Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Articulate what the coded data really means and how clinical documentation impacts it
  - Implement CDI documentation tips for the Hospital Readmissions Reduction Program (HRRP) (acute myocardial infarction, heart failure, pneumonia, COPD, total hip arthroplasty, total knee arthroplasty, and following CABG)
  - Reorganize strategies for working with other departments such as case management and quality to improve quality outcome reporting

CMS Value-Based Purchasing Goals

- The Department of Health and Human Services (HHS) announced in January 2015 a new set of goals and a timeline for tying Medicare payments to quality or value through alternative payment models
  - Tie 30% (up from 20%) of traditional Medicare payments by the end of 2016 thru ACOs (accountable care organizations) and bundled payments
  - Tie 50% by the end of 2018
- HHS also set a goal of tying 85% of all traditional Medicare payments to quality or value by 2016 and 90% by 2018 through programs such as the Hospital Value-Based Purchasing Program and the Hospital Readmissions Reduction Program
CMS Value-Based Purchasing Goals

Hospital Value-Based Purchasing Programs

- Hospital quality initiatives are aimed at improving the quality, efficiency, and overall value of healthcare.
- Inpatient hospital programs:
  - Hospital Inpatient Quality Program (IQR)
  - Hospital Value-Based Purchasing Program (HVBP)
  - Hospital Readmissions Reduction Program (HRRP)
  - Hospital-Acquired Condition Reduction Program (HAC)

Hospital Readmissions Reduction Program

- Of the three P4P (pay for performance) programs, the readmissions penalties are the most significant for inpatient payments in FY 2015. Hospitals may now lose up to 3% of reimbursement moving forward, depending on their readmissions performance.
**HRRP Reimbursement Impact**

<table>
<thead>
<tr>
<th>Condition</th>
<th>FY 2011 payments</th>
<th>FY 2014 payments</th>
<th>FY 2015 payments</th>
<th>FY 2016 payments</th>
<th>FY 2017 payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Max penalty</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Acute MI</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Heart failure</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>COPD</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Total hip/knee</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>CABG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned readmissions excluded</td>
<td>X Version 2.1</td>
<td>X Version 2.1</td>
<td>X Version 3.0</td>
<td>X Version 3.0</td>
<td></td>
</tr>
<tr>
<td>Based on discharges</td>
<td>7/1/08–6/30/11</td>
<td>7/1/09–6/30/12</td>
<td>7/1/10–6/30/13</td>
<td>7/1/11–6/30/14</td>
<td>7/1/12–6/30/15</td>
</tr>
</tbody>
</table>

**National trends**
- 2,610 hospitals fined
- Increase of 433 in FY 2015
- Average penalty 0.63
- Increase from 0.38 in 2015
- 39 had full 3% penalty
- 496 have 1% penalty

Source: Kaiser Health News
May 1, 2015
Hospital Readmissions Reduction Program

- Readmission refers to a patient being admitted to a hospital within a certain time period from an initial admission
- Per CMS, Medicare readmissions have been generally defined as a patient being hospitalized within 30 days of an initial hospital stay
- If a hospital has a high proportion of patients readmitted within a short time frame, it may be an indication of inadequate quality care in the hospital or a lack of appropriate coordination of post-discharge care

Hospital Readmissions Reduction Program

- Per CMS, historically about one in five Medicare patients discharged from a hospital are readmitted within 30 days
- Readmission rates vary substantially by hospital and by geographic area
- Readmission rates are generally higher for hospitals serving vulnerable populations

Hospital Readmissions Reduction Program

- Factors affecting readmissions:
  - Patient’s diagnoses
  - Severity of illness
  - Patient’s behavior
    - Adherence to discharge instructions
    - Availability and quality of post-discharge care
  - Some readmissions are planned (follow-up surgery, rehabilitation, transfer)
Hospital Readmissions Reduction Program

- Readmissions excluded:
  - Neonates
  - Cystic fibrosis
  - Palliative care patients
  - Most HIV DRGs
  - “Left against medical advice”
- The percentage of “acceptable” readmissions is risk-adjusted when the patient has certain secondary diagnoses
- Planned readmission for a procedure (i.e., AMI and planned PCI or CABG)

Hospital Readmissions Reduction Program

- Continuing controversy:
  - Observation vs. inpatient
  - All readmissions vs. avoidable readmissions
  - Lack of risk adjustment for key socioeconomic factors (usually outside the hospital’s control)
  - The inclusion of readmissions unrelated to the initial admission
  - How penalties are calculated

Hospital Readmissions Reduction Program

- Based on reported outcomes:
  - Principal diagnosis
    - Acute MI
    - Heart failure
    - Pneumonia
    - COPD
    - THA
    - TKA
    - Following CABG (coming in 2017)
- Be cautious with the conversion from ICD-9 to ICD-10
Readmissions Greater Among Younger Persons With Disabilities

Figure 2.6a  Percentage of Hospital Admissions with a Readmission within 30 days by Number of Chronic Conditions and Age: 2010

Source: CMS, MLN Connects National Provider Call, IMPACT Act: Connecting Post-Acute Care Across the Care Continuum, February 4, 2016

The Readmissions Diagnoses

- Acute MI
- Heart failure
- Pneumonia
- COPD
- THA
- TKA
- Following CABG (coming in 2017)

Acute Myocardial Infarction*
Inclusion Criteria

1. Principal diagnosis of AMI
2. Enrolled in Medicare FFS or are VA beneficiaries
3. Aged 65 and over
4. Discharged alive from a non-federal acute care hospital or VA hospital
5. Not transferred to another acute care facility
6. Enrolled in Part A and Part B Medicare for the 12 months prior to the date of admission, and enrolled in Part A during the index admission

For the rest of the medical diagnoses, all of the criteria are the same except for the principal diagnosis.
Acute Myocardial Infarction* Exclusion Criteria

1. Without at least 30 days of post-discharge enrollment in FFS Medicare
2. Discharged against medical advice (AMA)
3. Same-day discharges

For the rest of the medical diagnoses, all of the criteria are similar

Outcome Criteria All Measures

• 30-day time frame
  - Rationale: The use of the 30-day time frame is a clinically meaningful period for hospitals to collaborate with their communities to reduce readmissions.

• All-cause unplanned readmission
  - Rationale: From a patient perspective, an unplanned readmission from any cause is an adverse event.

• Unplanned readmission
  - Rationale: Planned readmissions are generally not a signal of quality of care. Including planned readmissions in a readmission measure could create a disincentive to provide appropriate care to patients who are scheduled for elective or necessary procedures within 30 days of discharge. (CMS)

For the rest of the medical diagnoses, all of the criteria are the same except for the principal diagnosis

Acute Myocardial Infarction – Diagnoses

• Codes for AMI cohort

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I21.01</td>
<td>STEMI involving left main coronary artery</td>
<td>I21.26</td>
<td>STEMI involving left anterior descending artery</td>
</tr>
<tr>
<td>I21.02</td>
<td>STEMI involving left anterior descending artery</td>
<td>I21.3</td>
<td>STEMI involving unspecified site</td>
</tr>
<tr>
<td>I21.09</td>
<td>STEMI involving other sites</td>
<td>I21.4</td>
<td>STEMI involving other coronary artery of anterior wall</td>
</tr>
<tr>
<td>I21.1</td>
<td>STEMI involving inferior wall</td>
<td>I21.5</td>
<td>STEMI involving inferior wall</td>
</tr>
<tr>
<td>I22.0</td>
<td>Subsequent STEMI involving anterior wall</td>
<td>I22.6</td>
<td>Subsequent STEMI involving inferior wall</td>
</tr>
<tr>
<td>I22.1</td>
<td>Subsequent STEMI involving inferior wall</td>
<td>I22.7</td>
<td>Subsequent STEMI involving right coronary artery</td>
</tr>
<tr>
<td>I22.2</td>
<td>Subsequent STEMI involving right coronary artery</td>
<td>I22.8</td>
<td>Subsequent STEMI involving left circumflex coronary artery</td>
</tr>
<tr>
<td>I22.3</td>
<td>Subsequent STEMI involving left circumflex coronary artery</td>
<td>I22.9</td>
<td>Subsequent STEMI involving unclassified site</td>
</tr>
</tbody>
</table>

©2016 HCPro, a division of BLR. All rights reserved. These materials may not be duplicated without express written permission.
Heart Failure
Inclusion Criteria

1. Principal diagnosis of heart failure
2. Enrolled in Medicare FFS or are VA beneficiaries
3. Aged 65 and over
4. Discharged alive from a non-federal acute care hospital or VA hospital
5. Not transferred to another acute care facility
6. Enrolled in Part A and Part B Medicare for the 12 months prior to the date of admission, and enrolled in Part A during the index admission

Heart Failure

• Codes for heart failure cohort

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I11.0</td>
<td>Acute heart failure with heart failure</td>
</tr>
<tr>
<td>I13.0</td>
<td>Chronic heart failure with heart failure and stage I through stage IV, or unspecified IDI</td>
</tr>
<tr>
<td>I13.1</td>
<td>Acute heart failure with heart failure and with stage V, or ESRD</td>
</tr>
<tr>
<td>I50.1</td>
<td>Left ventricular failure</td>
</tr>
<tr>
<td>I50.20</td>
<td>Acute systolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.21</td>
<td>Chronic systolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.22</td>
<td>Chronic systolic (congestive) heart failure with stage 5 CKD, or ESRD</td>
</tr>
<tr>
<td>I50.23</td>
<td>Acute non-chronic systolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.30</td>
<td>Unspecified diastolic (congestive) heart failure</td>
</tr>
</tbody>
</table>

Pneumonia
Inclusion Criteria

1. Principal diagnosis of pneumonia
2. Enrolled in Medicare FFS or are VA beneficiaries
3. Aged 65 and over
4. Discharged alive from a non-federal acute care hospital or VA hospital
5. Not transferred to another acute care facility
6. Enrolled in Part A and Part B Medicare for the 12 months prior to the date of admission, and enrolled in Part A during the index admission
### Pneumonia

- **Codes for pneumonia cohort**

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>J12.0</td>
<td>Adenoviral pneumonia</td>
<td>J15.3</td>
<td>Pneumonia due to streptococcus, group A</td>
</tr>
<tr>
<td>J12.1</td>
<td>RSV pneumonia</td>
<td>J15.7</td>
<td>Pneumonia due to Mycoplasma pneumonia</td>
</tr>
<tr>
<td>J12.2</td>
<td>Other viral pneumonia</td>
<td>J15.9</td>
<td>Unspecified bacterial pneumonia</td>
</tr>
<tr>
<td>J12.3</td>
<td>Parainfluenza virus pneumonia</td>
<td>J16.0</td>
<td>Etiology not specified</td>
</tr>
<tr>
<td>J12.4</td>
<td>Other bacterial pneumonia</td>
<td>J16.8</td>
<td>Pneumonia due to other specified infectious organisms</td>
</tr>
<tr>
<td>J12.5</td>
<td>Unspecified viral pneumonia</td>
<td>J16.9</td>
<td>Pneumonia, unspecified</td>
</tr>
</tbody>
</table>

*All of these PNs as PDX will take you to MS-DRGs 133–135*

---

### Pneumonia

- **Codes for pneumonia cohort**

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>A48.1</td>
<td>Pneumonia due to legionnaires’ disease</td>
<td>J15.211</td>
<td>Pneumonia due to MRSA</td>
</tr>
<tr>
<td>J11.00</td>
<td>2009 H1N1 influenza with pneumonia</td>
<td>J15.212</td>
<td>Pneumonia due to MRSA</td>
</tr>
<tr>
<td>J11.00</td>
<td>Unidentified influenza with unspecified type of pneumonia</td>
<td>J15.29</td>
<td>Pneumonia due to other specified infectious organisms</td>
</tr>
<tr>
<td>J15.0</td>
<td>Pneumonia due to Klebsiella pneumonia</td>
<td>J15.5</td>
<td>Pneumonia due to E. coli</td>
</tr>
<tr>
<td>J15.1</td>
<td>Pneumonia due to Mycoplasma pneumonia</td>
<td>J15.6</td>
<td>Pneumonia due to other specified infectious organisms</td>
</tr>
<tr>
<td>J15.20</td>
<td>Pneumonia due to unspecified bacteria</td>
<td>J15.8</td>
<td>Pneumonia due to other specified bacteria</td>
</tr>
</tbody>
</table>

*All of these PNs as PDX will take you to MS-DRGs 177–179*

---

### COPD

**Inclusion Criteria**

1. Principal diagnosis of COPD or principal diagnosis of respiratory failure with a secondary diagnosis of COPD exacerbation
2. Enrolled in Medicare FFS or are VA beneficiaries
3. Aged 65 and over
4. Discharged alive from a non-federal acute care hospital or VA hospital
5. Not transferred to another acute care facility
6. Enrolled in Part A and Part B Medicare for the 12 months prior to the date of admission, and enrolled in Part A during the index admission
**COPD**

- Codes for COPD cohort

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>J44.1</td>
<td>Chronic obstructive pulmonary disease</td>
<td>J44.9</td>
<td>Chronic obstructive pulmonary disease, unspecified with unspecified asthma, unspecified exacerbation</td>
</tr>
<tr>
<td>J42</td>
<td>Unspecified chronic obstructive pulmonary disease</td>
<td>J44.9</td>
<td>Chronic obstructive pulmonary disease, unspecified with unspecified asthma, unspecified exacerbation</td>
</tr>
<tr>
<td>J43.8</td>
<td>Other emphysema</td>
<td>J44.9</td>
<td>Chronic obstructive pulmonary disease, unspecified with unspecified asthma with status asthmaticus</td>
</tr>
</tbody>
</table>

- Acute and chronic respiratory failure (principal diagnosis when combined with a secondary diagnosis of COPD with exacerbation) [J44.1]

**THA & TKA**

**Inclusion Criteria**

- **SPECIFIC!**
- Having a qualifying elective primary THA/TKA procedure
- Rationale – elective primary THA/TKA procedures are defined as those procedures **not** having any of the following:
  - Femur, hip, or pelvic fractures coded in the principal or secondary discharge diagnosis fields of the index admission
  - Partial hip arthroplasty (PHA) procedures with a concurrent THA/TKA
  - Resurfacing procedures with a concurrent THA/TKA

**THA & TKA**

**Inclusion Criteria (cont.)**

- Mechanical complication coded in the principal discharge diagnosis field
- Malignant neoplasm of the pelvis, sacrum, coccyx, lower limbs, or bone/bone marrow or a disseminated malignant neoplasm coded in the principal discharge diagnosis field
- Removal of implanted devices/prostheses
- Transfer from another acute care facility for the THA/TKA
THA & TKA
Exclusion Criteria

- Without at least 30 days of post-discharge enrollment in FFS Medicare
  - Rationale: The 30-day readmission outcome cannot be assessed in this group since claims data are used to determine whether a patient was readmitted
- Discharged against medical advice (AMA)
  - Rationale: Providers did not have the opportunity to deliver full care and prepare the patient for discharge
- Admitted for the index procedure and subsequently transferred to another acute care facility
  - Rationale: Patients admitted for the index procedure and subsequently transferred to another acute care facility are excluded, as determining which hospital the readmission outcome should be attributed to is difficult
- With more than two THA/TKA procedure codes during the index hospitalization
  - Rationale: Although clinically possible, it is highly unlikely that patients would receive more than two elective THA/TKA procedures in one hospitalization, which may reflect a coding error

THA & TKA
Codes for THA & TKA cohort

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>0SR9019</td>
<td>Replacement of right hip joint with synthetic substitute, cemented, open approach</td>
</tr>
<tr>
<td>0SR8019</td>
<td>Replacement of left hip joint with synthetic substitute, cemented, open approach</td>
</tr>
<tr>
<td>0SR904A</td>
<td>Replacement of right hip joint with synthetic substitute, uncemented, open approach</td>
</tr>
<tr>
<td>0SR804A</td>
<td>Replacement of left hip joint with synthetic substitute, uncemented, open approach</td>
</tr>
<tr>
<td>0SR907Z</td>
<td>Replacement of right hip joint with synthetic substitute, open approach</td>
</tr>
<tr>
<td>0SR807Z</td>
<td>Replacement of left hip joint with synthetic substitute, open approach</td>
</tr>
</tbody>
</table>

18 total codes for THA & TKA cohort – all start with 0SR_...

Not listing all codes here.

Following CABG
Exclusion Criteria

- Without at least 30 days of post-discharge enrollment in FFS Medicare
  - Rationale: The 30-day readmission outcome cannot be assessed in this group since claims data are used to determine whether a patient was readmitted.
- Discharged against medical advice (AMA)
  - Rationale: Providers did not have the opportunity to deliver full care and prepare the patient for discharge.
- Subsequent qualifying CABG procedures during the measurement period
  - Rationale: CABG procedures are expected to last for several years without the need for revision or repeat revascularization. A repeat CABG procedure during the measurement period very likely represents a complication of the original CABG procedure and is a clinically more complex and higher-risk surgery. We (AMA) therefore, select the first CABG admission for inclusion in the measure and exclude subsequent CABG admissions from the cohort.
Following CABG
Exclusion Criteria

- CMS defines “isolated” CABG patients as those undergoing CABG procedures without concomitant valve or other major cardiac, vascular, or thoracic procedures.

<table>
<thead>
<tr>
<th>Procedure groups excluded from isolated CABG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valve procedures</td>
</tr>
<tr>
<td>Atrial and/or ventricular septal defects</td>
</tr>
<tr>
<td>Congenital anomalies</td>
</tr>
<tr>
<td>Other open cardiac procedures</td>
</tr>
<tr>
<td>Heart transplants</td>
</tr>
<tr>
<td>Aorta or other non-cardiac arterial bypass procedures</td>
</tr>
<tr>
<td>Head, neck, intracranial vascular procedures</td>
</tr>
</tbody>
</table>

Rationale: Represent higher risk population of patients

Following CABG
Exclusion/Inclusion Criteria

<table>
<thead>
<tr>
<th>Procedure groups considered for exclusion but ultimately included in isolated CABG:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer-assisted surgery</td>
</tr>
<tr>
<td>Placement of circulatory assist devices (includes ventricular assist devices [VADs], excludes implantation of cardiomyostimulation system, often planned)</td>
</tr>
<tr>
<td>Lead removal/revision/replacement</td>
</tr>
<tr>
<td>Pacemaker implantation</td>
</tr>
<tr>
<td>Implantable cardioverter defibrillator (ICD) implantation</td>
</tr>
<tr>
<td>Transmyocardial revascularization (TMR) procedures</td>
</tr>
<tr>
<td>Miscellaneous (e.g., other revascularization, cardiac massage, epicardial “maze” procedures intended to eliminate atrial fibrillation)</td>
</tr>
</tbody>
</table>

Rationale: The above procedures do not represent higher patient risk categories – these are also rare procedures that are discretionary and, as such, may provide additional hospital performance information

Following CABG

- For other diagnoses (AMI, heart failure, PNA, etc.)
  CMS takes the stance that the hospital that discharged the patient has the most influence over the patient’s risk of readmission. For this reason, the current publicly reported readmission measures are attributed to the hospital discharging the patient.
- CABG is different...
Following CABG

“Following CABG surgery, transfer to another acute care facility after CABG is most likely due to a complication of the CABG procedure or the peri-operative care the patient received and as such the care provided by the hospital performing the CABG procedure likely dominates readmission risk, even among transferred patients ... Therefore, for this measure, the readmission outcome is attributed to the hospital performing the first ("index") CABG, even if this is not the discharging hospital.”

(CMS – CABG Readmission Methodology Report)

CABG – Transfer Scenarios

- **Transfer scenario 1** indicates that a patient undergoes a CABG procedure at Hospital A and then is transferred to Hospital B (but does not receive additional CABG procedures)
  - The measure attributes the readmission outcome to Hospital A

- **Transfer scenario 2** indicates that a patient is admitted to Hospital A (but does not receive a CABG procedure) and is transferred to Hospital B to receive a CABG procedure
  - The measure attributes the readmission outcome to Hospital B

- **Transfer scenario 3** indicates that a patient undergoes a CABG procedure at Hospital A and then is transferred to Hospital B to receive a 2nd CABG procedure. The measure attributes the readmission outcome to Hospital A, which performed the index CABG procedure, and starts the 30-day window from the day of discharge from Hospital B. Similar to Scenario 1, this rare scenario is included in the measure as excluding it might miss important care quality information.
  - But the 30-day window from "day of discharge" starts from discharge from Hospital B
Following CABG

- Codes for CABG cohort.
- There are 240+ procedural codes for CABG in ICD-10. We will not list them here. Please use your coding books as you work through cases to establish these codes.

Risk Adjustment

“Once again the severity of illness based on comorbid conditions influences the risk adjustment. Sicker patients are expected to have higher readmission rates, so hospitals with a patient population reflecting higher severity will have their readmission rate adjusted downward and therefore are less likely to be penalized.”

—Pinson & Tang, 2016 CDI Pocket Guide

Risk Adjustment – All Diagnoses

There are tons of them!

- Metastatic cancer or leukemia
- DM or DM complications
- Protein-calorie malnutrition
- Disorders of fluid, electrolyte, or acid-base
- Iron deficiency or other specified anemias and blood disease
- Dementia & other specified brain disorders
- Liver or biliary disease
- Depression
- Drug/alcohol abuse, dependence, or psychosis
- Cardio-respiratory failure or shock
- Septicemia/shock
- Hemiplegia, paraplegia, paralysis, functional disability
- Respiratory dependence/failure
- CHF
- Angina or old MI
- Asthma
- Stroke
- COPD
- Pneumonia
- ESRD or dialysis, renal failure
- Decubitus ulcer or chronic skin ulcer

*Not an all-inclusive list.
Risk Adjustment

• ... what did you notice about the previous list? Several of these concepts we **already** focus on during CDI review!
  – Phew! 😊
• However, this is a great illustration of the importance of querying regardless of PDX, CC, MCC, SOI/ROM impact.
  – If we can get these diagnoses established in the record – regardless of “usual” CDI impact – this can help adjust your hospital’s risk score for this patient in the positive direction.

Results – Myocardial Infarction Example

• Why does all of this matter?
• Let’s find out!

Results – CMS

• Between July 2011–June 2012 and July 2013–June 2014, the observed readmission rate for AMI decreased from **17.8% to 16.0%**
  – However, the frequency of some model variables increased, which may reflect an increased rate of comorbidity in the FFS population but is also due, in part, to increased coding opportunities on administrative claims
Results

- The odds of all-cause readmission, if treated at a hospital one standard deviation above the national rate, were 1.33 times higher than the odds of all-cause readmission if treated at a hospital one standard deviation below the national rate
  - Of 4,384 hospitals in the study cohort:
    - 30 performed better than the U.S. national rate
    - 2,273 performed no different from the U.S. national rate
    - 23 performed worse than the U.S. national rate
    - 2,068 were classified as “number of cases too small” (fewer than 25) to reliably tell how well the hospital is performing

Noncompliance & Readmissions

- 89.7% – Reason for readmission listed as “other”
- 10.3% – Reason for readmission listed as “dietary or medication noncompliance-related”
  - 47% of adults have limited health literacy skills
  - 44% of adults are functionally health illiterate
  - 35%–54% of heart failure patients have limited health literacy

—The Advisory Board Company

Noncompliance

“CDI specialists can assist facilities by identifying when noncompliance plays a role in the readmission. By securing the necessary documentation to allow coders to report [noncompliance], hospitals can use this documentation and coded data to help prevent or appeal denials ... If [it] is reported in the top nine diagnosis codes when it is transmitted on the UB-04, [it allows] the payer to have the knowledge that patient noncompliance may have contributed to the readmission.”

—ACDIS
**Noncompliance**

**Frustrating!**

- If the patient is noncompliant, this needs to be documented and final-coded
- Noncompliance with:
  - Dietary regimen (Z91.11)
  - Dialysis (Z91.15)
  - Medication regimen *(SPECIFY THE DRUG)*
  - Underdosing
    - Intentional – other/unspecified (Z91.128)
    - Intentional – due to financial hardship of patient (Z91.120)
    - Unintentional – other/unspecified (Z91.138)
    - Unintentional – due to patient’s age-related debility (Z91.130)
  - Other medical treatment (Z91.19)
  - Unspecified (Z91.19)

---

**VBP/Quality Team**

- Clinical
- HIM/CDI
- Medical staff
- IT
- Nursing
- Finance
- Case management
- Quality

---

**Strategies to Improve Quality and Financial Outcomes**

- Must have C-suite buy-in – led by CEO
- Multidisciplinary team – clinical, quality, HIM, financial, and IT
- Promote a culture of transparency and integrity
- Two important areas to address:
  - Clinical data
  - Technology
**Strategies to Improve Quality and Financial Outcomes**

- Financial impact
- Know where your hospital stands on each selected measure for the baseline period and identify which measures have the best rate of return
- Understand how discharge volume by measure factors into the VBP score
- Ensure pricing is competitive and defensible

---

**Strategies to Improve Quality and Financial Outcomes**

- Assess inefficient areas
- Cross organizational governance
- IT involvement is critical
- Investment in comprehensive data collection and reporting systems
- Patient satisfaction
- Sharing of quality scores (ongoing)

---

**Strategies to Improve Quality and Financial Outcomes**

- Review of all reporting and audit mechanisms to assess for duplication of efforts and conflicting messages
- Focused review of cases with quality issues by an external auditor
- Development of multidisciplinary task force to develop workflow and shared processes with single point reference for providers
Strategies to Improve Quality and Financial Outcomes

- Assess documentation and EHR capabilities
- Documentation guidelines and clinical definitions
- Use of quality tracking tool
- Determine problem quality issues and develop a focused corrective action plan
- Education for entire multidisciplinary team

Strategies to Improve Quality and Financial Outcomes

- Run, use, and share reports – look at your data
  - Severity of illness
  - Risk of mortality
  - Present on admission
  - PSI (patient safety data)
  - Length of stay
  - Readmissions
  - Cost per patient

Strategies to Improve Quality and Financial Outcomes

- Accurate clinical documentation impacts:
  - Coding
  - Severity of illness (SOI)
  - POA/HAC
  - Case-mix index (CMI)
  - Core measures
  - Patient safety
  - Outcome measures
  - Profiling
  - Compliance
  - Audits
  - And more...
**Strategies to Improve Quality and Financial Outcomes**

- CDI specialists should look for documentation that:
  - Supports coding of chronic conditions, CCs, and MCCs
  - Supports documentation to support assignment of correct principal vs. secondary diagnoses
  - Supports planned readmissions
  - Defines the plan of care and the discharge plan
  - Shows continuity of care and high-quality care for all diagnoses identified during the inpatient stay
  - Identifies patients that have clinical indicators to trigger a readmission (malnutrition, multiple changes in medications, etc.)

---

**Thank you. Questions?**

icharland@panaceainc.com

mmoys@panaceainc.com

In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section at the front of the program guide.

---

**References**

- Advisory Board. Aug 5, 2014 article. "Early takeaways from the final FY 2015 payment rule"
- Health Affairs, Health Policy Brief, Medicare Hospital Readmissions Reduction Program. November 12, 2013
- Hospital 30-Day Acute Myocardial Infarction Readmission Measure Methodology. Prepared for the Centers for Medicare & Medicaid Services (CMS) by Yale University/New Haven Hospital Center for Outcomes Research & Evaluation. June 9, 2016
- Hospital-level 30-Day All-Cause Unplanned Readmission-Following Coronary Artery Bypass Graft Surgery. Prepared for the Centers for Medicare & Medicaid Services (CMS) by Yale University/New Haven Hospital Center for Outcomes Research & Evaluation. Revised February 1, 2016
References

- Hospital-Level 30-Day All-Cause Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA): Measure Methodology Report. Yale University/New Haven Hospital Center for Outcomes Research & Evaluation. June 25, 2012.
- Pinson, R. & Tang, C. 2016 CDI Pocket Guide. HCPro: Danvers, MA.