Learning Objectives

• At the completion of this educational activity, the learner will be able to:
  – Define healthcare in evolution: Key performance indicators that assess value in care delivery across the continuum
  – Relate the importance of CDI advancement through physician leadership
  – Outline an effective approach to a successful physician advisor program
  – Apply Dr. Teague’s insight to integrate clinical care delivery with CDI to achieve financial accuracy and optimal outcome performance

Healthcare Reform: Volume to Value
CMS: Value-Based Modeling

Assessing Value: Hospital Incentives and Penalties

Value: Hospital-Centric Pay-for-Performance
Value: Care Coordination—Alternative Payment Models (APMs)

- MS-DRG-anchored episode-based payments with quality-adjusted target prices
- Quality composite score determines:
  - Eligibility for reconciliation payment
  - Amount of repayment or reconciliation payment (through reduction in the CMS discount %)

Category 3 APMs built on fee-for-service architecture

B APMs with upside gainsharing/downside risk

- EPMs
  - CJR
  - SHFFT
  - AMI
  - CABG

Assessing Value: Hospital Reputation

December 2016 Hospital Rating

*969 hospitals not rated due to data insufficiency

Source: Hospital Compare

Line of Sight: CDI Impact Across Programs

CMS star rating (Mortality)  
CJR (TIA/TIA complications)

Physician Quality Payment Program

VBP and HACRP
CMS star rating (Surgery of Care)

CMS star rating (Readmissions)
<table>
<thead>
<tr>
<th>Performance Categories</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td></td>
</tr>
<tr>
<td>Improvement</td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td></td>
</tr>
<tr>
<td>Reputation</td>
<td></td>
</tr>
</tbody>
</table>

### Do Penalties Improve Care?

**Original Investigation: Innovations in Health Care Delivery**

Association Between Hospital Penalty Status Under the Hospital Readmission Reduction Program and Readmission Rates for Target and Nontarget Conditions

Noa B. Rose, MD, MPH, Jose L. Ao, MD, MSc, T. Tony Tran, MD, MPH, and T. Tony Tran, MD, MPH

*Journal of Hospital Medicine*

Overall, readmission rates have dropped by approx. 1% without increase in LOS or mortality.
Commercial Payers Following CMS Lead

70% payers

CDI Program Advancement

- Health system leadership team awareness
  - Claims-based outcomes linked to payment and reputation
  - CDI impact on outcome performance beyond MS-DRGs

1. Advancing CDI expertise
   - Expand CDI beyond MS-DRGs
   - Develop quality measure expertise
   - Broaden risk adjustment knowledge
   - Other key areas: CPT, utilization

2. CDI program engagement
   - Aligned focus with organizational priorities
   - Advance physician advisor role
   - Data-driven, collaborative approach to identify and address opportunities

Value: Clinical Documentation Integrity

- Reimbursement and reputation is impacted by value-based outcome performance and population risk
- Documentation across the continuum drives high-quality cost-effective care

1 1

2 2

3 3

15

16

17

18
Clinical Documentation Integrity

• Improve the clinical reliability and integrity of healthcare data, thereby appropriately defining the patient population under treatment across the continuum
• Outcomes
  – Financial accuracy with cost justification
  – Congruent quality performance scores reflective of care delivery
  – Improved population analytics by precisely identifying patient complexity
  – Improve care delivery

Reality of Care Delivery: The Clinical Divide in Documentation

Provider view  CMS view

Consequences of Documentation Gaps

• Loss of revenue
• Increased denials with repayment penalties
• Increased penalties (loss of incentives) in performance models
• Poor reputation
• Consumer market changes
• Workforce cutbacks
• Worsened patient care due to loss of resources
Targeting Physician Engagement

- **Meaningful**
  - Accountability, transparency, knowledge, care delivery

- **Efficacy**
  - Can I really do this? Workflow with ease!

- **Autonomy**
  - Empower sense of ownership and control

- **Collaboration**
  - Provide resource for knowledge: MD should not be the coding expert

- **Positive relationship**
  - Team with common goal: Creditable high-quality care

- **Mastery**
  - Demonstrate success!!

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Beyond a “Champion”: CDI Physician Advisor

- Negotiates a successful long-term relationship between the CDI team and providers
- Enhances physicians’ clinical understanding and provides expert opinion regarding clinical validity assessments and query development for the CDI team
- Specialty-specific “line of service” leaders will impact quality outcomes and ICD-10-CM/PCS unique to their specialty

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Who Is the Best Physician Advisor?

- **Interest**
  - Broad clinical knowledge base
  - Respect from medical staff or “clout”
  - Ability to effectively communicate with physicians and non-physicians

- **Availability**
  - Clinically practicing in setting where role impacts
Hard Work Pays Off: Physician Advisor Training

- Amass the fundamentals through comprehensive study:
  - Inpatient prospective payment system
  - Quality including cohort/risk adjustment
  - Utilization management
  - Ambulatory (E/M, HCCs in MIPS and ACOs, etc.)
  - Postacute care
  - Fundamentals of physician advisor role
  - Mentoring

- Ongoing maturation with advancing leadership role

Success Hinges on Role of CDI Physician Advisor

- With comprehensive training, long-term influence on:
  - MS-DRG validation
  - Cohort and risk adjustment for mortality, readmission, complication, MSPB measures, and modified PSI-90
  - APR-DRG risk of mortality and severity of illness
  - DRG and code adjustments by outside reviewers
  - Utilization management across the continuum
  - ICD-10 clinical validation and medical staff education
  - Ambulatory setting with HCCs and CPT

From Soup to Nuts: Bringing Your Physician Advisor Program to Life

- Physician advisor training (three days, in-person, local)
  - Physician-led
  - Delivered from a clinical perspective in relation to common disease processes
  - Hands-on workgroup with direct application of fundamentals
    - DRG Expert
    - Codebook
    - 3M basics
    - AHA Coding Clinic
    - Actionable resources to use daily
      - CC/MCC/HCC
      - Quality impact
    - Mentoring
      - Reinforcing education through direct chart reviews
      - Coaching to develop effective negotiation skills
From Soup to Nuts: Bringing Your Physician Advisor Program to Life

- Physician advisor training
  - CDI and coding managers
  - Clinical documentation specialists
  - Long-term feedback and support
  - Medical staff office and CMOs
  - Physician advisor colleagues
  - AHIMA resources
  - ACDIS resources

From Soup to Nuts: Bringing Your Physician Advisor Program to Life

- Training complete, now what?
  - Inbox is open!
    - Unanswered query
      - What's the problem?
        - MDs are unaware of coding guidelines
          - Examples:
            - Path report authentication
            - POA
            - Nonspecific/poorly codeable documentation
          - CDIs/coders
            - Query content and effective process (electronic)
            - DRG or quality impact?

From Soup to Nuts: Bringing Your Physician Advisor Program to Life

- Conversations with physicians
  - Maintain clinical practice
    - In the trenches
      - Non-CDI discussions (e.g., care of the patient)
  - Broaden understanding of CDI impact
    - DRG and CMI
      - Quality and risk adjustment (e.g., readmissions, mortality, PSI, complications)
      - Advancing CDI into provider practices
  - Face-to-face is best
    - Hospital units, lounge, or their office
    - Service line meetings...get the leaders on board
  - Phone call
    - Interruptions
      - Text
      - HIPAA compliant?
    - Email
      - Unread
Bridging the Gap: Clinical Terminology

76-year-old male smoker, HTN, HLD awakens with HA, difficulty speaking, and right-sided weakness. Head CT neg. ASA begun. MRI revealed acute left MCA region ischemic stroke with mild edema and mass effect. Dysphagia noted on day 3 with an aspiration event associated with transient SOB and tachypnea. Treated with supplemental O2 and nebs. Discharged to SNF on Day 6.

Documentation defines severity and risk through accurate code assignment.

Example of Stroke Documentation

<table>
<thead>
<tr>
<th>Physician #1</th>
<th>Physician #2</th>
<th>Physician #3</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><strong>Identical diagnoses in discharge summary</strong></em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ischemic stroke due to suspected left MCA thrombosis, HTN—essential HLD</td>
<td>Ischemic stroke due to suspected left MCA thrombosis, HTN—essential HLD</td>
<td>Ischemic stroke due to suspected left MCA thrombosis, HTN—essential HLD</td>
</tr>
<tr>
<td><em><strong>Other diagnoses documented in DC summary</strong></em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td>Headache</td>
<td>Cerebral edema/biopsia compression</td>
</tr>
<tr>
<td>Dyspnea</td>
<td>SOB</td>
<td>Acute resp. failure</td>
</tr>
<tr>
<td>Weakness</td>
<td>Right hemiplegia</td>
<td>Right hemiplegia</td>
</tr>
<tr>
<td>Relative weight</td>
<td>0.7510</td>
<td>1.0946</td>
</tr>
<tr>
<td>Length of stay</td>
<td>2.3 days</td>
<td>3.6 days</td>
</tr>
<tr>
<td>Risk of mortality</td>
<td>1 (minor)</td>
<td>2 (moderate)</td>
</tr>
<tr>
<td>Severity of Illness</td>
<td>1 (minor)</td>
<td>2 (moderate)</td>
</tr>
</tbody>
</table>

Targeted Approach Yields Demonstrable Benefits

<table>
<thead>
<tr>
<th>Physician Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agree Rate</strong></td>
</tr>
<tr>
<td><strong>Response Rate</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>82%</td>
<td>84%</td>
<td>86%</td>
<td>88%</td>
<td>90%</td>
</tr>
</tbody>
</table>
Physician-Specific Data Enhances Participation

Gain Support Through Awareness

Chief of Staff: Ongoing Professional Practice Evaluation
### Documentation Opportunities

![Image](image-url)

### Specialty Focused: Nephrology

<table>
<thead>
<tr>
<th>Nonspecific Documentation Terms</th>
<th>Specific Documentation &quot;Codeable&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altered mental status (AMS)</td>
<td>Encephalopathy, acute delirium (4)</td>
</tr>
<tr>
<td>Renal insufficiency (acute or chronic), azotemia, uremia, renal failure unspecified</td>
<td>AKI, acute renal failure, ATN, CKD (stage I-V), uremia, renal failure</td>
</tr>
<tr>
<td>Dyspnea, tachypnea, SDB</td>
<td>Acute resp failure, acute pulmonary edema, chronic resp failure</td>
</tr>
<tr>
<td>Wound, erythematous skin</td>
<td>Pressure ulcer (stage I-V), arterial ulcer, acute osteomyelitis, cellulitis left ankle</td>
</tr>
<tr>
<td>Infiltrate</td>
<td>Pneumonia, likely aspiration</td>
</tr>
<tr>
<td>Failure to thrive</td>
<td>Severe malnutrition</td>
</tr>
<tr>
<td>Urine (not codable term)</td>
<td>Sepsis, septic shock, sepsis due to UTI and/or early sepsis</td>
</tr>
<tr>
<td>Bacteremia</td>
<td>Sepsis, septic shock (if indicators are met)</td>
</tr>
<tr>
<td>Volume overload</td>
<td>Acute diastolic heart failure, acute pulmonary edema</td>
</tr>
<tr>
<td>Severe debility</td>
<td>Functional quadriplegia (bedridden)</td>
</tr>
</tbody>
</table>

### Mortality—Risk Adjustment

- APR-DRG risk of mortality (ROM)
  - Predicts **in-hospital** risk based on severity of **acute illness**
  - Scale
    - Minor = 1 ... Why haven’t you discharged already?
    - Moderate = 2
    - Major = 3
    - Extreme = 4 ... Hospice appropriate?
Mortality Review: Beyond Documentation Impact

- HMS is attending or consulting
- Packet or email (if can obtain license) to every HMS MD who entered a bill
- Request mandatory response but < 10 min anticipated
- Chart review not required

Email

- Review email impressions from MDs
- Uncover system issues, identify safety concerns, improve patient care
- Risk adjustment with additional documentation/coding opportunities

Hospitalist Committee

- Review email impressions from MDs
- Uncover system issues, identify safety concerns, improve patient care
- Risk adjustment with additional documentation/coding opportunities

Mortality Review Committee (Peer-Protected and Confidential)

- Committee recommendations
  - Improve documentation, which better captures expected mortality
    - Shock, severe malnutrition, history of PTCA/CABG, visual loss, OA
    - Bottom line: Thorough and comprehensive
  - Early goals of care discussion
    - Lower threshold for palliative medicine consultation
    - Improve comfort level of HMS MDs discussing palliative care consultation with patients/families
    - Scripting statements
  - Monthly two-hour mortality review committee meetings
  - Surveys responses essential; activity hour eligible
  - Committee members to review prior to meetings

Outcome Data Drives Performance Improvement

Lowering Overall Mortality Rates

- Actual
- Expected

2008: 2.8%
2009: 2.5%
2010: 1.8%
2011: 1.3%
2012: 1.5%
2013: 1.3%
2014: 1.3%
2015: 1.8%
2016: 1.4%
Patient Safety Indicators: Understanding Methodology

- Comparison analytics
  - “Postop”—significance?
    - Ileus
    - Hematoma
    - Resp failure
    - AFib
    - HTN
    - AKI
- PSI 15: Accidental puncture and laceration
PSI Reviews: Track Success!

From Soup to Nuts: Bringing Your Physician Advisor Program to Life

MD receptivity to CDI
- Quality reflected by documentation
- Risk adjustment
  - Readmissions
  - Mortality
  - Length of stay
- In their contract!
  - Answer rate > 90%
  - Unable to determine < 10%

RNs can stage but not allowed to diagnose. Need MD to provide diagnosis, location, and POA status.
Clinical Indicator Committee

Purpose: Establish expert, local opinion for contentious and highly scrutinized diagnoses — sepsis, respiratory failure, MI, encephalopathy, etc.

Goals: Develop clinical indicators for specified diagnoses incorporating evidence-based medicine and coding guidelines.

Why: Improve the quality of documentation and coding, which affects patient care, readmissions, mortality, PSI, RACs, denial management, and facility reimbursement.

Who: OLOL medical staff, CDI, coders, quality, denials, nursing, etc.

When: Monthly meeting with multidisciplinary attendance depending on topic discussed.

How: Facilitywide education communicated via individual departments and service lines.

Physician Advisor Impact: Case-Mix Index

1.637 1.662 1.712
FY 2014 FY 2015 FY 2016
Key Takeaways

- Pay-for-performance demands evolution within clinical documentation integrity programs
- Physician engagement is critical to the success of CDI across the continuum
- Active/well-trained CDI physician advisors unite the CDI team through evidence-based clinical insight
- The value of an effective CDI physician advisor is immeasurable
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 at the front of the program guide.