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**Category:** Value-based care (Delivery of care where reimbursement is based on patient health outcomes)

**Title:** Clinical Outcomes: Reducing Mortality with Documentation Excellence

## ABSTRACT BODY

Background: The 2014 CMS Value Based Purchasing data reported an unexpectedly high rate for 30-day Acute Myocardial Infarction (AMI) mortality at Carolinas Medical Center (CMC). Chart review of 236 mortality cases from the first quarter of 2014 identified that ~ 30% of the cases should not have had AMI designated as the principal diagnosis for the inpatient admission. To rectify the discrepancy between clinically coded and chart abstracted data, a two-phased Clinical Documentation Excellence strategy was implemented.

Methods: A multi-disciplinary team (comprised of providers, administration, quality, analytics, and coding/documentation excellence specialists) implemented the following model in two phases at Atrium Health's highest volume CV centers to improve outcome reporting and identify accurate patient risk profiles:

  1. Develop a "hard stop" process so that records from all patients with a principal diagnosis of AMI are reviewed prior to final billing

  2. Develop concurrent coding so that records are reviewed in real time

Results: The rolling year AMI observed mortality rate through December 2015 and December 2018 were 11.83% and 9.42%, respectively. This resulted in a 2.41% mortality rate decrease and meeting the stretch goal.

Conclusions: The hard stop and concurrent coding strategy have led to early improvement in measured AMI mortality rates and, if sustained, may lead to an established 'best practice' that is scalable across multiple service lines and facilities.

**Clinical Implications**: My study will help enable cardiovascular clinicians to create processes to assure accurate coding and documentation which in turn will result in accurate assessment of outcomes.