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Engaging New Sites: Community and Critical Access Hospitals

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Presented By

- **Jessie Roske, MD, FHM,** is physician section director improvement/medical director CDI, internal medicine hospitalist at CentraCare Health in St. Cloud, Minnesota. Her CDI work began as self-learning efforts, gradually growing to medical director by 2019. Specific projects include expansion of enterprisewide CDI support, development of mortality and quality reviews, multidisciplinary cosign for diagnosis capture, facility clinical indicators to standardize education and combat denials, and physician leadership in evaluation and management.

Presented By

Ann Zierden, RN, CCDS, is director of inpatient CDI at CentraCare Health in St. Cloud, Minnesota. She is a member of the ACDIS Leadership Council and a past member of the ACDIS Leadership Council Mastermind. Her roles at CentraCare Health have included utilization review, quality resources, infection prevention and control, and CDI. She was integral in the expansion of the CDI department and creating an integrated CDI program from one flagship hospital to six critical access hospitals and one community hospital. She currently leads a team of 14 CDI RNs.

Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
  - Identify two unique quality metrics in community and/or critical access hospitals
  - Describe the unique reimbursement opportunity in critical access hospitals
  - Recognize three opportunities for change management in the community and critical access hospital culture
  - Describe at least two unique tips for educational content for rural health expansion

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Inpatient CDI Program

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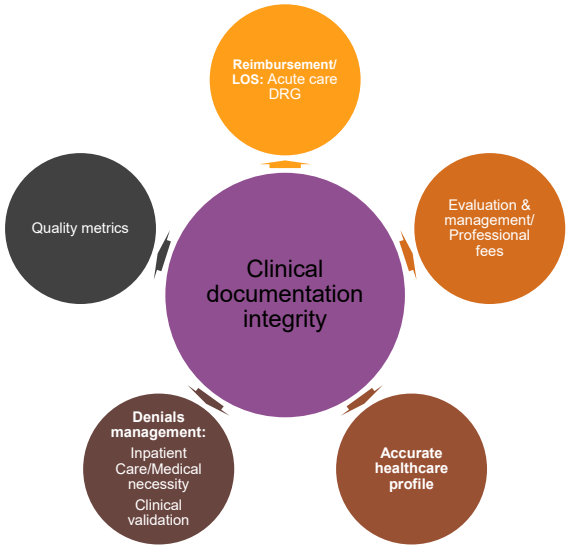
Vision of the Program

- CDI is a system-level priority that aligns acute care needs with population health and provider engagement, ***<u>meeting the needs of providers for all aspects of documentation, providing the tools and education to ease the burden of the work as much as possible.</u>***
- Backbone of CDI: Provider education with CDRN support



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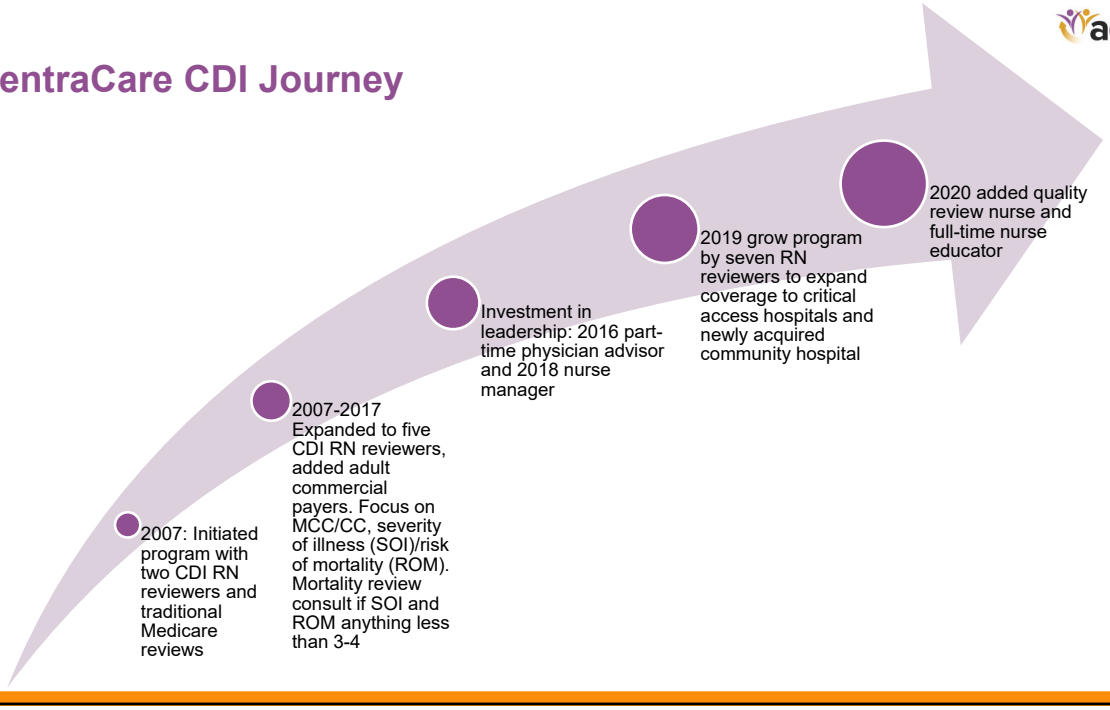
CentraCare CDI Journey



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CentraCare CDI Current State

Footprint:

• CDI reviews at two IPPS hospitals
  • 116-bed community hospital
  • 489-bed Level II trauma center
• CDI reviews at six critical access hospitals
• Review focus: Inpatient adult medical/surgical, OB/GYN, pediatrics, NICU, and inpatient behavioral health
• We review for:
  • CC/MCC/HCC capture
  • Present on admission (POA) status
  • Clinical validation
  • Appeals support
  • Improving quality outcome scores supporting the Value-Based Program
  • HAC-PSI
  • Mortality reviews for observed to expected ratio (O/E)
  • SOI/ROM for risk adjusted quality metrics

Team:
• 12 RN FTE dedicated to inpatient • One FTE educator • 1.5 FTE quality and denials RN • One FTE CDI director • 0.25 FTE medical director • 0.20 FTE provider advisors (different specialties, some physician, some APP) • **Review rate of 78% (all payers)

Flagship Programs

- Regular contact between CDI medical director and section meetings
- Regular CDI and coding education sessions
- Multidisciplinary cosign
- Standardized note library
- Facility clinical indicator library
- Evaluation and management collaboration with coding and compliance
- Clinical validation process
- Payer appeals

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Rural Health

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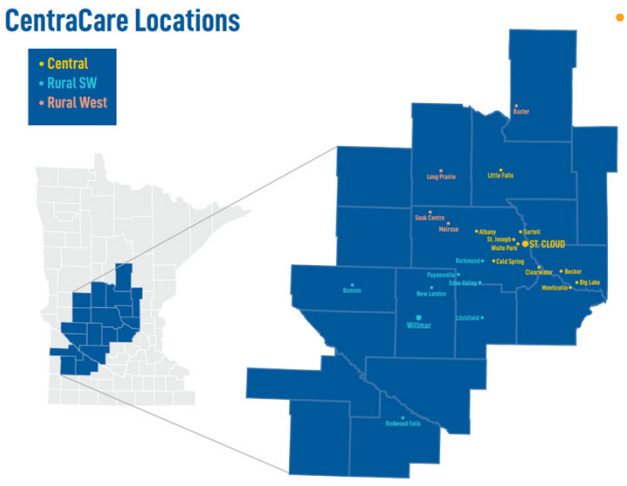
Rural Is a Social, Economic, and Cultural Designation



- Know your designations:
  - IPPS hospitals may service rural areas
  - Critical access hospital (CAH) is a CMS designation based on size, location, and services
  - Funding via Medicare Rural Hospital Flexibility Program (Flex Program)

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Community and Critical Access Hospitals: Quality

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Quality Profiling Is in the Public Domain

- Quality is typically expressed with consideration for ***risk adjustment and/or inclusion/exclusion criteria***:
  - Length of stay
  - Mortality
  - Cost of care
  - Reported conditions/complications

Accurately documenting complexity of care allows risk adjustment that demonstrates your quality of care

Our Community Hospital Is an Inpatient Prospective Payment System (IPPS) Hospital

Same processes, reviews, and education as our large complex acute care flagship hospital

Multiple areas have documentation opportunities

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Review for the High Impact Areas With Documentation Opportunity

- CMS P4P
  - QualityNet Home (cms.gov)
  - Inpatient measures sets (eCQM, HAI, hybrid measures)
  - Claims-based measures (HVBP mortality and complication measures, PSI90)
  - Hospital Inpatient Quality program measures (IQR, HAC reduction program, hospital readmission reduction program, HVBP overlap)
- AHRQ
  - https://qualityindicators.ahrq.gov/
  - Additional patient safety indicators
  - Preventative quality indicators
  - Inpatient quality indicators
  - Pediatric quality indicators
- Joint commission
  - Measures | The Joint Commission
  - ORYX® Quality Initiatives Program

CMS.gov

AHRQ

The Joint Commission

Get to know your quality team (abstracting and reporting)

https://upload.wikimedia.org/wikipedia/commons/b/ba/Agency_for_Healthcare_Research_and_Quality_Logo.png
https://en.wikipedia.org/wiki/File:The_Joint_Commission_logo.svg

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Critical Access Hospitals

Some unique metrics

Many areas of overlap with IPPS

Unique Considerations for CAH

- Funding via Medicare Rural Hospital Flexibility Program (Flex Program) requires Medicare Beneficiary Quality Improvement Project (MBQIP) measures
  - Many areas of overlap with IPPS (readmissions, complications, HAI, PC-01 etc)
  - eCQM will meet this metric (two for one)
- Additional reporting is voluntary

Rural Health Accountability

- National Quality Forum of CMS in 2022 reconvened the Rural Health Advisory
  - Updated key rural measures
  - Originally developed in 2017-2018
- National Rural Health Association
  - Recognizes top 20 critical access hospitals

https://upload.wikimedia.org/wikipedia/en/thumb/f/f0/National_Quality_Forum_logo.png/220px-National_Quality_Forum_logo.png
https://upload.wikimedia.org/wikipedia/en/4/44/National_Rural_Health_Association_%28emblem%29.gif

Key Rural Measures: Hospitals

- Areas currently tracked and publicly reported
  - *Hospital wide CMS-aligned unplanned readmission measure*
  - Safe use of opioids
  - Use of antipsychotics in older adults in inpatient hospital setting
  - Emergency transfer communication measure
  - *NHSN CAUTI outcome measure*
  - Severe sepsis and septic shock: management bundle (SEP-1)
  - Percent of residents with a UTI (Long-stay)
  - ACS-CDC surgical site infection outcome measure
  - NHSN hospital onset C. diff infection outcome measure
  - *PC-01 Early elective delivery*
  - *PC-02 Cesarean birth (future)*
  - *Claims-only hospital wide risk-standardized mortality measure*
  - Median time of ED arrival to ED departure

**Blue italics have documentation opportunity: Overlap with IPPS*

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Community and Critical Access Hospitals: Reimbursement

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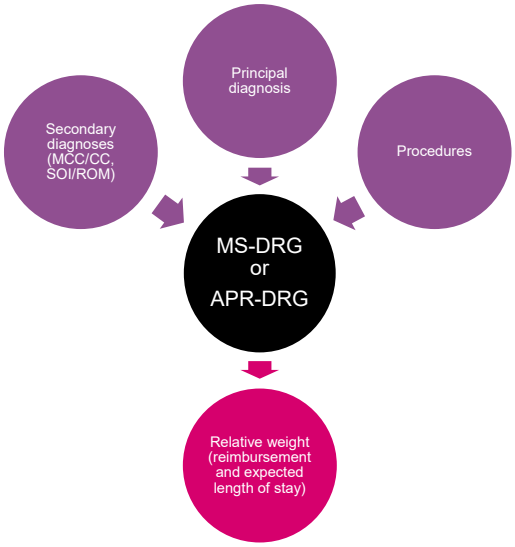
Reimbursement 101



- Medicare pays acute care hospitals using MS-DRGs
- Medicare pays CAHs at 101% of reasonable costs
- ***Commercial payers use MS-DRG or APR-DRG regardless of hospital type****

*Some variations based on shared risk or percent of charges depending upon contracts

Model Opportunity

- Case mix index (CMI) versus peers
- Considering individual service lines and the clinical reality
- Unique opportunity in newborn care
  - At our CAH, deliveries and newborn represent the most common DRGs
  - Disproportionately represented in commercial payers
  - Massive difference in relative weight between normal newborn and neonatology

	FY19 Full Year Data				FY20 July 19–January 21 Data			
	FY19 Actual	FY19 Vizient Peer Group Comparison^	CMI Difference	Annual opportunity*	FY20 actual	FY20 Vizient Peer Group Comparison^	CMI Difference	Annual opportunity*
Community IPPS	0.9469	1.0542	0.1073	$1,790,296	1.1206	1.2658	0.1452	$1,866,148
*Opportunity calculated at Service Line Level, not overall CMI								
Specific service lines representing the bulk of opportunity:								
General Medicine				$559,278				$343,062
General Surgery				$138,161				$227,387
Neonatology**				$638,727**				$670,838**
Trauma				$87,851				$53,920
Cardiology				$101,163				$151,398
Vascular surgery				$100,506				$127,697
Pulmonary/critical care				$72,211				$47,660

***Alternative detailed newborn and neonatology analysis suggests $409,008 opportunity annually*

^Compare Hospitals: Atlantic Health System Hackettstown Med Ctr Warren NJ, Intermountain Healthcare Cedar City Hospital UT, Novant Health Haymarket Med Ctr VA, Prisma Health Baptist Easley Hospital SC, Prisma Health Greer Memorial SC, ProHealth Oconomowoc WI, UCHealth Longs Peak Hospital CO, Umass Memorial Marlborough Hosp MA, UNC Rockingham Health Care NC, Central Vermont Med Ctr VT, Lexington Med Ctr Wake Forest Baptist Health NC, Wilkes Med Ctr Wake Forest Baptist Health NC

Newborn Analysis Is Unique

Basics:

- Normal newborn weight is 0.2024
- Average neonatology service line weight at CAH is 2.0107*
- Neonate being premature is a clinical fact not impacted by documentation

What is your clinical team documenting?

- What shifts a term neonate from normal newborn to *neonatology* service line?
- What shifts a premature newborn from premature with*out* significant problems to premature *with* significant problems?

*FY21 Vizient CAH

CAH FY20*–FY22 Data: Annual Newborn Opportunity

	CAH FY20	CAH FY22	Compare group**	Weight***
Normal newborn (795)**	74.4%	67.9%	66.3%	0.1905
Neonatology (791-794)	25.6%	32.1%	33.7%	2.0000
**Lower is favorable				
Volume per year	68	106		
Financial opportunity*	**$91,917**	**$22,268**		
	CAH FY20	**CAH FY22**	**Compare group****	**Weight*****
793 portion of neonatology**	3.2%	18.0%	18.0%	3.9792
794 portion of neonatology	98.6%	81.3%	82.0%	1.4084
**Higher is favorable				
Volume per year	31	32		
Financial opportunity*	**$76,876**	**($3,978)**		
	CAH FY20	**CAH FY22**	**Compare group****	**Weight*****
791 portion of prematurity**	N/A - low volume	NA – just 2 cases	34.4%	3.8738
792 portion of prematurity	N/A - low volume	NA – just 2 cases	65.6%	2.3374
**Higher is favorable				
Volume per year****	1.5	2		
Financial opportunity*	N/A - low volume	N/A - low volume		
***If shifted to peer group with WOO = $6,500				
TOTAL	**$168,793 opportunity**	**$18,290 opportunity**		
Net gain in FY22	**$150,503**			

This hospital has slight opportunity in fewer normal newborn but overall significant improvement

*FY19 = baseline preintervention; financial opportunity based on CAH FY19 and historical WOO
**Peer group is CAH FY22
***Weights based on CY2022 at time of this analysis

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Community and Critical Access Hospitals: Change Management

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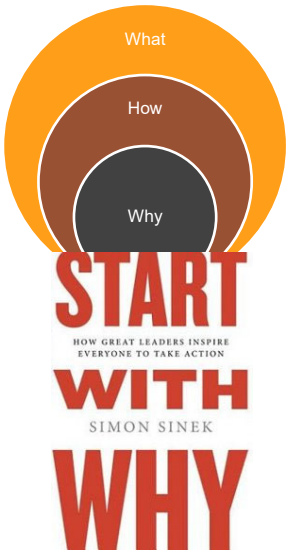
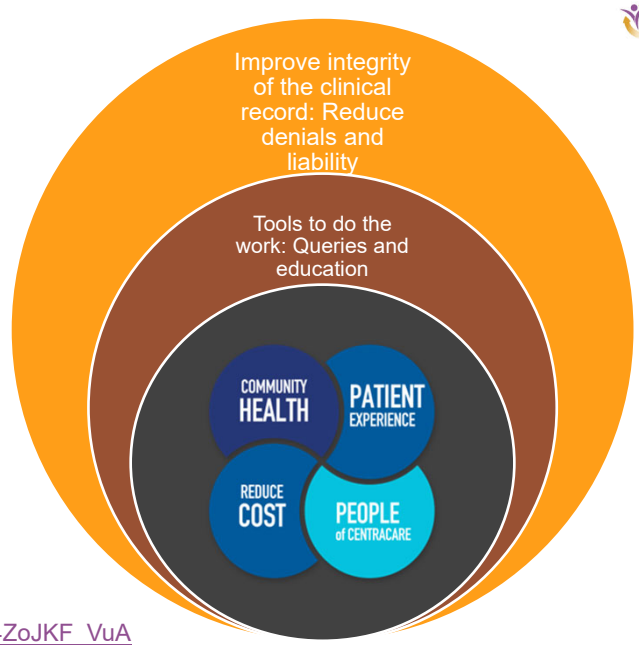
Know and Recruit the Players

- Local executive approval and support
- Recruit provider advisors
- CDI RN from local team
- Quality team member
- Surgical areas covered by organization or private practice
- OB and newborn care covered by organization or private practice
- Multidisciplinary teams (RD, WOC)

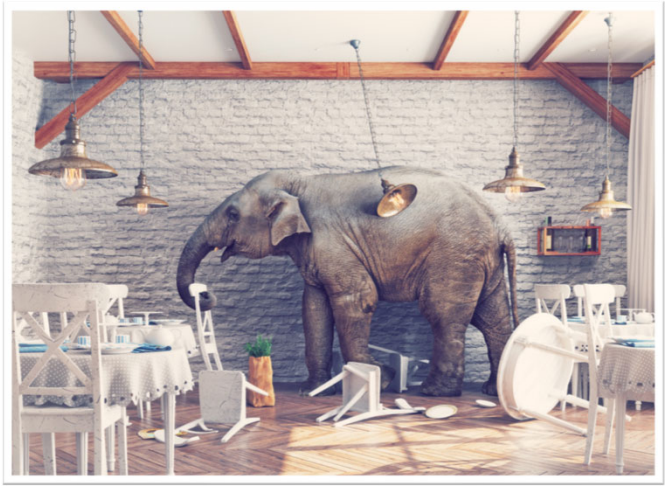




TED Talk: Simon Sinek
https://www.youtube.com/watch?v=u4ZoJKF_VuA

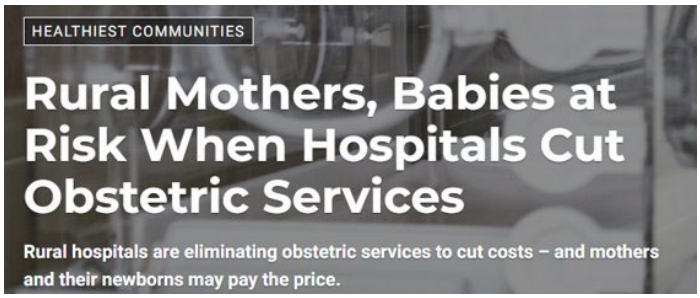
https://upload.wikimedia.org/wikipedia/en/8/8b/Start_With_Why.jpg

Address the Revenue Question



Funding for Strategic Initiatives Is Driving by Operating Margins

Margin %	Routine replacement	Large (>$7M) initiatives	Community dividend	Clinical footprint	Impact
1%	N	N	N	N	A 1% margin will not fund routine capital needs nor any strategic initiatives
2%	Y	Limited	Limited	N	A 2% margin funds routine capital needs, but only limited strategic initiatives
3%	*Y*	*Y*	*Y*	*Limited*	A **thriving, growing** CentraCare **requires a 3%+ margin**



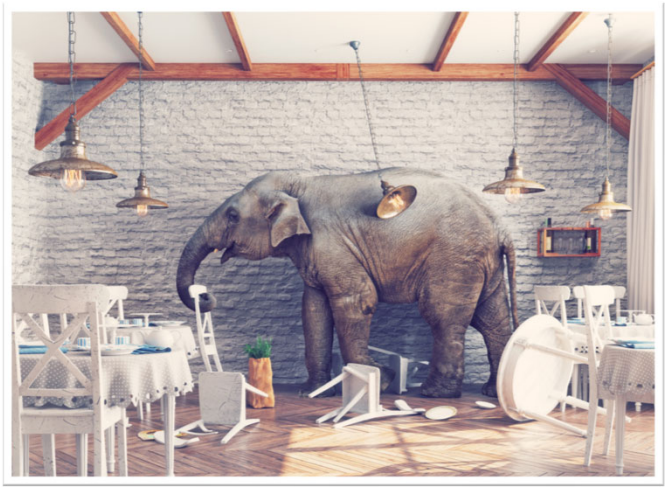
Despite cuts at hospitals, state still delivers on rural obstetrics

"Only 46 percent of rural hospitals provide OB," Topchik said. "So the fact that Minnesota is the best means you're the ... best of something bad."

Chartis has tracked 134 rural hospitals that stopped scheduling deliveries since 2011, including 13 in Minnesota. They are in Baudette, Onamia, Madelia, Ely, Grand Marais, Appleton, Dawson, Canby, Springfield, Lake City and Wabasha. OB services ceased in Albany as well due to the hospital's closure.

US News and World Report June 2019. What Happens When Rural Communities Lose Their Hospital Maternity Care? (usnews.com)
Star Tribute. February 2019. Despite cuts at hospitals, state still delivers on rural obstetrics (startribune.com)

Some of the Rules Seem Illogical



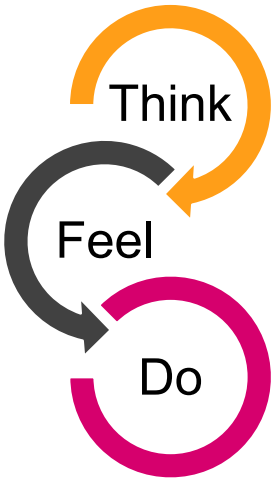


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Image by Gerd Altmann from Pixabay

Find messaging that works

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Where Do You Stand Compared to Peers?

Peer comparison (Vizient CAH)	1.1233
Baseline CAH-1	0.9501
Baseline CAH-2	0.8332
Baseline CAH-3	0.7010
Baseline CAH-4	0.7941
Baseline CAH-5	0.7530
Baseline CAH-6	0.8358

Peer comparison (Vizient community hospital)	1.4392
Baseline community IPPS hospital	1.1150

Are your patients less sick or are you under-capturing complexity?

CAH Financial Impact: Non-CMS

IMPACT

July 1, 2019–March 31, 2020		Baseline	0.8332		
Quarter	CMI	Cases	Delta	Revenue	Impact (ΔCMI*volume*WOO)
Q4 FY20 (Apr –June 2020)	0.9033	43	0.0701	$302,967	$23,512
Q1 FY21 (July-Sept 2020)	1.1049	50	0.2717	$430,911	$105,963
Q2 FY21 (Oct-Dec 2020)	1.0148	51	0.1816	$362,284	$64,831
Q3 FY21 (Jan-Mar 2021)	0.9733	44	0.1401	$299,776	$43,151
Q4 FY21 (Apr –June 2021)	0.8664	57	0.0332	$345,694	$13,247
Q1 FY22 (Jul-Sep 2021)	0.9885	64	0.1553	$442,848	$69,574
Q2 FY22 (Oct-Dec 2021)	1.1528	63	0.3196	$472,072	$130,876
Q3 FY22 (Jan-Mar 2021)	0.9128	39	0.0796	$231,395	$20,179
Q4 FY22 (Apr –June 2022)	0.8438	49	0.0106	$268,750	$3,376
Q1 FY23 (Jul-Sep 2022)	0.9636	75	0.1304	$469,755	$63,570
				Total	$538,279

CDI education and queries began April 2020

- Vizient compare 2022 Critical Access Hospitals
- CMI Last 4 Quarters Rolling: **1.0791**

*WOO for CAH = $6500 as defined internally related to payer mix

Original identified annual opportunity $66,568-$73,469

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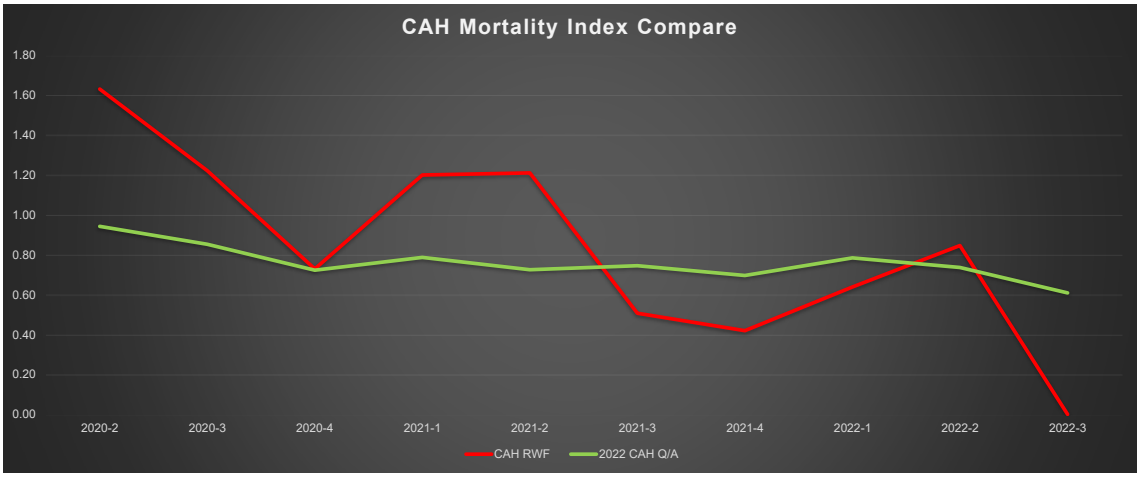
CAH Mortality Index

IMPACT



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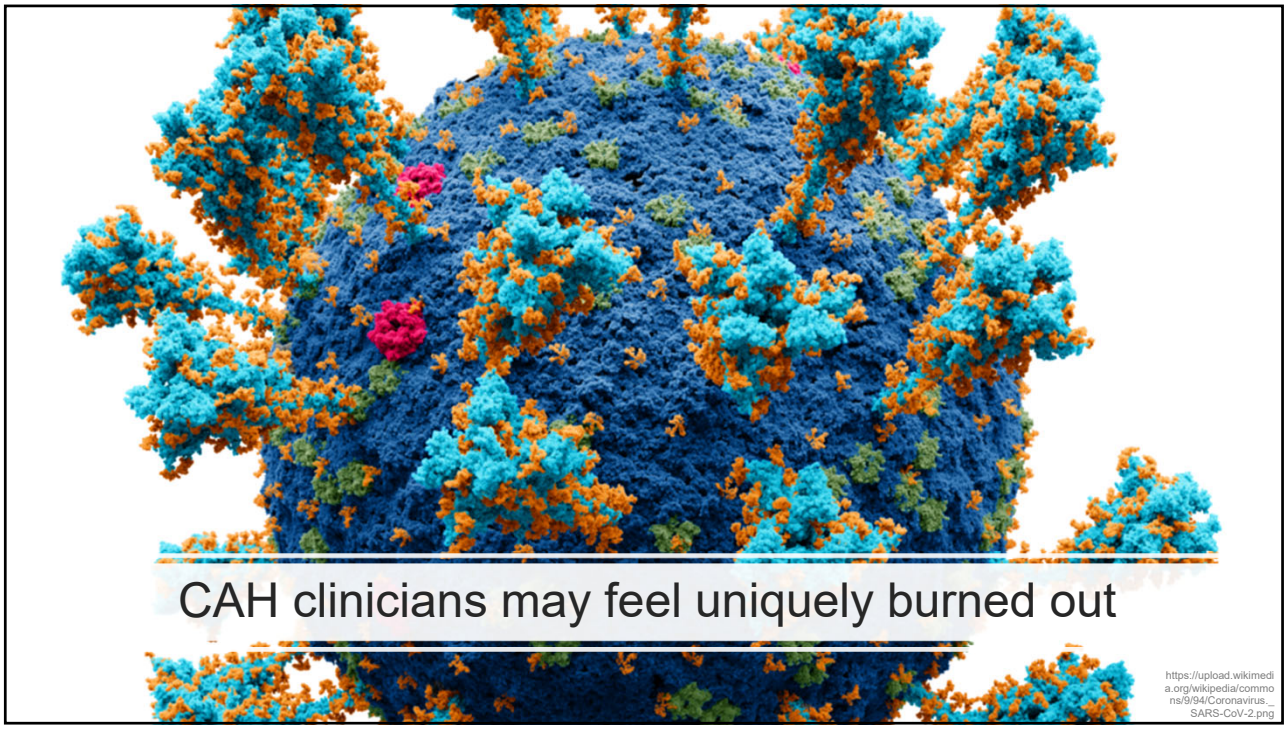

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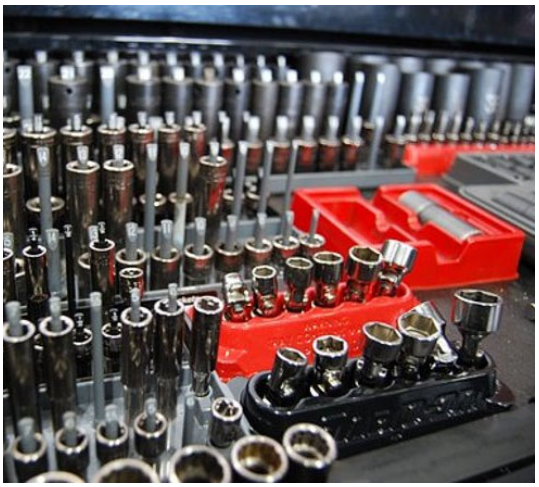
TOOLS TO DO THE WORK



- Provider education
- Queries
- Smart phrase tools/dot phrases
- Tip sheets
- Note template development/adjustment
- Transparency and shared data
- Multidisciplinary cosign opportunities

TOOLS TO DO THE WORK: QUERIES

I am a
CLINICAL
DOCUMENTATION
SPECIALIST,
I solve problems you don't know you have, in ways you can't Understand.

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TOOLS TO DO THE WORK: EDUCATION

- Simple pearls
- Connect to clinical guidelines
- Share actual cases/queries

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Community and Critical Access Hospitals: Unique Educational Content

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Newborn Conditions

DRG Opportunity

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NEWBORN CODING DOES NOT FUNCTION IN MCC/CC

In general, these conditions translate to these DRGs, but sometimes multiple codes make this complex. **Document accurately what is present and trust the coder to do their job**

Examples of "other significant problems" in neonates	DRG 794
ABO/Rh incompatibilities	Fractured clavicle due to birth injury
Apnea	Hydrocele
Bradycardia	Hyperbilirubinemia or prematurity
Breast engorgement in newborn	Hyperthermia or hypothermia
Bronchopulmonary dysplasia	Hypoperfusion
Congenital renal failure	Neutropenia
CMV infection	Petechiae
Conjunctivitis and dacryocystitis	Phrenic nerve paralysis
Down syndrome	Polycythemia
Encephalopathy, hypoxic ischemic, mild	IUGR
Facial nerve injury	Ankyloglossia (Tongue Tied)
Fetal alcohol syndrome	Transient ileus
Fetal distress	Transient tachypnea of newborn (TTN) Type II RDS

Examples of "major problems" in neonates	DRG 793
Arrest, cardiac	Malnutrition
Cerebral edema due to birth injury	Meconium aspiration with or without respiratory symptoms
Convulsions	Necrotizing enterocolitis
Dehydration	Phrenic nerve paralysis
Drug withdrawal	Pneumonia, congenital
Encephalopathy, hypoxic ischemic, moderate or severe	Respiratory failure
Hemorrhage, cerebral, intraventricular, subarachnoid, subdural, subgaleal, due to birth injury	Sepsis, neonatal
Hydrops fetalis	Small for gestational age BW <2000 gms
Hypermagnesemia	Thrombocytopenia
Hypocalcemia	Hypoglycemia
Ileus, meconium	Intestinal obstruction

Another common opportunity to capture complexity:

Feeding problems of newborn

- Specify breast or bottle
- Does not shift DRG but is common and impacts SOI

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Newborn Affected by Maternal Condition

- Applies when newborn is observed/evaluated for suspected/at risk condition due to maternal condition:
  - When condition is present **or suspected** based on signs/symptoms → Potential affect to DRG/SOI/ROM
    - **Basic rules: Suspected/likely/probable/possible counts**
    - ***Must document signs/symptoms exhibited by newborn and treatment***

EXAMPLE:

- Neonates with hypermagnesemia may present with respiratory impairment, generalized hypotonia, and GI hypomotility mimicking intestinal obstruction.
- Document: “Neonatal Hypermagnesemia (suspected) from maternal treatment with magnesium sulfate prior to delivery, signs of *** requiring additional supportive care”
  - ***Carry this all the way to the discharge summary.***

(Reference: Hypermagnesemia, Ferry, J., Updated: Jan 8, 2010, http://emedicine.medscape.com/article/921382-overview)

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Newborn Respiratory Conditions (Specific to <28 Days of Life)

- "Other significant problems:" Transient tachypnea of newborn (TTN) (a.k.a. wet lung syndrome, a.k.a. neonatal respiratory distress syndrome II, a.k.a. neonatal respiratory distress):
  - A self-limited condition commonly seen in full-term neonates due to excessive fluid accumulation in the lungs.
  - Diagnostic criteria:
    - RR >60 past the first 4 hours of life. Usually resolved within 24-72 hours.
    - *CXR: Fluid in fissures or perihilar streaking.*
    - *NOT requiring O_2*
- "Major problems:" Newborn respiratory failure
  - Diagnostic criteria:
    - Tachypnea with RR ≥ 60; or Apnea > 20 seconds or apnea < 20 seconds associated with bradycardia (HR <100)
    - O_2 sats <88% with signs of retractions, nasal flaring or lethargy.
    - Requiring resp. support ≥ 2LPM NC, CPAP, or MV, **and/or** any FI O_2 (>0.21%) or **any** amount of respiratory support **at or after 30 minutes from delivery.**
  - **Spectrum: Transient tachypnea of newborn (TTN) with respiratory failure: TTN progressing to require O_2 support.**
- Neonatal respiratory distress syndrome I (a.k.a. neonatal respiratory distress syndrome)

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Neonatal Acute Respiratory Failure (Specific to <28 Days of Life)

Documentation must include one or more of the following signs and symptoms

- Grunting
- Cyanosis
- Retractions
- Apnea >20 seconds or apnea <20 seconds associated with badycardia (HR<100)
- Nasal flaring
- Tachypnea (>60)
- O_2 sats <88%

AND

Respiratory intervention/treatment:

- Oxygen at ≥ 2LPM and/or
- Any FI O2 (>21%)

OR

- **Any** amount of respiratory support **at or after 30 minutes from delivery**

Includes oxygen delivery by:

- Blow-by
- Nasal canula
- Non-invasive positive pressure ventilation (CPAP/BiPAP)
- Mechanical ventilation

Atrial blood gases (ABG) are NOT required to make the diagnosis

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Example of Opportunity

- Born at 37 weeks, four days gestation, 5 pounds, 11 ounces, primary c-section (failed induction in mom with severe PIH)
- Provider documentation: Moderate respiratory compromise. Required resuscitation including PPV, CPAP, and blow-by oxygen. Mother was on magnesium.
- Nurse notes: Resuscitative efforts for one hour. Breaths given three different times for failed wean. Bluish gray all over, resuscitation efforts due to bradycardia (HR 80 on warmer) minimal movement, and weak cry. Left lung wet, right lung clear upon auscultation. Retractions continued. PPV via T-piece was used to deliver 100% oxygen at 10L to baby. SpO2 to 75%. O2 flow 5-10L.

MS-DRG	Description	RW	GLOS	Reimbursement*	Example	SOI	ROM
795	Normal newborn	0.2024	3.1	$1,863	Existing documentation: Respiratory compromise. 5 lbs 11oz	1	1
794	Neonate with other significant problems	1.4951	3.4	$13,765	Opportunity: **Small for gestational age** (5#11oz)	**2**	1
793	Full term neonate with major problems	4.2240	4.7	$39,386	Opportunity: **Neonatal hypermagnesemia (suspected) from maternal treatment with magnesium sulfate for PIH** (Respiratory Symptoms)	2	1
793	Full term neonate with major problems	4.2240	4.7	$39,386	Opportunity: **Acute hypoxic respiratory failure** (caused by neonatal hypermagnesemia as above)	**3**	**2**

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Obstruction With Delivery

Need Specificity

- ***Must state cause***:
  - "Arrest of dilation"
  - "Arrest of descent"
  - Persistent OP, OT, asynclitic position
  - CPD, macrosomia
  - Shoulder dystocia
- **NOTE: possible/probable/suspect count*
- Would it help to have a SmartPhrase?

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Impact: Reimbursement

Depending on scenario can impact SOI and reimbursement

Example:
- 29-year-old, G2P1, scheduled induction for maternal request at 39 weeks, four days
- Cervix 2cm, -3, 70% effaced at admission
- Internal fetal monitoring for late decelerations
- Pushed > 3 hours Primary → C-section for arrest of descent
  - Tell us WHY there was arrest of descent → **Obstructed** labor due to **Occiput Posterior** Position

APR-DRG	Title	Weight	GLOS-days	Reimbursement	SOI	ROM
540	Cesarean section without sterilization with arrest of descent	0.4932	2.76	$3,208	1	1
540	Cesarean section without sterilization with arrest of descent due to obstruction from OP position	0.6093	3.40	$3,960	2	1

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Impact: Quality

- IQI 21: Cesarean delivery rate
- IQI 33: Primary cesarean delivery rate, uncomplicated
- PC 02: Cesarean birth

Exclusion criteria

Abnormal presentation

Preterm labor with preterm delivery

Stillbirth/intrauterine death

Multiple gestation

https://upload.wikimedia.org/wikipedia/commons/b/ba/Agency_for_Healthcare_Research_and_Quality_Logo.png
https://upload.wikimedia.org/wikipedia/en/thumb/f/fd/The_Joint_Commission_logo.svg/1920px-The_Joint_Commission_logo.svg.png

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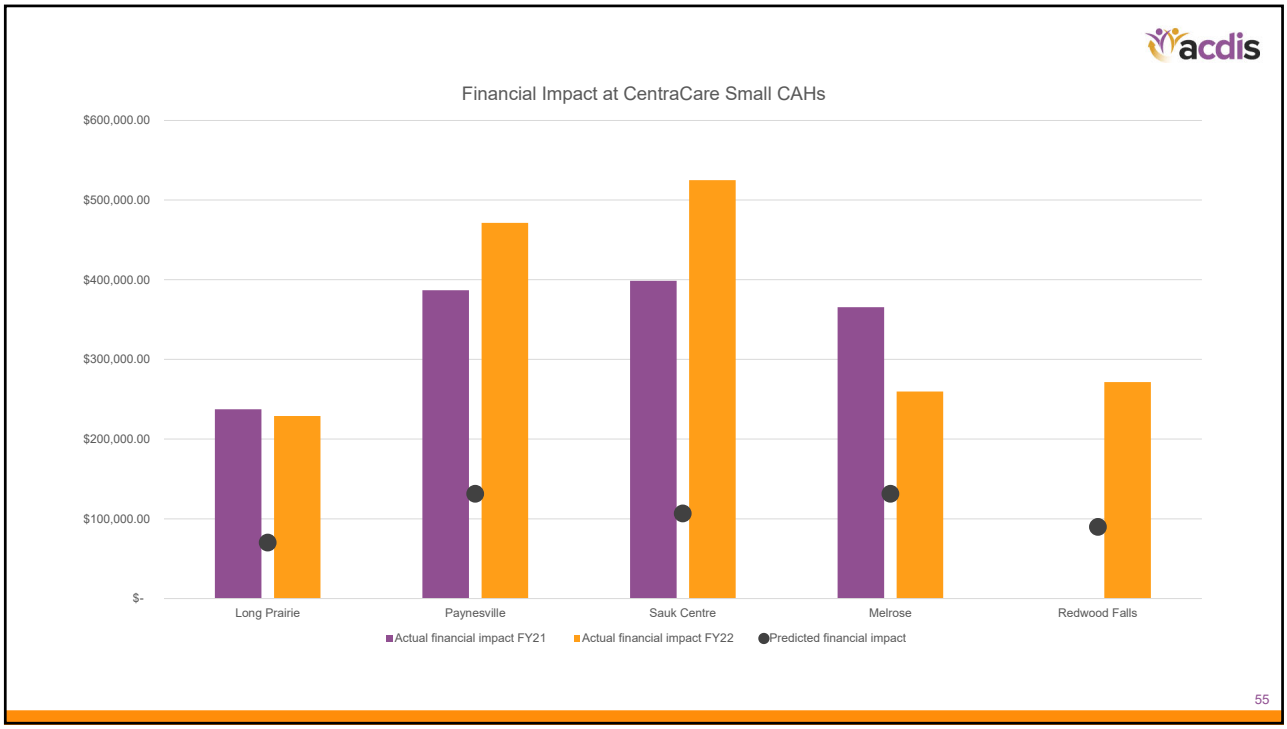
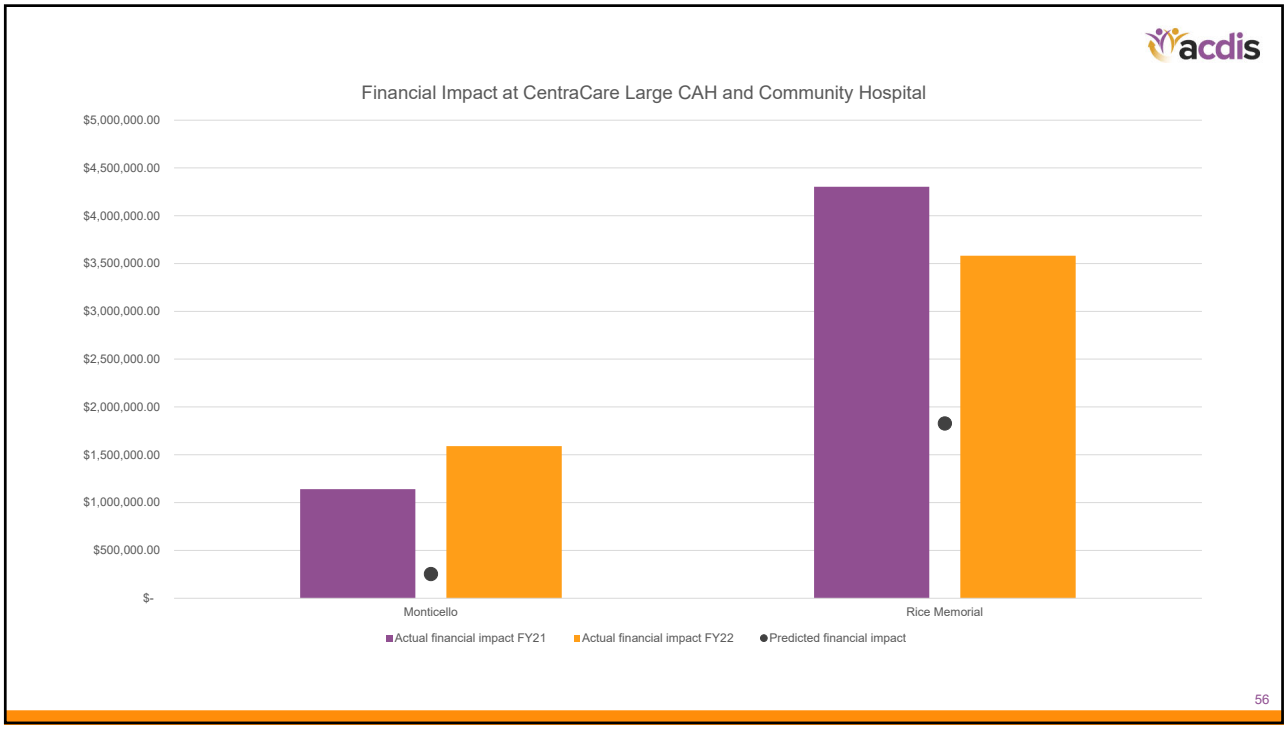
Community and Critical Access Hospitals: Results So Far





CentraCare Health System Q&A Domain Performance by Hospital

Hospital	Overall	Mortality	Efficiency	Safety	Effectiveness	Patient Centeredness	Equity
Community Hospitals (CHs, n = 268)							
Community IPPS Hospital	64	101	51	135	81	97	1

Source: Quality & Accountability Study (Q&A) Period 4 2022
Specialty and critical access hospitals not included in system Q&A domain view

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Thank you. Questions?

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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 of the program guide.

Value-based Purchasing: CDI Spaces

Person and community engagement: Eight measures of patient satisfaction from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey

Efficiency and cost reduction: Medicare spending per beneficiary (MSPB) = all Part A and B payments to all providers from three days prior to admission through 30 days post-discharge

Safety:

- *PSI-90 composite measure*
- CLABSI
- CAUTI
- CDI (Clostridium difficile infection)
- MRSA bacteremia (positive blood culture),
- SSI (surgical site infections) for abdominal hysterectomy and colon surgery.

Clinical outcomes:

- *30-day mortality rates for acute MI, heart failure, COPD, pneumonia, CABG*
- *THA/TKA complication rate.*

**Blue italics have documentation opportunity*

There are very specific inclusion and exclusion criteria that should be reviewed on a case-by-case basis by subject matter experts

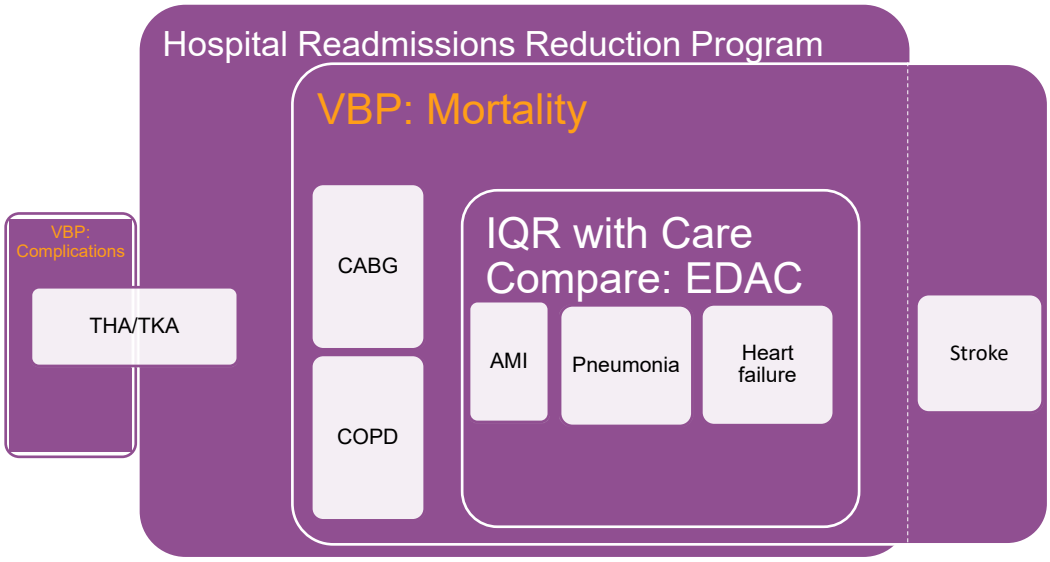
Patient Safety Indicator 90 (PSI 90)

- Composite of 10 individual PSI measures:
  - **PSI 03 Pressure Ulcer Rate**
  - PSI 06 Iatrogenic Pneumothorax Rate
  - PSI 08 In-Hospital Fall with Hip Fracture Rate
  - PSI 09 Postoperative Hemorrhage or Hematoma Rate
  - PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
  - **PSI 11 Postoperative Respiratory Failure Rate**
  - **PSI 12 Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate**
  - **PSI 13 Postoperative Sepsis Rate**
  - PSI 14 Postoperative Wound Dehiscence Rate
  - PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate

Includes a composite of the above 10 "claims-based" Patient Safety Indicators (PSIs). These are derived from ICD-10 codes with POA status assigned on the hospital claim and determined by physician documentation.

All are individually weighted: **Note that four measures (pressure ulcer, postoperative respiratory failure, perioperative PE/DVT, postoperative sepsis) contribute 77% to the total PSI-90 measure score.**

Clinical Outcomes in VBP Have Risk Adjusters and Exclusion Criteria



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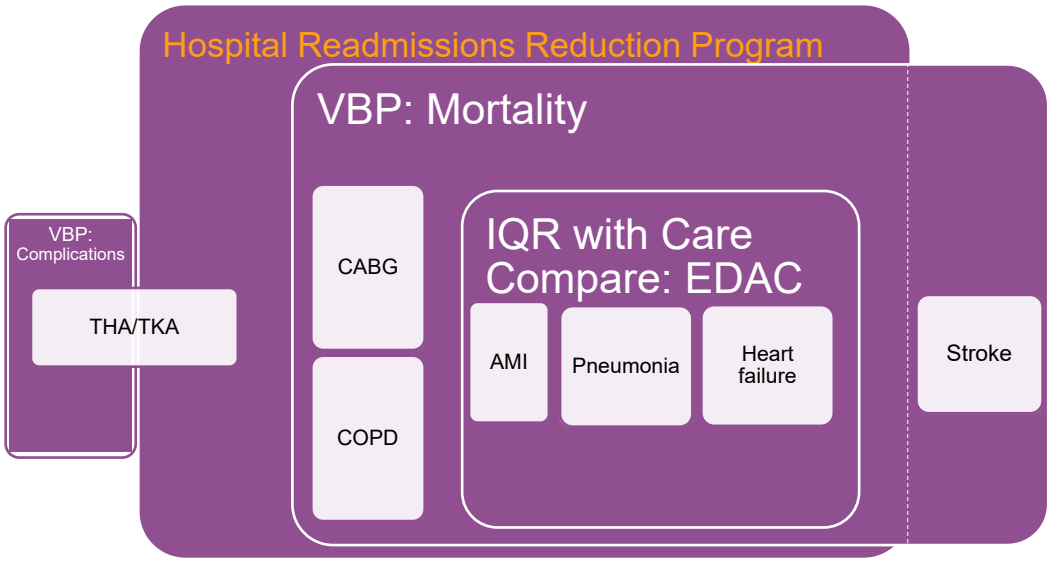
Readmissions Are Impacted by Getting the Inclusion (Usually Principal Diagnosis) Correct and Capturing Risk Adjusters



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CDI Spaces: Common Mortality Risk Adjusters

*POA is often necessary
**Admission type of urgent vs emergent

- Frequently missed and queried For risk adjusted diagnosis codes
  - Fluid and electrolyte disorders
  - Coagulation defects
  - Thrombocytopenia
  - Shock
  - Encephalopathy
  - Cachectic/cachexia
  - Debility and fatigue: Age-related debility, bed confinement status, reduced mobility, limitation of activities due to disability, chronic fatigue, neoplasm related fatigue
  - Do not resuscitate (DNR)
  - Glasgow Coma Score (GCS)
  - NIHSS scores
  - Valve disease (rheumatic/non-rheumatic)
- Frequently missed risk adjusted procedure codes
  - CPAP
  - HFNC
  - Vent coding and dates performed (within 48 hours of admission is a common variable on the calculators)