DRCHSD Summit

Delta Region Community Health Systems Development Program | 2023

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Quality Approaches to Reducing Hospital Readmissions and Improving Transitions of Care

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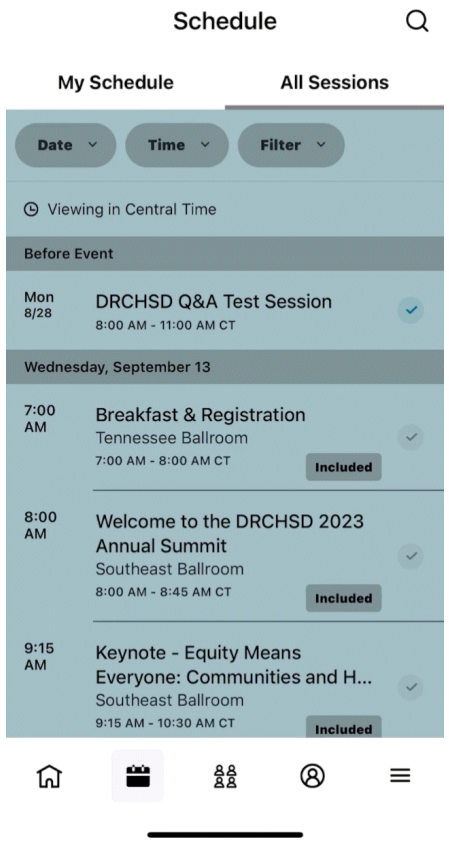

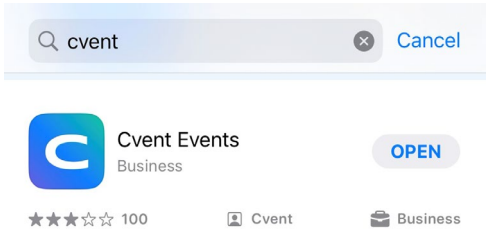

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INTRODUCTIONS

QUALITY APPROACHES TO REDUCING HOSPITAL READMISSIONS AND IMPROVING TRANSITIONS OF CARE..

Valorie Clouse, FNP, AGNP, CCM, FORVIS

& Lindsay Corcoran, MHA, Senior Consultant, Stroudwater

FORVIS

STROUDWATER

TODAY'S DISCUSSION

- The journey from hospital to home is a pivotal phase in a patient's healthcare experience. It is vital for effective coordination, communication, and care to drive the best possible patient outcomes. By reducing readmissions and improving transitions of care hospitals can create tremendous value for patients and the healthcare system.

- Key Objectives:
  - **Understand the interaction between reducing hospital readmissions and optimizing transitions of care**
  - **Explore quality-driven approaches that hospitals can adopt to improve readmissions and transitions of care**
  - **Recognize the operational and financial impact of a Transitional Care Management program**

TRANSITIONS OF CARE

DEFINING TRANSITIONS OF CARE

"a set of actions designed to ensure coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location"

- *-The American Geriatrics Society*

POP QUIZ

What percentage of 30-day hospital readmissions are estimated to be slightly to completely preventable?

- 68%
- 38%
- 47%
- 23%
- 11%

POP QUIZ, CONTINUED

Most factors that contribute to slightly-to-completely preventable 30-day readmissions occur during what phase?

- During index stay and follow-up care
- During index stay and transitions of care
- During transitions of care and follow-up care
- None of the above

HOW DO WE MANAGE TRANSITIONS OF CARE?

- How Do We Define Transitions of Care?
  - "Transitions of care" describes the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another

WHAT?	**Facilitating interactions**
WHO?	**Between healthcare professionals and patients**
WHERE?	**At every point along their journey**
WHEN?	**As they move from one healthcare setting to another**

WHY IS IT IMPORTANT TO MANAGE TRANSITIONS OF CARE?

When transitions between healthcare settings are not actively managed, there is a higher risk of:

- Delays in receiving appropriate treatment
- Mortality and morbidity
- Readmissions
- Additional/ duplicated tests
- Lack of follow-up
- ED visits
- Adverse events
- Provider/Patient dissatisfaction
- Increased primary care utilization

FACTORS INFLUENCING POOR TRANSITIONS OF CARE

- Deficiencies in communication between healthcare team members in the current setting and setting where the patient is going
- Management of follow-up care left up to patient/family to navigate
- Lack of essential patient education on care at home
- Inability of patient/family to follow the plan of care

Source: American Academy of Ambulatory Care Nursing

HOSPITAL READMISSIONS

IT TAKES AN INTERNAL & EXTERNAL TEAM!

To think simply within our own silo as an acute care facility won't be effective in managing the readmission issue.

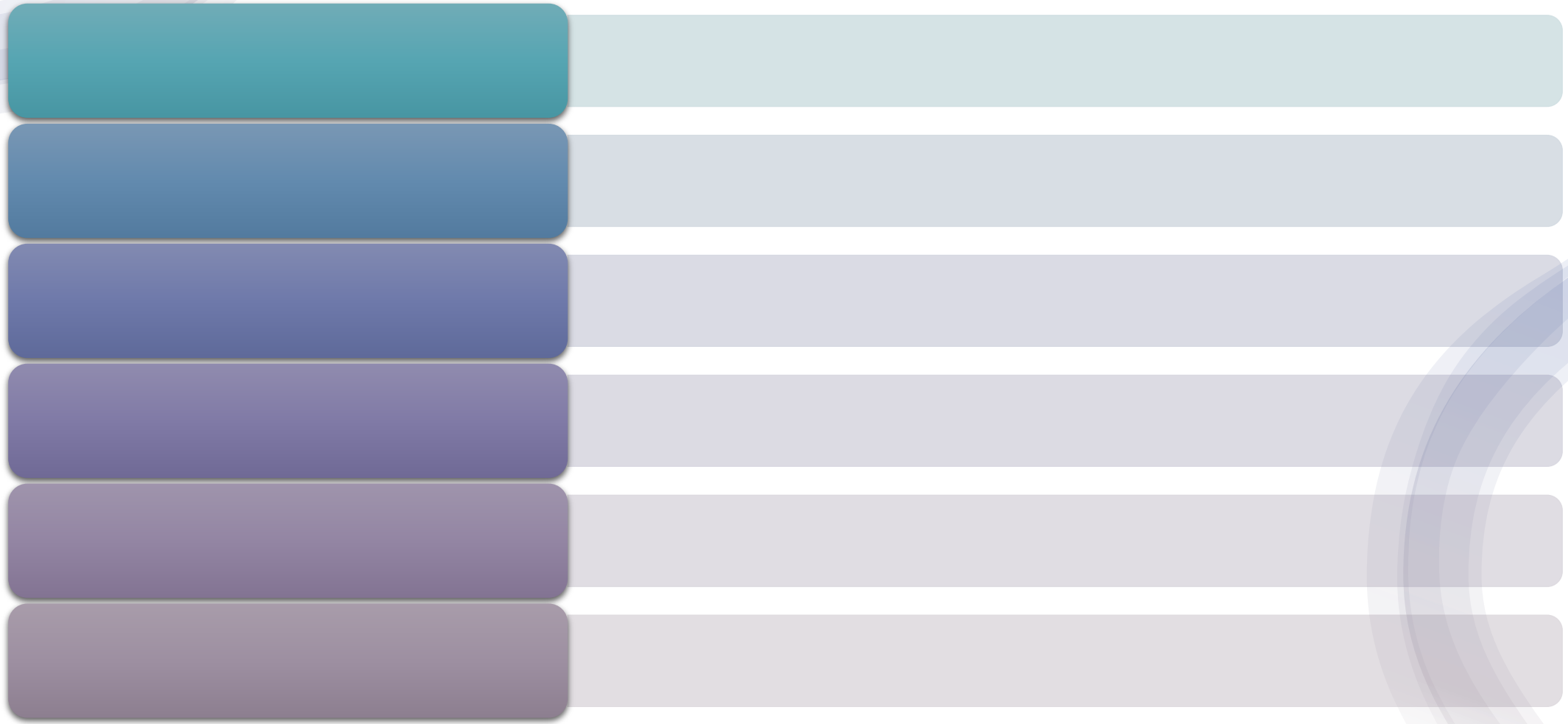
Tim Charles, CEO, Mercy Medical Center Cedar Rapids, Iowa

HOSPITAL READMISSIONS DEFINED

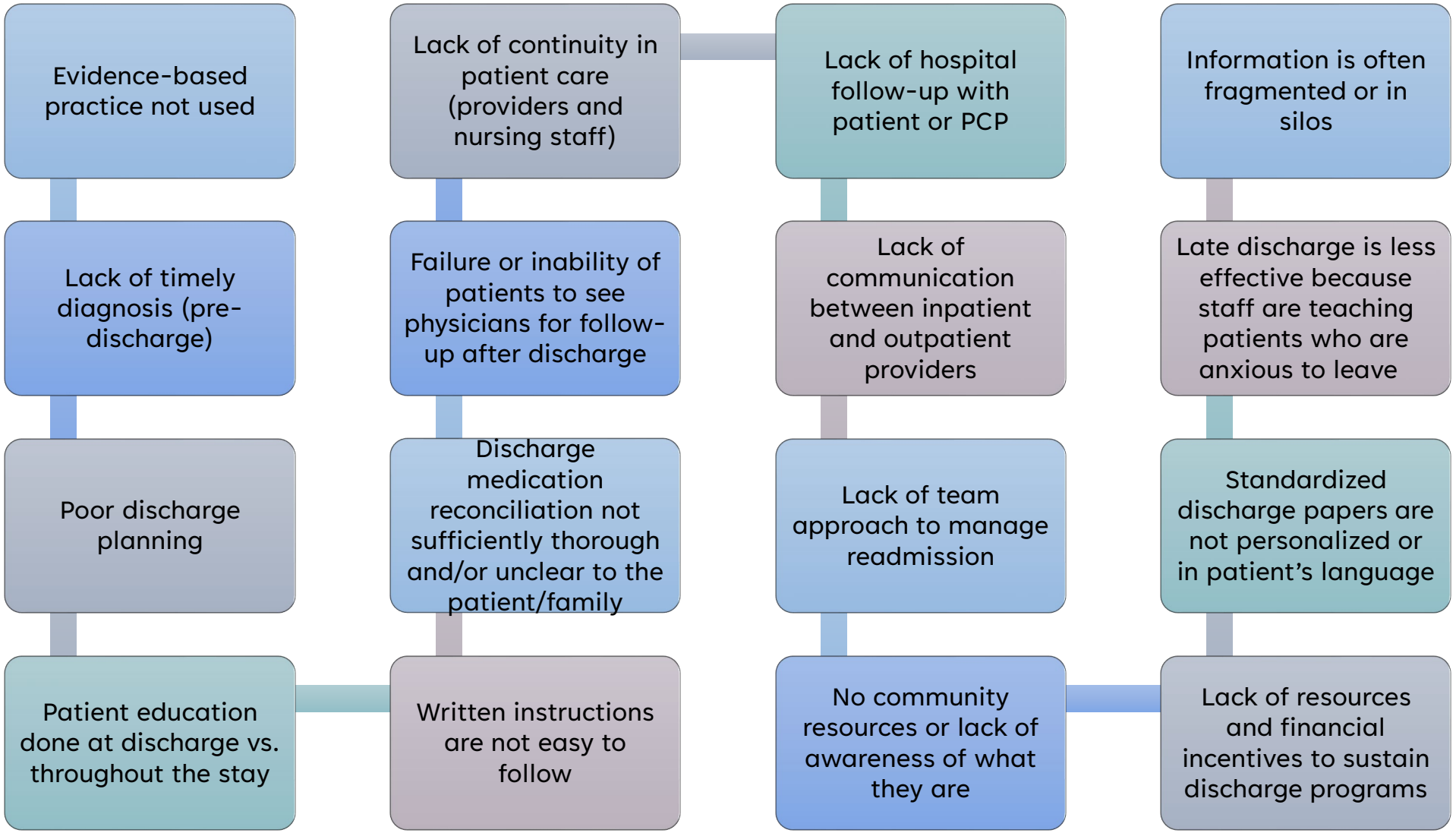
- According to CMS, hospital readmission is when a patient is admitted again to the hospital within a specific time frame (30 days) after being discharged from a previous hospitalization
- CMS tracks readmission rates for certain medical conditions and surgical procedures
  - AMI (acute myocardial infarction)
  - COPD (chronic obstructive pulmonary disease)
  - HF (heart failure)
  - Pneumonia
  - CABG (coronary artery bypass graft) surgery
  - THA/TKA (total hip and/or total knee arthroplasty)
- Hospitals (only PPS) are penalized when their readmission rate is higher than expected readmission rates under the Hospital Readmissions Reduction Program (HRRP)

HOSPITAL READMISSIONS DEFINED (CONT.)

- Medicare's 30-day rule and reimbursement changes were designed to encourage acute care hospitals to reduce readmissions by addressing several factors, such as:
  - Decreasing medical errors and hospital-acquired conditions
  - Appropriate patient/significant other information/teaching at discharge
  - Improved patient compliance with post-care instructions
  - Adequate follow-up from PCPs and specialists as needed
  - Increased reliance on family and community caregivers



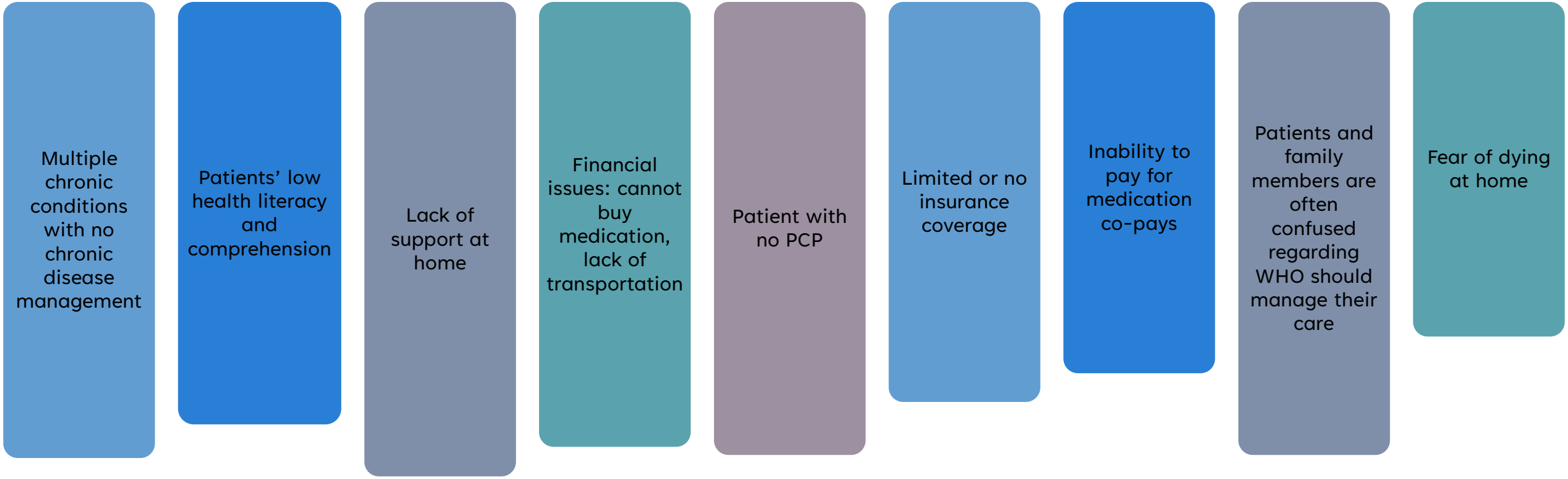
FACTORS CONTRIBUTING TO READMISSIONS



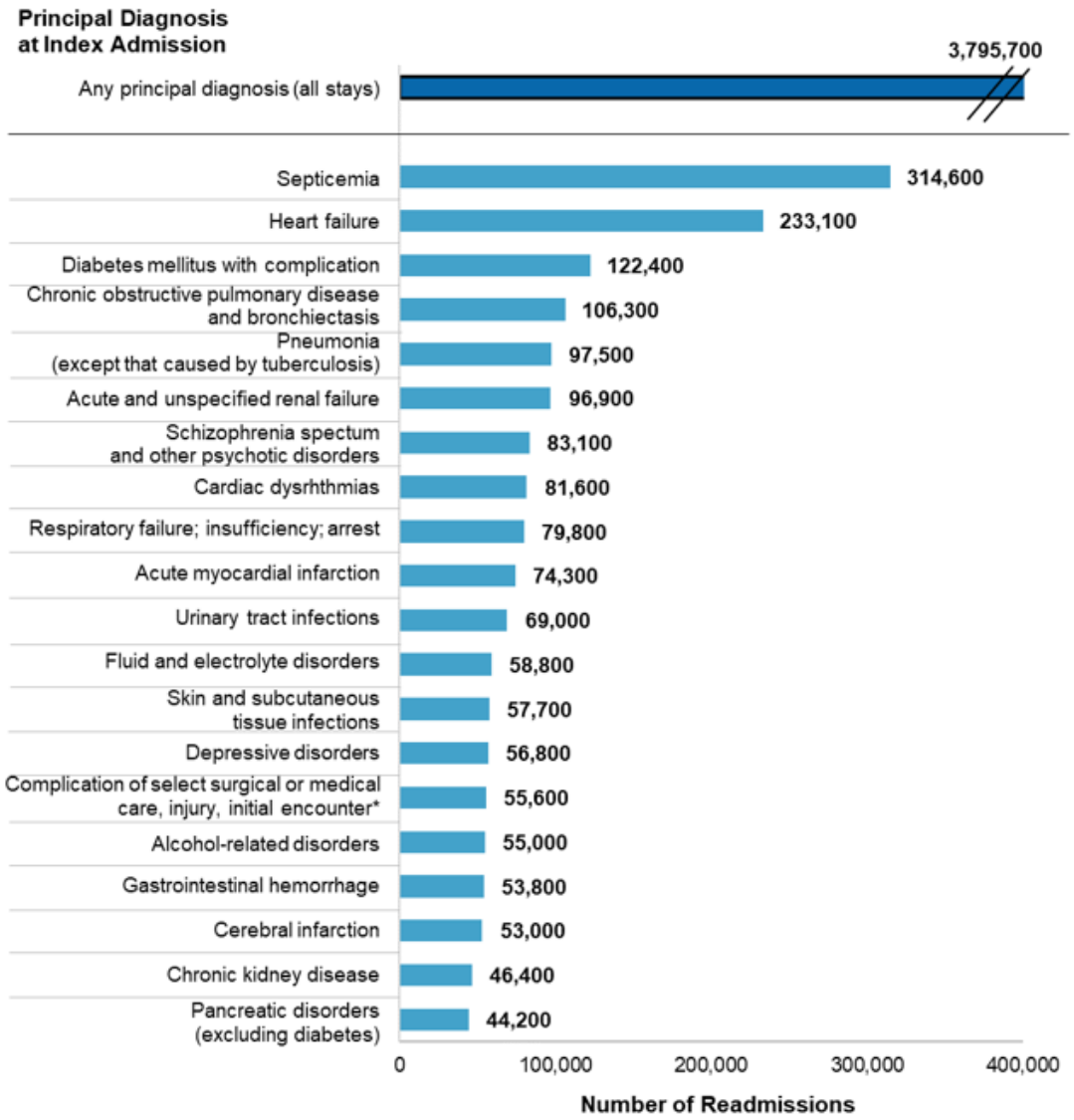
Healthcare Provider Driven

FACTORS CONTRIBUTING TO READMISSIONS..

Patient Driven



DIAGNOSES WITH THE HIGHEST NUMBER OF 30-DAY ALL-CAUSE ADULT HOSPITAL READMISSIONS, 2018



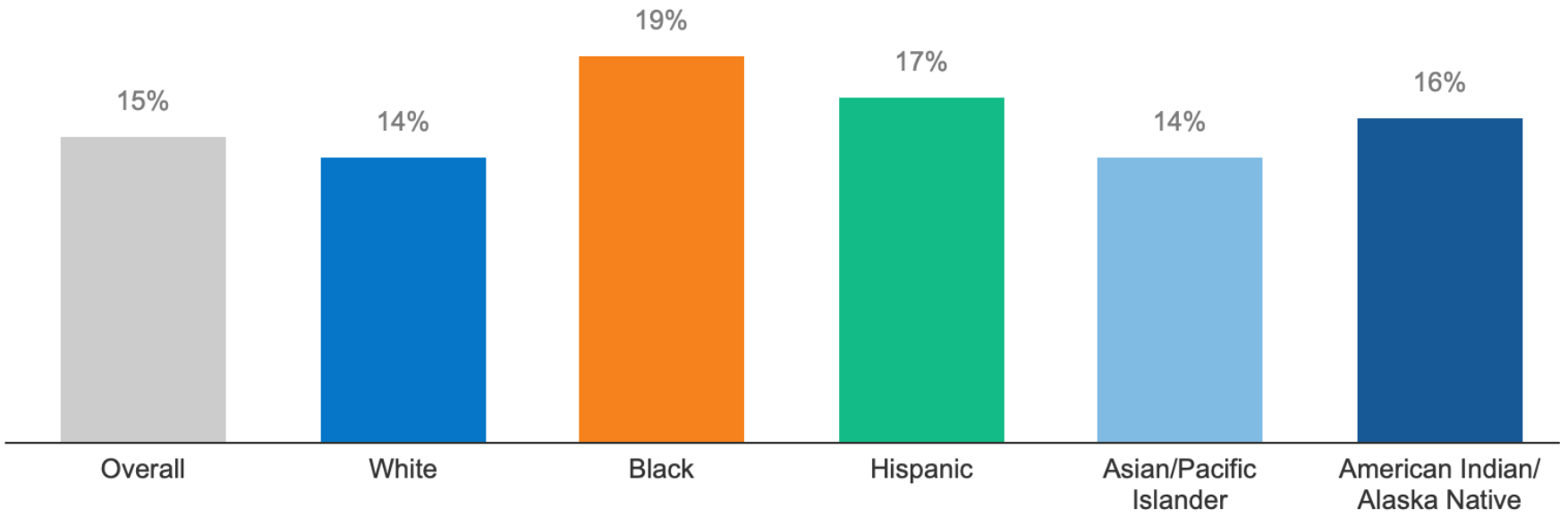
https://hcup-us.ahrq.gov/reports/statbriefs/sb278-Conditions-Frequent-Readmissions-By-Payer-2018.jsp#:~:text=Hospital%20stays%20for%20septicemia%20at,for%20one%20in%20five%20readmissions

READMISSIONS BY RACE/ETHNICITY

Figure 21

Hospital Readmission Rates Are Higher Among Black Medicare Beneficiaries Than Among Beneficiaries in Other Racial/Ethnic Groups

30-day readmission rates among beneficiaries in traditional Medicare, 2016:



NOTE: Data for unknown racial/ethnic groups not shown. Hospital readmissions are defined by CMS as inpatient stays that occur within 30 days of discharge from the initial inpatient hospitalization

SOURCE: CMS Office of Minority Health. Impact of Hospital Readmissions Reduction Initiatives on Vulnerable Populations. Baltimore, MD: Centers for Medicare & Medicaid Services; September 2020

KFF

Source: https://www.kff.org/report-section/racial-and-ethnic-health-inequities-and-medicare-access-to-care-and-service-utilization/

RURAL READMISSION RATE – 13.48

HCUPnet: Readmission Stays, National

Years: 2020

Type of Readmission: All

Outcomes: All

Characteristic: Patient Urban/Rural R..

Characteristic Levels: All

☐ **Show 95% CI**

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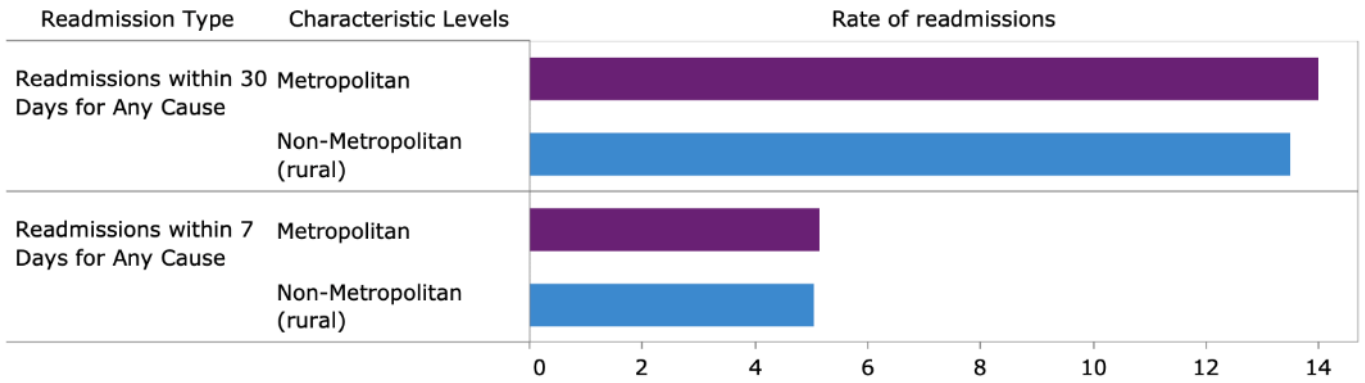
Readmission Stays by Type and Patient Urban/Rural Residence, United States, 2020
Graphed: Rate of readmissions

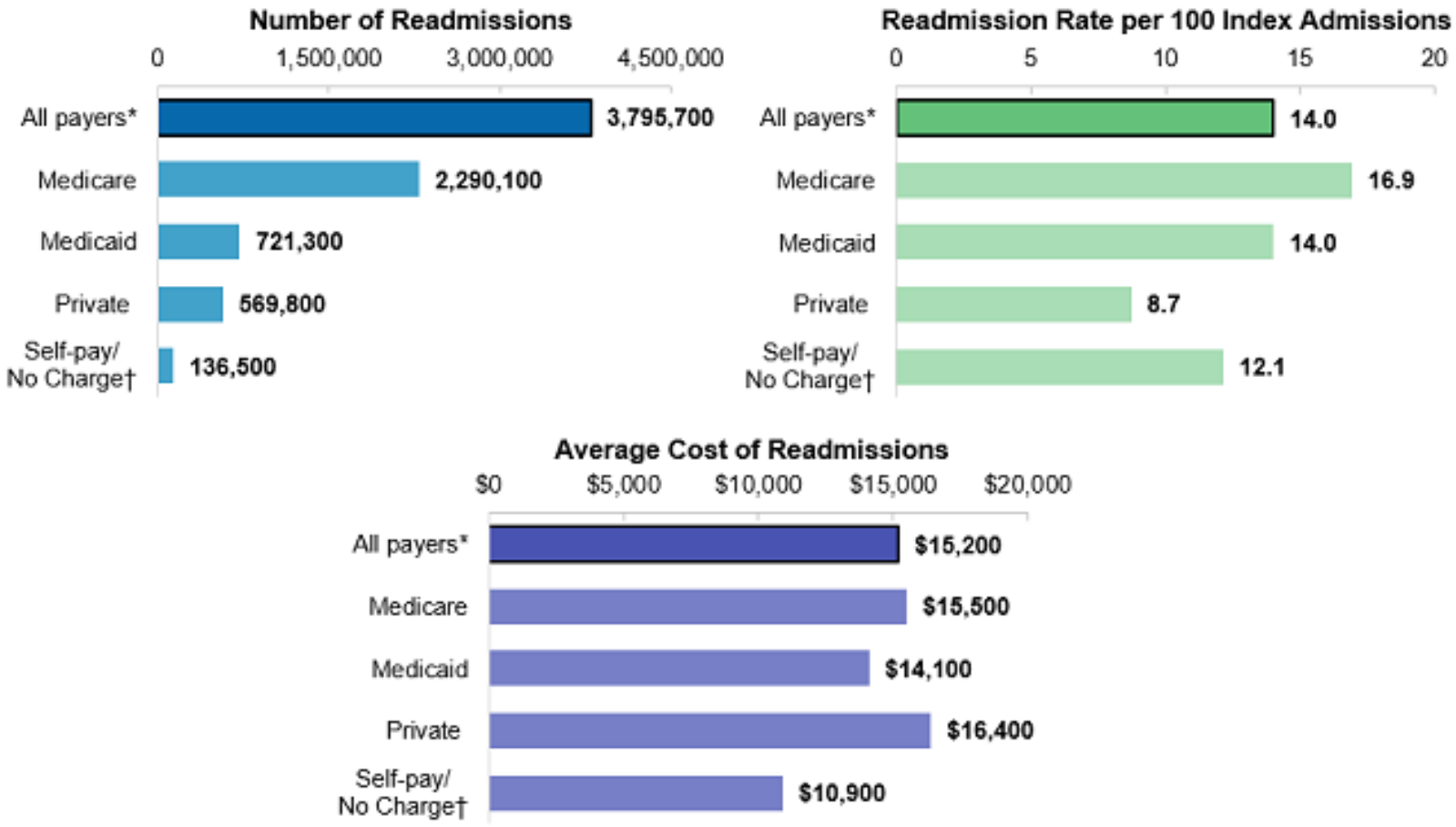
Outcome to Graph: Rate of readmissions



Characteristic Levels	Index Stays		Readmissions within 30 Days for Any Cause			Readmissions within 7 Days for Any Cause		
	Number of index stays	Average hospital costs per stay	Number of readmissions	Average hospital costs per stay	Rate of readmissions	Number of readmissions	Average hospital costs per stay	Rate of readmissions
Metropolitan	21,005,556	15,641	2,940,755	17,810	14	1,079,614	18,197	5.14
Non-Metropolitan (rural)	4,278,626	14,971	576,706	16,220	13.48	215,731	16,676	5.04

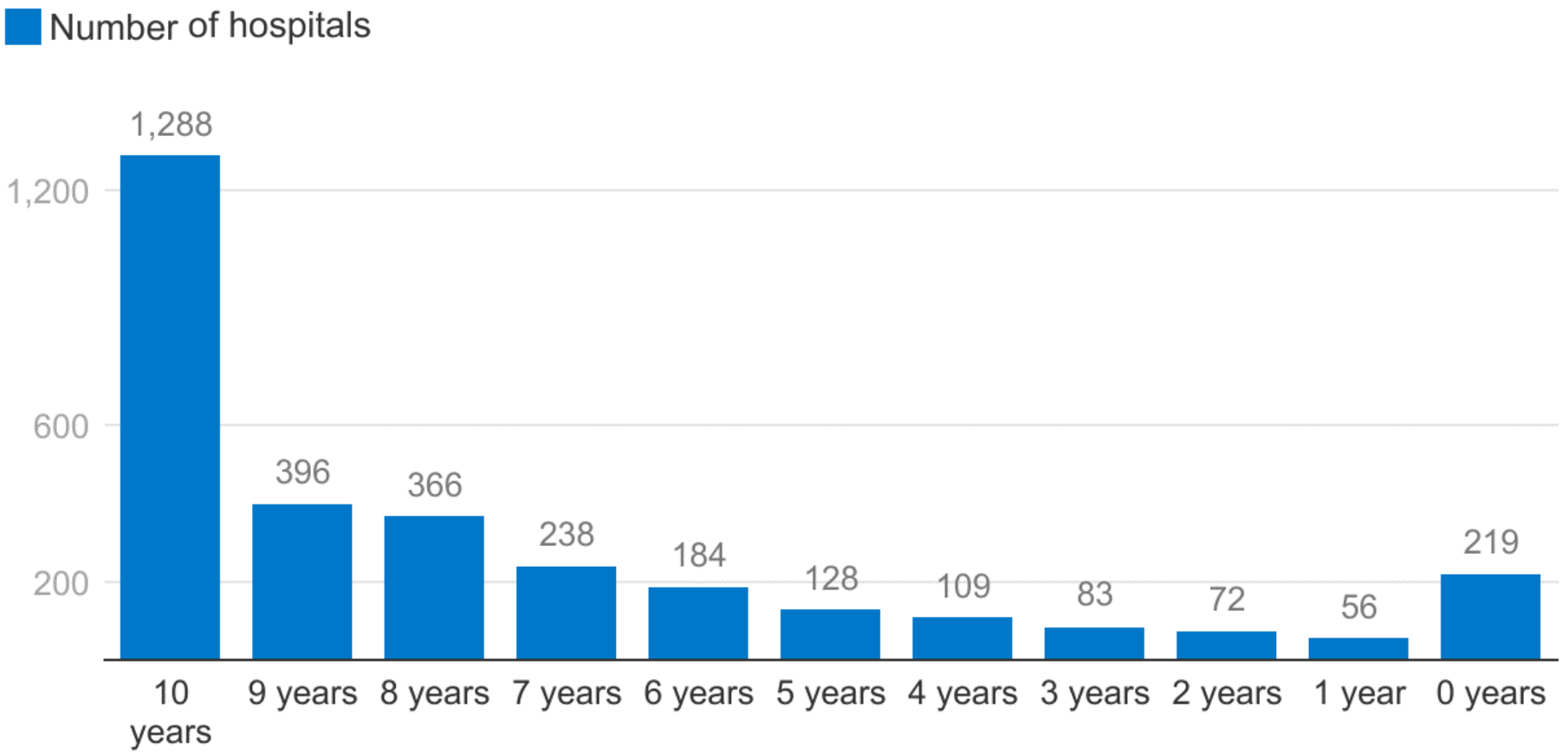
Source: https://datatools.ahrq.gov/hcupnet/?tab=readmissions&dash=47

MEDICARE ACCOUNTED FOR 60.3% OF READMISSIONS



Source: https://hcup-us.ahrq.gov/reports/statbriefs/sb278-Conditions-Frequent-Readmissions-By-Payer-2018.jsp#

OVER 9 IN 10 ACUTE-CARE HOSPITALS PENALIZED

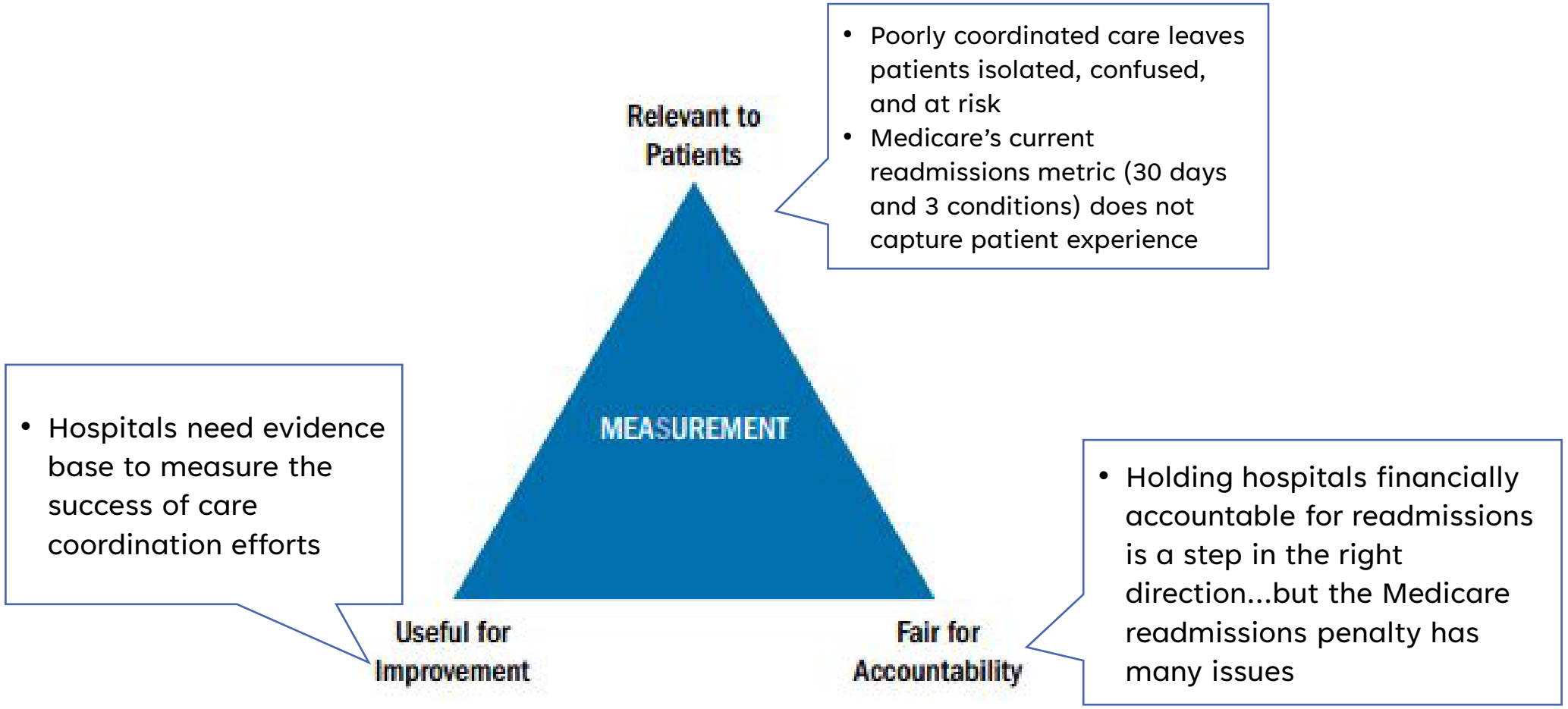


SOURCE: KHN reporting based on data from the Centers for Medicare & Medicaid Services

KHN

Source: https://www.kff.org/health-reform/slide/10-years-of-hospital-readmissions-penalties/

WHY DO WE MEASURE READMISSIONS?



- Poorly coordinated care leaves patients isolated, confused, and at risk
- Medicare's current readmissions metric (30 days and 3 conditions) does not capture patient experience

- Hospitals need evidence base to measure the success of care coordination efforts

- Holding hospitals financially accountable for readmissions is a step in the right direction…but the Medicare readmissions penalty has many issues

Source: The Commonwealth Fund's Institute for Healthcare Improvement 9/13 Issue Brief
Hospital Readmissions: Measuring for Improvement, Accountability, and Patients

QUALITY APPROACHES FOR REDUCING HOSPITAL ADMISSIONS AND IMPROVING CARE TRANSITIONS

CARE COORDINATION AND COLLABORATION

- Effective communication among healthcare providers
- Strategies – care teams, IDT rounding, discharge planning, readmission risk assessment

CREATING A STANDARDIZED SYSTEM *that never actually discharges patients, but instead cares for them across the healthcare continuum*

- Establish a clear standardized process and stick to it
- Designate a multidisciplinary team both internally and externally
- Ensure the hospital is working with primary and community care members
- Gather patient-specific information and weave it into daily care plan
- Equip staff and clinicians with the tools needed to provide continuous care
- Conduct an inventory and gap analysis of community initiatives, programs, and resources
- Create a data dashboard to drive improvement from the current state

PATIENT EDUCATION AND EMPOWERMENT

- Educating patients and caregivers about their conditions and care plans
- Strategies: self-management tools, medication management, medication reconciliation, post-discharge follow-ups

COMMUNICATING WITH PATIENT, FAMILY & CAREGIVER

- Instill patient and family ownership for self-care
- Practice bi-directional communication, inclusion and collaboration
- Encourage personal motivation: What are the patient's long-term health goals?
- Train at-home caregivers while the patient is in the facility—involve all involved
- Consider the patient's mindset when planning care
- Ensure the use of cultural and language concordance to promote health literacy

DISCHARGE PLANNING

PREPARING FOR DISCHARGE AT ADMISSION AND ONGOING

- Utilize the readmission risk assessment tool and create categories for low, medium and high-risk patients
- Conduct a comprehensive assessment to determine the patient's physical and psychosocial needs
- Screen for Social Determinants of Health such as:
  - Housing instability
  - Transportation
  - Food insecurity
  - Violence
  - Poverty
  - Literacy
- Collaborate with the pharmacist to create a complete list of medications, current and new
- Ensure the patient receives a nutrition consult
- Schedule time for the discharge planner to sit with the patient and caregivers to review the plan and answer questions
  - Discuss financial concerns related to co-pays and purchasing medication
  - Ask questions to gauge the patient's knowledge regarding their health problem(s)
  - Inform patient they will receive ongoing education on medications, managing disease, and signs and symptoms to report to physician
- Place the admission/discharge packet in the patient's room in an easily visible and accessible location
- Refer to discharge packet and plan frequently and instruct all disciplines to use the admission/discharge packets when providing educational materials

DISCHARGE PLANNING..

Modified LACE Tool

Attribute	Value	Points	Prior Admit	Present Admit
Length of Stay	Less 1 day	0		
	1 day	1		
	2 days	2		
	3 days	3		
	4-6 days	4		
	7-13 days	5		
	14 or more days	6		
Acute admission	Inpatient	3		
	Observation	0		
Comorbidity: (Comorbidity points are cumulative to maximum of 6 points)	No prior history	0		
	DM no complications, Cerebrovascular disease, Hx of MI, PVD, PUD,	1		
	Mild liver disease, DM with end organ damage, CHF, COPD, Cancer, Leukemia, lymphoma, any tumor, cancer, moderate to severe renal dz	2		
	Dementia or connective tissue disease	3		
	Moderate or severe liver disease or HIV infection	4		
	Metastatic cancer	6		
Emergency Room visits during previous 6 months	0 visits	0		
	1 visits	1		
	2 visits	2		
	3 visits	3		
	4 or more visits	4		
	Take the sum of the points and enter the total ➔			

- Score ≥ 11 identifies patient at risk

DISCHARGE PLANNING...

Use CARE when explaining and/or teaching

Control. We appreciate being able to control situations. Give patients choices about when/where to learn new info.

Active. We learn best when we're engaged and involved. Make education interactive.

Relevant. We assume more responsibility for information that's relevant to our needs. Explain how information fits into patient's life.

Experience. We understand better when we see a connection to past encounters. Relate education to the patient's life experiences.

IMPORTANCE OF DISCHARGE PLANNING

- Only 59.6% of discharged patients can accurately describe their diagnosis
- Only 43.9% of patients recalled the details of their appointment
- 75% of US adults are non-adherent in at least one way
- Only 37% can state the purpose of their medications
- Up to 1/3 of adults discharged from a hospital do not see a physician within 30 days

Source: https://pubmed.ncbi.nlm.nih.gov/23958851/

MEDICATION MANAGEMENT

- Medication management at discharge is crucial to ensure a smooth transition from hospital to home
  - Prevention of medication errors
  - Ensure patient continues necessary treatments
  - Reduces the risk of adverse events
  - Promotes patient safety
  - Reduces the risk of readmission

LEVERAGE TECHNOLOGY

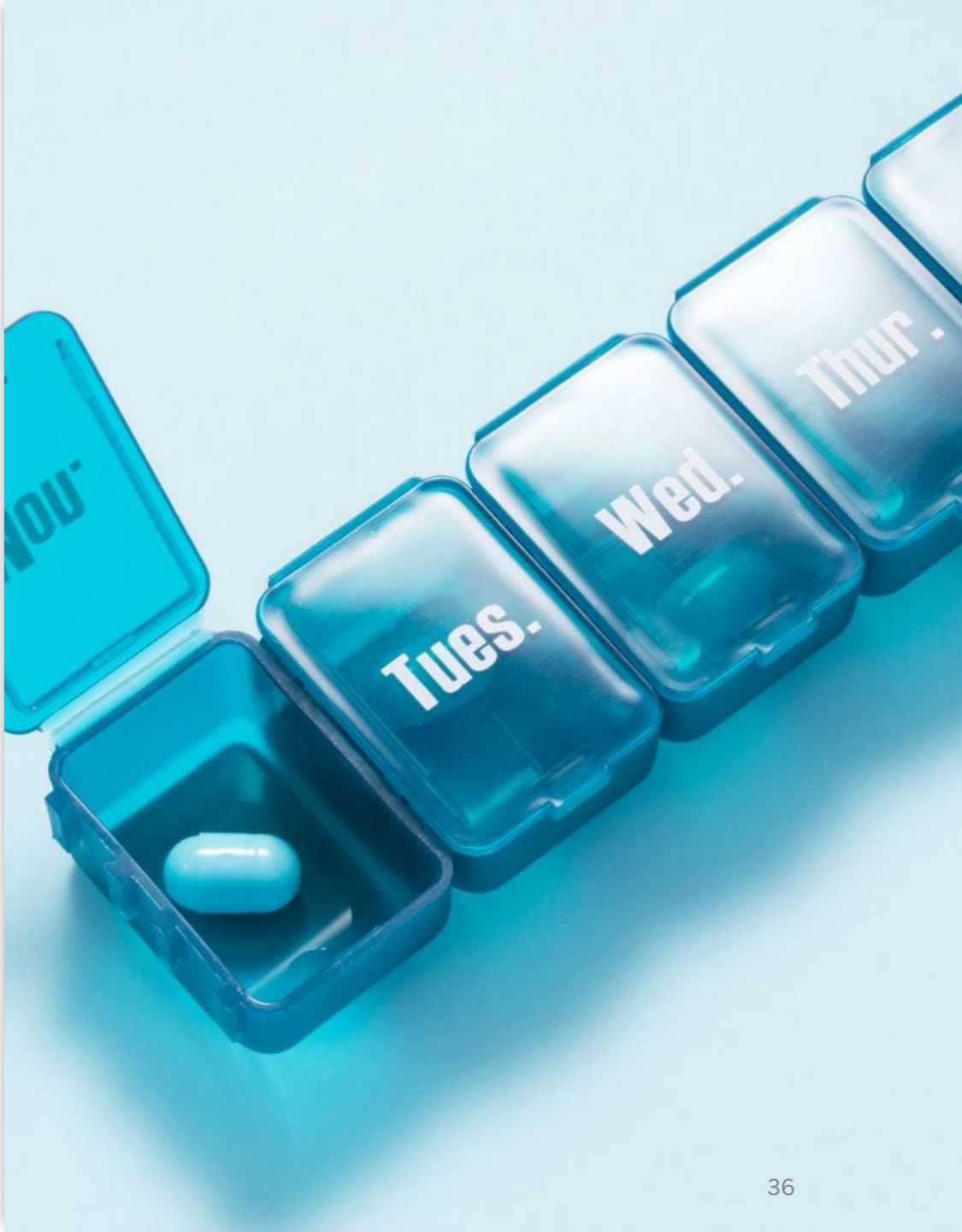
Tools for enhancing communication and information exchange

Patient portal, EHR, telehealth, remote monitoring, APPs, etc.

LEVERAGE TECHNOLOGY..

- Apps such as Health ID, BlueLoop, Diabetes in Check, On Track Diabetes, Pillboxie, MediSafe Medication Management, and MedHelper Pill Reminder, to name just a few
- Patient Portals for the EMR
- Electronic pill boxes

- Barriers to leveraging technology
  - Unfamiliar or uncomfortable
  - Literacy challenges
  - Connectivity issues
  - State / county infrastructure



PUTTING THIS INTO PRACTICE: TRANSITIONAL CARE MANAGEMENT – FOCUSED STRATEGY FOR IMPROVING TRANSITIONS OF CARE

WHY IMPLEMENT TRANSITIONAL CARE MANAGEMENT?

- Siloed, disconnected healthcare
- Incomplete transfer of information
- Typical challenges:

Discharge plan confusion	**Medication issues**	**Knowing who to ask**	**Caregiver needs**	**Managing existing chronic conditions**
Mental health *(Depression, anxiety, disengagement, cognition)*	Self-advocacy	Self-management	Community resources	Appointment logistics *(Scheduling, transportation)*

Source: CMS 2023 Physician Fee Schedule

SEVEN FOUNDATIONS FOR SAFE TRANSITIONS OF CARE

These seven elements must be in place for a safe transition to occur from one healthcare setting to another.

Source: The Joint Commission, 2013

GOALS OF TRANSITIONAL CARE MANAGEMENT

Maintain short and mid-term medical stability

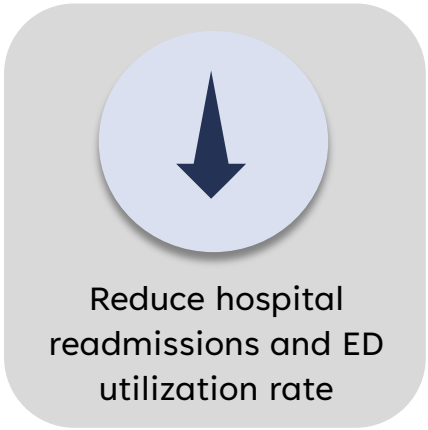
Build a strong connection with primary care

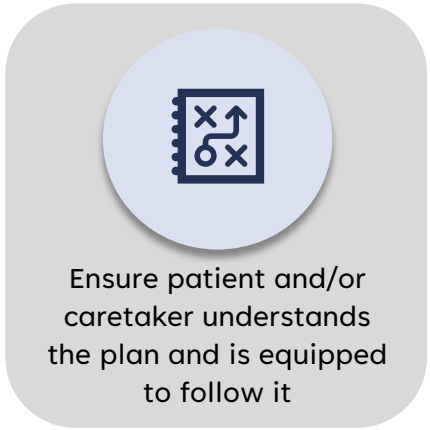
Identify patients who need extended care team support

Increase community resource use

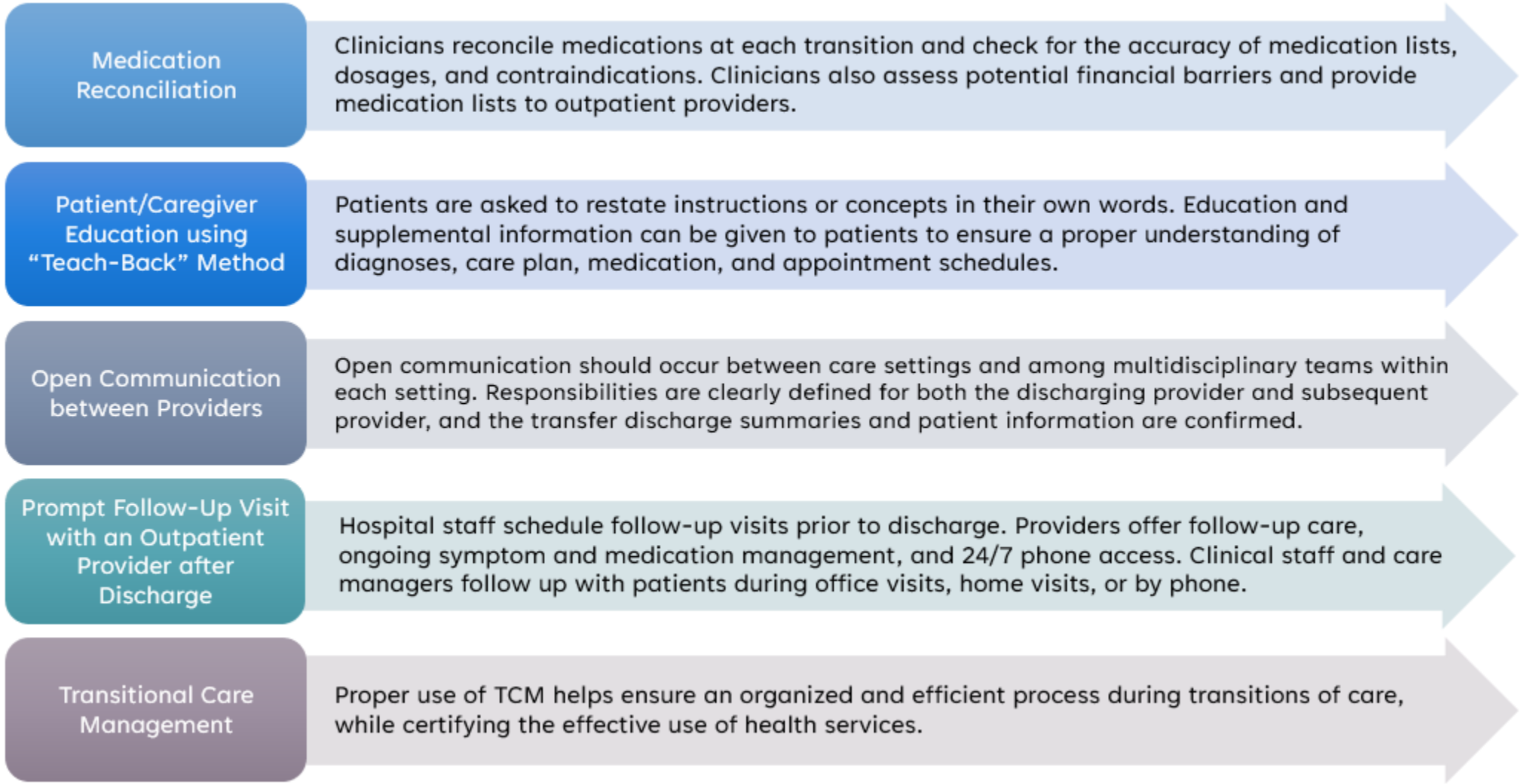
Increase self-efficacy and patient engagement

GOALS OF TRANSITIONAL CARE MANAGEMENT (CONT.)



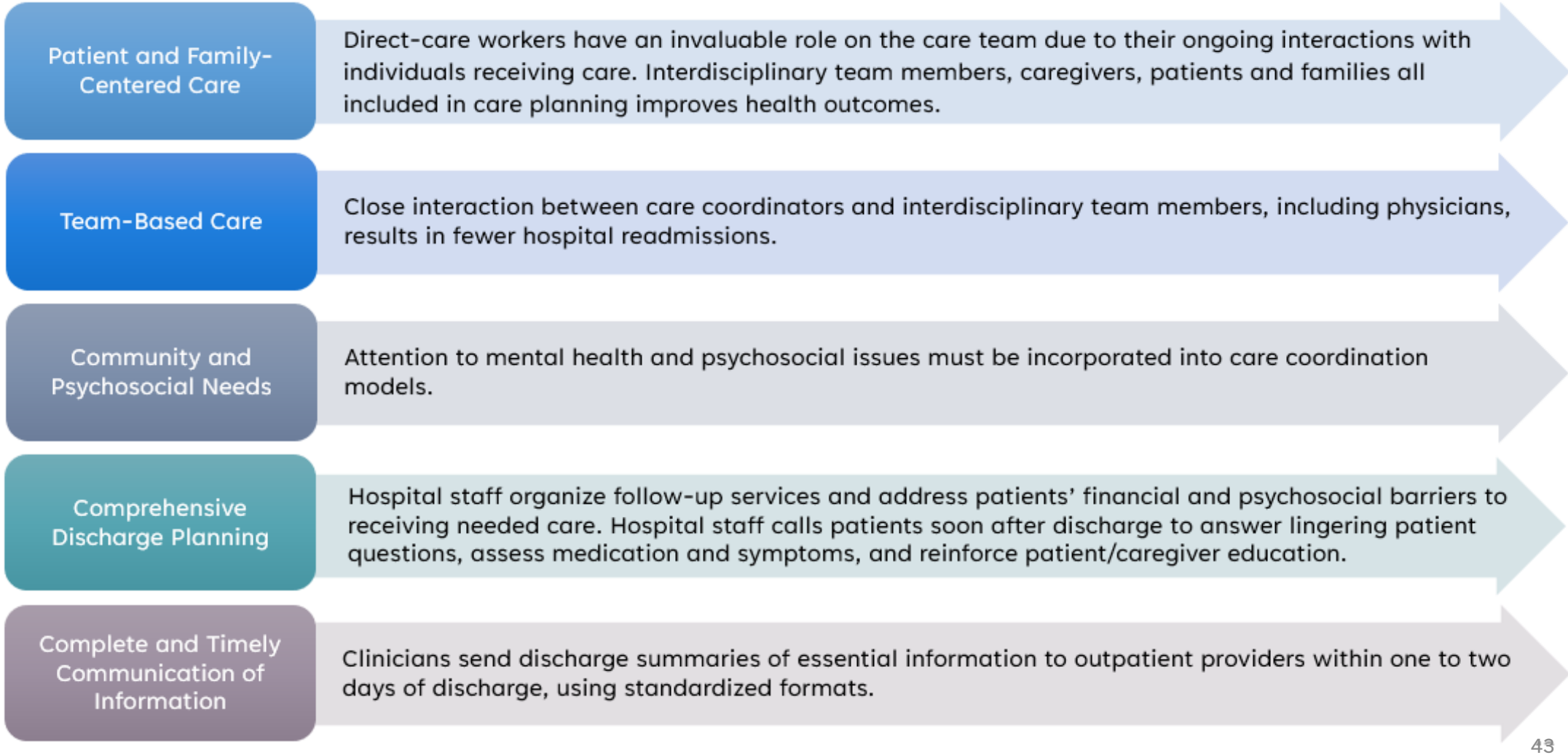


EFFECTIVE STRATEGIES TO IMPROVE TRANSITIONS OF CARE



Source: CHRT, Care Transitions: Best Practices and Evidence-based Programs, 2014

EFFECTIVE STRATEGIES TO IMPROVE TRANSITIONS OF CARE…



Source: CHRT, Care Transitions: Best Practices and Evidence-based Programs, 2014

BEST PRACTICE METHOD FOR COMPLETING FOLLOW UP PHONE CALLS

Identification	Notification Patient eligibility
Engagement	Telephonic **What are the patient's goals, values and preferences?**
Assessment	Your manner of asking is *everything* Not a single interaction •Balance emergent needs with completion of the interview
Care plan	Drives every single interaction **Does the care plan address care gaps and follow-up needs**
Intervention	Care coordination, case management, patient engagement, provider engagement

BENEFITS OF TCM

- **Financial**
  - Higher reimbursement rates from CMS compared to other service codes
  - Reimbursement for previously unpaid services
- **Patient Experience**
  - Improved patient satisfaction scores
  - Cost savings
  - Timely, intentional care
- **Quality**
  - Prevents readmissions
  - Reduces leakage to outside networks/organizations

PATIENT EXPERIENCE BENEFITS OF TCM

ESTABLISHES A POINT OF CONTACT AFTER LEAVING THE HOSPITAL FOR QUESTIONS OR CONCERNS

REDUCES UNNECESSARY ED VISITS AND PREVENTS READMISSIONS

ENSURES PATIENT HAS ALL MEDICATIONS AND SYMPTOMS ARE MANAGED

REDUCES ANXIETY AS PATIENTS TRANSITION FROM ONE CARE SETTING TO ANOTHER

IMPROVES PATIENT SATISFACTION SCORES

QUALITY BENEFITS OF TCM

PREVENTS AVOIDABLE ED VISITS

PREVENTS READMISSIONS

REDUCES/PREVENTS ADVERSE OUTCOMES

REDUCES LEAKAGE TO OUTSIDE HEALTHCARE ORGANIZATIONS

TRANSITIONAL CARE MANAGEMENT: FINANCIAL IMPACT

FINANCIAL BENEFITS OF TCM: DECREASED SPEND PER BENEFICIARY

- PMPY spend on patients who were engaged for TCM after a qualifying discharge was $700 lower on average versus patients who only had an E&M visit with their provider, and $2,068 lower than patients who had no visits following discharge

Patient Group	# Beneficiaries	% Beneficiaries	PMPY Spend	Total Spend
No Clinic Visit after Qualifying Discharge	3,647	29%	$9,352	$34,106,524
E&M Visit after Qualifying Discharge	5,046	40%	$7,946	$40,097,371
TCM Visit after Qualifying Discharge	4,050	32%	$7,284	$29,501,572

FINANCIAL BENEFITS OF TCM: INCREASED REIMBURSEMENT ON TCM VISITS

Case Study:

- Over the last 12 months, only 32% of beneficiaries with qualifying discharges had a TCM visit billed to CMS
  - If these patients had been engaged for TCM, average reimbursement would be $23-$158 higher per beneficiary than average reimbursement for an E&M visit

Code	Code Description	Avg. Reimbursement	# Qualifying Discharges	% Qualifying Discharges
99202	Office/Outpatient Visit (New)	$43	19	0.1%
99203	Office/Outpatient Visit (New)	$60	133	1.0%
99204	Office/Outpatient Visit (New)	$96	248	1.9%
99205	Office/Outpatient Visit (New)	$130	111	0.9%
99211	Office/Outpatient Visit (Established)	$11	15	0.1%
99212	Office/Outpatient Visit (Established)	$27	148	1.2%
99213	Office/Outpatient Visit (Established)	$47	1,443	11.3%
99214	Office/Outpatient Visit (Established)	$68	2,393	18.8%
99215	Office/Outpatient Visit (Established)	$102	371	2.9%
99495	TCM 14-Day	$125	2,068	16.2%
99496	TCM 7-Day	$169	1,982	15.6%

TCM DOCUMENTATION CHECKLIST

Is the initial discharge date documented?

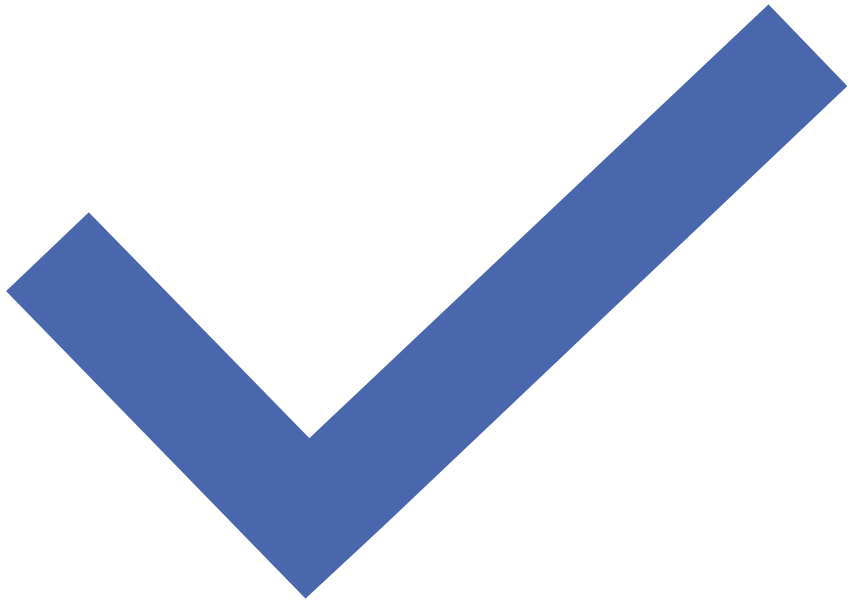
Date of post-discharge communication with patient or caregiver is documented AND occurs within 48 business hours of initial discharge date?

Is date of first face-to-face visit documented?

Does the provider document medication reconciliation and complexity of medical decision-making (moderate or high)?

CMS REIMBURSEMENT FOR BILLING TCM CODES COMPARED TO E&M CODES

CPT	CPT Description	FFS Amount
99213	Office Visit Established Pt	$83.23
99214	Office Visit Established Pt	$118.14
99215	Office Visit Established Pt	$166.07
99495	Transitional Care Mgmt 14 days	$187.58
99496	Transitional Care Mgmt 7 days	$254.22



CONCLUSION

APPENDIX

SCRIPT FOR FOLLOW UP CALLS

POST-VISIT/STAY CLINICAL PHONE CALL SAMPLE	
EMPATHY AND CONCERN	Hello, [Patient Name], this is [Caller Name] from [Hospital Name], and Dr. [Name] asked that I call and check on you after your recent visit to the hospital. Is this a good time?
CLINICAL OUTCOMES	▪ Were your discharge instructions clear and understandable? (Yes/No). Please tell me in your own words how you are to care for yourself at home. ▪ Are you having any unusual symptoms or problems? (Specific to problem- i.e., dressing, pain, bruising or swelling, N/V) ▪ Have you filled your new prescriptions yet? Do you have any questions about those medications? ▪ Were you able to make a follow-up appointment with the physician?
REWARD AND RECOGNITION	Are there any physicians, nurses, or hospital staff you would like us to recognize for doing a very good job?
PROCESS IMPROVEMENT	Thank you for taking the time to share with me about your care and recovery. Do you have any suggestions for us?

E X A M P L E

Introduction/Reason for Calling/Concern	Hello "___"? Hi, my name is "____" and I am calling from Franklin Hospital emergency department. I am calling because you were recently discharged from our emergency department and I wanted to see how you were doing since your visit. Do you mind if I ask you a couple questions to see if there is anything I can assist you with?
Condition/Outcomes	How have you been feeling since your last visit with us? Has your condition improved, stayed the same, or worsened?
Discharge Instructions	Do you understand your discharge instructions?
Medications/Prescriptions (if applicable)	I see that you were prescribed "___" in the emergency department. 1) Did you have any trouble filling that prescription after your discharge? 2) Do you have any questions about the medications you were prescribed?
Follow-Up Care	1) I'd like to talk about your follow-up appointment. You were instructed to follow-up within "___" days, when are you going to see your doctor? If you don't have a primary care physician, would you like us to make an appointment for you? 2) Are you doing ok caring for yourself at home?
Questions	If any questions or problems come up, do not hesitate to give us a call or contact your family doctor.
Closing	Thank you for choosing Franklin Hospital for your healthcare needs.

***** Remember to never leave confidential information on a voicemail**

EXAMPLE WORKFLOW FOR PATIENT FOLLOW UP

Assessment and Treatment Plan:

- The medical team assesses the patient's condition and creates a treatment plan.
- Determine the need for follow-up care based on the severity of the condition and expected recovery time.

Appointment Scheduling:

- Schedule a follow-up appointment with an appropriate healthcare provider (e.g., primary care physician, specialist) before discharge.
- Consider the patient's availability, transportation, and the urgency of the follow-up.

Communication with Patient:

- Inform the patient and their family/caregiver about the scheduled follow-up appointment.
- Explain the purpose of the appointment, its importance, and any instructions (e.g., fasting, medication changes) to follow.

Appointment Details:

- Provide the patient with the appointment date, time, location, and any necessary contact information.
- Ensure the patient understands the importance of attending the appointment and its role in their recovery.

Documentation:

- Document the scheduled follow-up appointment in the patient's medical records.
- Include details about the appointment, provider's name, and reason for the follow-up.

Medication and Instructions:

- Review the patient's medication list and any changes made during hospitalization.
- Ensure the patient understands their medication regimen, dosages, and any modifications.

Discharge Instructions:

- Provide the patient with written discharge instructions that include information about the follow-up appointment.
- Include any special precautions, dietary restrictions, or activity limitations.

Transportation and Logistics:

- Assist the patient in arranging transportation to the follow-up appointment if needed.
- Address any logistical concerns the patient might have, such as insurance coverage.

Communication with Outpatient Provider:

- Notify the outpatient provider about the scheduled follow-up appointment, sharing relevant medical information.

Patient Education:

- Educate the patient about the importance of attending the follow-up appointment and how it contributes to their overall recovery.

Patient Reminder:

- Provide a reminder to the patient a day or two before the scheduled follow-up appointment, either through a phone call, text message, or email.

Follow-Up Appointment:

- The patient attends the scheduled appointment, discusses progress and concerns with the healthcare provider, and receives any necessary adjustments to the treatment plan.

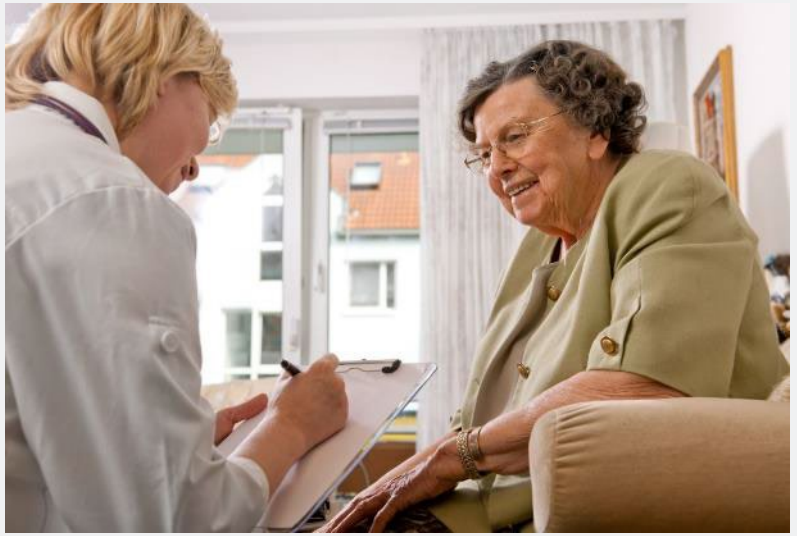
Feedback and Continuation:

- The healthcare team gathers feedback on the process and identifies areas for improvement in the follow-up workflow.
- Continue to monitor the patient's progress and adjust the treatment plan as needed

THE TEACH-BACK METHOD

- **The Teach-back Method:** Teach-back is a way for practitioners to confirm that what they explain to the patient was clear and understood. Patient understanding is confirmed when the patient explains it back to the practitioner or does a return demonstration (instead of just saying, “Yes, I understand.”)

Darren A. DeWalt, MD, MPH



E X A M P L E

Social Determinent Screening Form

Client Name (Last, First):_____ Date of Birth: _____

Physical Address: _____ City/Town: _____ State: _____ Zip code: _____

Primary Care Provider Name: _____Gender: ☐ Male ☐ Female ☐ Other _____

Best Telephone Number to Call:_____ E-mail:_____

Best time to contact: _____ Health Insurance: _____

Highest Level of education completed: ☐ No High School or GED (Z55.9) ☐ High School or GED

☐ Associates Degree ☐ Bachelor's Degree ☐ Master or Doctoral Degree

Ethnicity: ☐ White ☐ Latino ☐ Black/African-American ☐ Asian ☐ Middle Eastern ☐ Other:_____

Primary Language: ☐ English ☐ Spanish ☐ Other:_____

In the last 12 months:		Yes	No
	Would food assistance benefit you? (Ex. WIC, SNAP, meal sites) (Z59.4)		
	Do you have trouble keeping up with your utility bills? (Z59.8)		
	Do you have stable housing? (Z59.1)		
	Are you currently Homeless? (Z59.0)		
	Do you feel safe in your neighborhood? (Z59.1)		
	Do you need help caring for your family? (Ex. A child, parent, or spouse) (Z59.9)		
	Do you have a primary care provider?		
	Do you visit them once a year for a checkup?		
	Do you have health insurance?		
	Do you ever skip medications to save money? (Z59.7)		
	Do you need help finding a job? (Z56.0)		
	Do you have a cell phone?		
	Do you have reliable transportation? (Z59.9)		
	Are any of your needs urgent?		
	Would you like to receive assistance with any of these needs? Which ones?		

Comments:

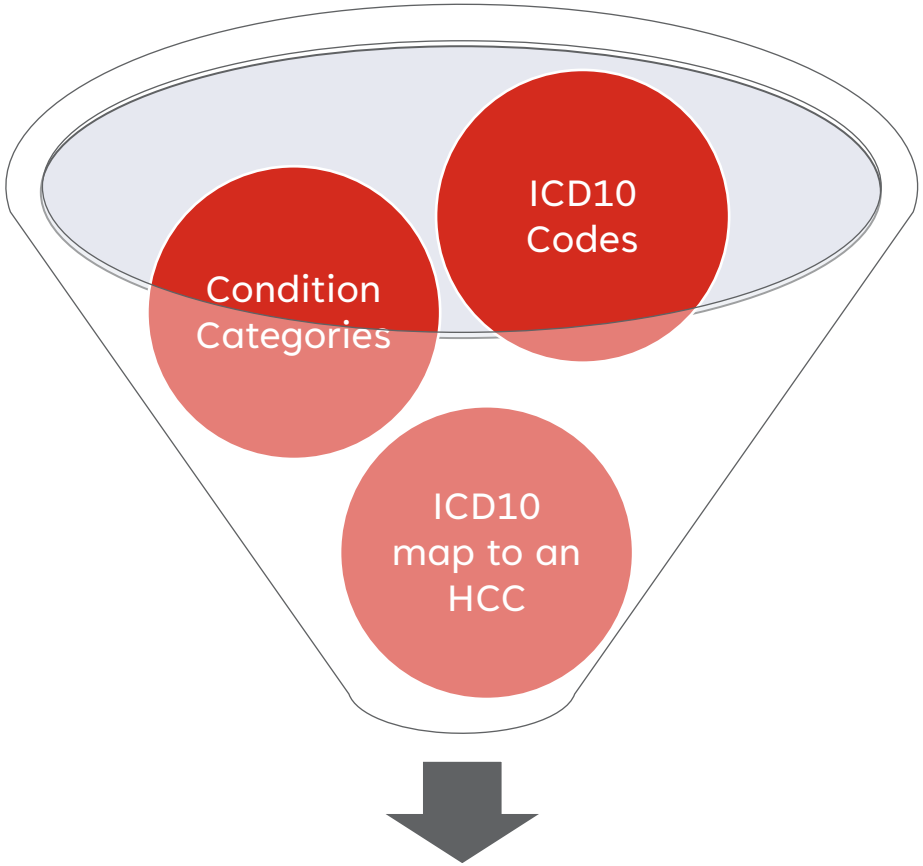
_____

Patient Authorization Obtained: ☐ Yes ☐ No

Staff member name: _____ Location: _____

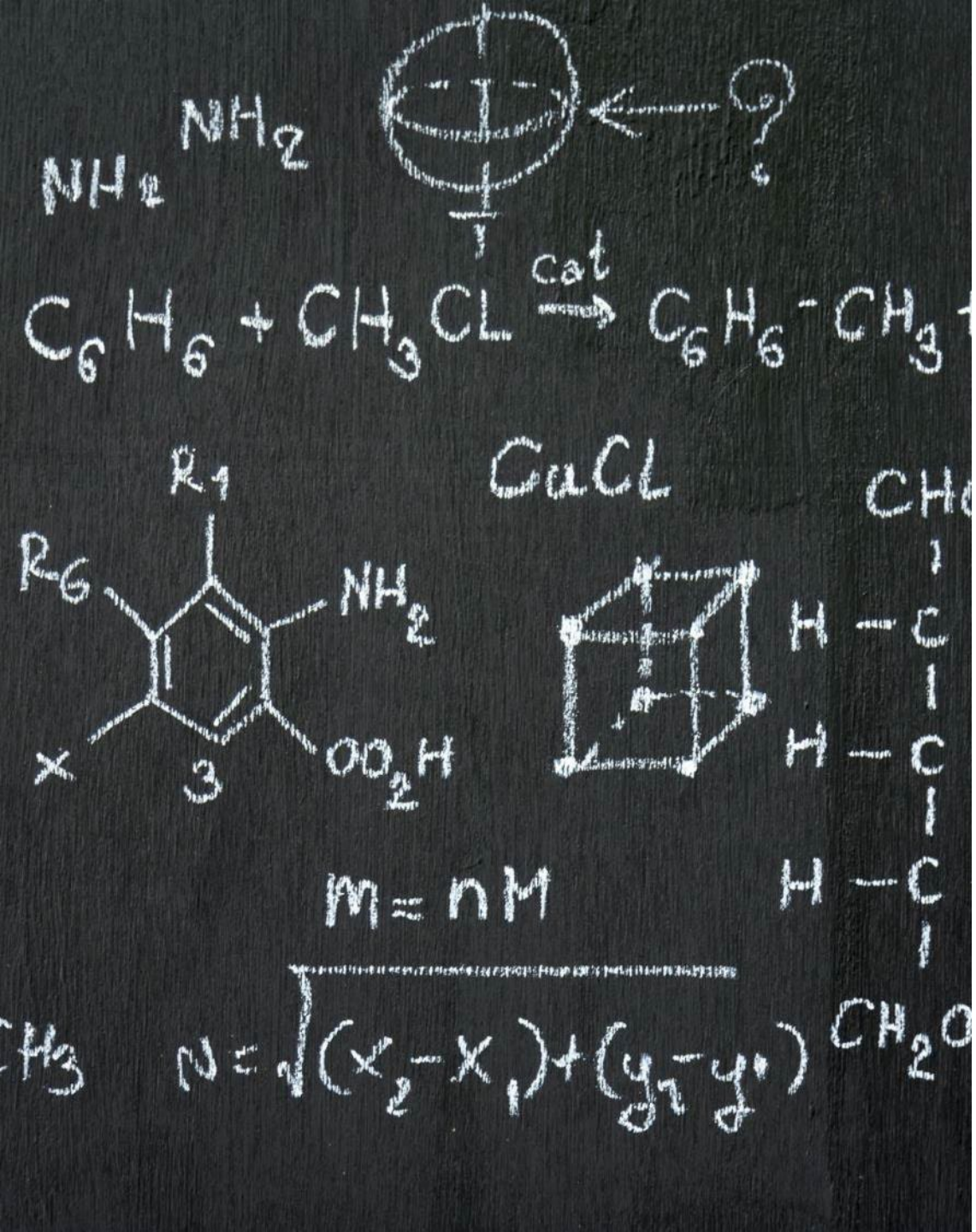
RISK ADJUSTMENT CODING

- Diagnosis Coding/ ICD-10 codes only
- Hierarchical Condition Category
- Each Condition Category carries a RAF score
- Captures full burden
- Estimates expected future cost
- Resets YEARLY



A CLOSER LOOK AT RISK ADJUSTMENT CALCULATION

- Based on documentation and coding of certain diagnosis codes EVERY calendar year
- Numerical value for each diagnosis is added to produce the Risk Adjusted Factor (RAF)
  - Average patient of average health → **RAF = 1.0**
  - Healthy Patient → **RAF < 1.0**
  - Patient with Multiple illnesses → **RAF > 1.0**
- A dollar value is assigned to these numbers, adjusted year
  - $9,350 = RAF 1.0 score



RISK SCORE CALCULATION EXAMPLE

- **Simple risk score calculation**
  - Identify relevant demographic characteristics
  - Identify relevant HCCs
  - Sum the relevant coefficient (relative factor)
- **Adjusted payment is RAF x base rate**
- **If the base rate is $1,000 then 1.010 x $1,000= $1,010**

RISK SCORE CALCULATION EXAMPLE..

	Predicted Cost
Male age 80-84	$4,660
AMI = HCC 81	$2,438
COPD = HCC 108	$3,129
Total predicted cost (sum)	$10,227
Population mean cost	$9,051
Risk score = (predicted cost)/(mean cost)	**1.130**

- **Male**
- **82 years old**
- **Prior year diagnosis of AMI and COPD**
- **The beneficiary is predicted to be 13%more expensive compared to the average Medicare beneficiary**

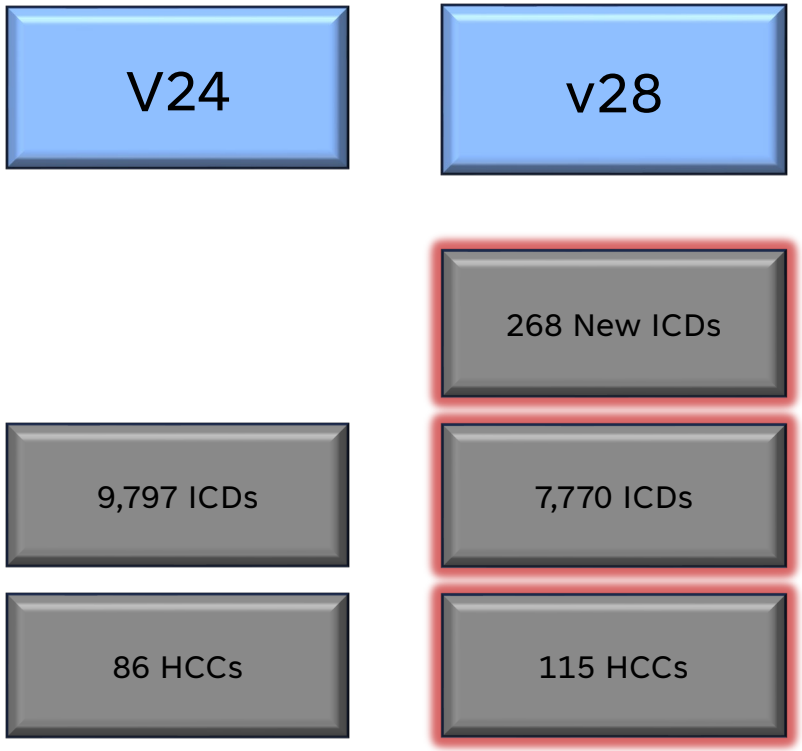
TRANSLATING THE RAF TO PAYMENT

No Diagnoses		Incomplete Documentation		Complete Documentation	
76-year-old female	0.317	76-year-old female	0.317	76-year-old female	0.317
Medicaid eligible	0.151	Medicaid eligible	0.151	Medicaid eligible	0.151
		CKD Stage 4	0.284	CKD Stage 4	0.284
		Heart failure	0.310	Heart failure	0.310
		Diabetes	0.106	Diabetes w/renal complications	0.307
		DM + HF + CKD	0.600	Hemiplegia	0.498
				BKA status	0.567
				PEG status	0.581
				DM + HF + CKD	0.600
RAF	0.506	RAF	1.768	RAF	3.615
Estimated annual payment	$4,048	Estimated annual payment	$14,144	Estimated annual payment	$28,920

WHAT TO FOCUS ON

- Understanding the new updates to the HCC model
- Reviewing Coding Guidelines
- Coding and Documentation Training
- Coding to the highest degree of Specificity
- Set Clinical and Administrative support

COMPARISON BETWEEN MODELS V24 & V8



How will RAF Scores be impacted by version 28?

1) Reduction in Diagnosis codes
2) New Diagnosis Codes
3) HCC Coefficient Updates

REFERENCES

REFERENCES..

- CMS MLN: https://www.cms.gov/files/document/mln908628-transitional-care-management-services.pdf

THANK YOU

STROUDWATER

FORVIS

Lunch
12:00 – 1:00 pm
Tennessee AB