trained to understand and then work closely with providers to develop and implement effective patient record documentation standards and practices) reflects increasing hospital commitment to improved documentation. This new supporting role is intended to close gaps in documentation needed for patient safety and quality of care, as well as for reimbursement protection. At some hospitals documentation specialists also take turns at or have primary POA documentation review responsibility similar to *Case Manager* roles previously discussed.

“One of the purposes of our program is to get complete, accurate documentation into the patient record.”

— *Cindy Dougherty, Director Quality Measurement/Improvement
Northwest Community Hospital*

- **Quality Nurses:** This role has mostly focused on assembling information needed for clinical performance measures such as core measures, which now must be reported externally. In many hospitals, the role has evolved to real-time assembly of information during patient stays, with the responsibilities of determining whether standards apply and whether there are apparent gaps in care or documentation. In this concurrent role, the

quality nurse typically interacts with the physician and other members of the patient care team to address any gaps identified, and in some hospitals this includes assisting with POA-related processes and documentation.

In any hospital, it is important that the particular mix of supporting roles is coordinated and efficient.

Managing POA Coding

POA coding has been required on Medicare claims for October 1, 2007 and subsequent discharges. CMS recommends the following documents for POA coding guidelines and instructions:

- ICN# 901046, Present on Admission (POA) Indicator Coding by Acute Inpatient Prospective Payment System (IPPS) Hospitals (summary)
- UB-04 Data Specifications Manual
- ICD-9-CM Official Guidelines for Coding and Reporting

According to nurses, coders and other hospital staff contacted, the challenge associated with POA coding is not the coding itself, but rather the potential for payment adjustments based on what may be deemed “insufficient confirming documentation.” As a result, coders are now expected to:

- Carefully review patient record documentation to be sure it supports POA coding
- Contact the physician, case manager or clinical documentation specialist for clarification when it does not
- Work closely and coordinate efforts with case managers, clinical documentation specialists and others involved in documentation improvement programs

“We were pleasantly surprised at how doable POA reporting was. We expected denials, re-submissions and other interruptions, but it all went very smoothly.”

— *Anonymous contact*

At two health systems contacted, POA indicators are now included with all claims to all payers, including those that have not demanded or requested the reporting. To date, neither has received feedback (negative or positive) from non-demanding payers about the reporting or its impact on claims payments.

HAC Payment Adjustment Provision — What are the Actual Impacts on Hospital Reimbursement?

The CMS HAC payment adjustment provision is significant because it is the first VBP initiative to enforce defined payment adjustments for a large volume of claims from hospitals throughout the United States. It is too early for individual hospitals to be experiencing the resulting reduced reimbursement. One reason is that CMS only began adjusting payment on October 1, 2008. The typical lag in claims processing means that the first affected claims are now probably only beginning to emerge. A second reason is that the selected HACs and never events are fortunately infrequent in an individual hospital, so that experience will have to be accumulated over a fairly long period of time. One hospital quality executive contacted believed that it would take at least a year before it will be possible to discern the impacts on revenues.

One prospective estimate based on assumed rates of adjustment for eight of the current 10 selected HACs predicts an FY 2009 reduction in Medicare claims payments of approximately \$26.7 million.²³ For the roughly 5,000 affected hospitals, that would amount to approximately \$5,340 per hospital.

CMS expects a greater overall impact. In 2007, the agency estimated that while direct Medicare payments will decrease by \$20 million per year, a far greater saving (to all payers) will ultimately be realized from 2.4 million fewer days billed for HACs, or \$9.3 billion per year.²⁴ Assuming roughly 5,000 affected hospitals,

that would amount to approximately \$1.86 million per hospital per year. Particularly in light of the increasing pressures to achieve healthcare reform results, we expect CMS (and other payers) will pay close attention to how closely those objectives are being met, and make program adjustments accordingly — that will both shift pressures to reduce costs squarely onto hospitals, and require significant ramp up over time as the non-payment programs mature.

The Bottom Line

The CMS HAC payment adjustment provision is neither the first nor the only initiative focused on holding hospitals accountable for HACs and never events. Since 2002, the National Quality Forum has maintained a list of preventable, injurious events that happen during hospital care and called for continued quality improvement in hospitals to ensure that they never occur.²⁵ A growing number of states now require hospitals to report the occurrence of HACs and/or never events and post the information obtained publicly.

Including HAC payment adjustment in VBP is also not the first program to link never events with reimbursement. In 2005, Health Partners (a Minnesota health plan) announced that it would no longer pay for (and patients should not be billed for) never events. In 2007, the Leapfrog Group, an employer coalition, issued a policy statement that hospitals should not be reimbursed for hospital care involving a never event.²⁷ In response to this policy and recommendations from the Institute for Healthcare Improvement and many state hospital associations, many hospitals voluntarily agreed not to bill in these instances.²⁸

Many commercial payers are working on or have never event payment policies in place. Examples include Aetna, which is including provisions in all new and renewed hospital contracts that require reporting and waiving charges for never events;²⁹ United Health Care, which began collecting POA data in January 2008 and demanded never event reporting in January 2009;³⁰ and CIGNA, which implemented an HAC payment adjustment program similar to the CMS provision initiative.³¹

“Effective October 1, 2008, ... we will review admissions with identifiable Never Events and Avoidable Hospital Conditions. If it is determined there were additional hospital days at a participating provider facility which directly and exclusively resulted from an Avoidable Hospital Condition (not present on admission), reimbursement for such additional inpatient days may be denied ... ”

— CIGNA Reimbursement Policy Statement³²

For hospitals, all of this history and activity provide a clear sign that non-payment will be a major element of hospital reimbursement. In anticipation, we recommend that hospitals do the following:

- In planning for the continued roll-out of the inpatient EHR, ensure that the data capture and decision support needs for minimizing HACs and documenting POA are addressed as soon as possible. HAC payment adjustment provision requirements clearly point to the importance of both better and coordinated interdisciplinary EHR charting tools (so nurses, physicians, and other caregivers can more easily coordinate POA as well as overall care documentation). Also note that many of the HACs currently included in CMS payment reduction involve surgical care, for which some pre-operative information may be captured by specialized applications rather than the hospital-wide EHR. Including staff familiar with the requirements is particularly important during implementation(s).

“Nearly 20 states already have or are considering methods to eliminate payment for some never events.”²⁶

- Many of the current and proposed CMS HACs involve infections. The CMS HAC payment adjustment provision adds yet another reason to equip the infection management team with the electronic tools they need to identify at-risk and infected patients as quickly as possible, to make appropriate treatment decisions, and to track and document outcomes. A critical byproduct is timely and complete information with which to understand where to focus screening at admission and improve overall infection prevention and management.
- The new supporting roles — clinical documentation specialist, concurrent coder, quality nurse — are here to stay. The most effective approach is one coordinated process that addresses documentation needs for quality management, HAC/POA and MS-DRGs, and equips the team members with the tools they need to work efficiently (including as a team). Customized reporting and prompting using the tools available in the EHR or in specialized clinical surveillance applications will make the work both more efficient and effective.

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