Let’s Get Real: Does CDI Improve Patient Care?

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Learning Objectives

• At the completion of this educational activity, the learner will be able to:
  – Describe the impact that the evolution of CDI has on patient care
  – List and share examples where CDI helps to achieve the Triple Aim of healthcare reform
  – Define a potential future role of CDI as patient care coordinators
Steps for Attendees to Answer/View Polling Questions

1. Navigate to the event *Agenda* in the main menu
2. Tap the **name of the current session** to view the session details page
3. Tap **Polls**
4. Tap the **name of the poll**
5. Tap your **answer** choice and then tap **Submit**
Polling Question 1

• Have you been asked by providers, “Does CDI improve my patient’s health and how I deliver care?”
  – Yes, by providers interested in relating the importance of documentation to care delivery
  – Yes, by providers frustrated by queries
  – No
  – I don’t know
Historical View of CDI: Physician’s Perspective

- Hospital “bean” counters
- Documentation police
- “Pink” sheets ... what?
- Constantly changing the rules
- “What do you mean it’s not sepsis?”
- Wait ... physician performance ...
- Colleague
Can you further specify congestive heart failure with EF of 30% as:

1. Acute systolic HF
2. Acute-on-chronic systolic HF
3. Chronic systolic HF
4. Other ________
5. Unable to determine
Traditional CDI Focus

- **Inpatient**
  - MS-DRG
    - Principal diagnosis
    - Principal procedure
    - CC/MCC capture
  - APR-DRG
    - Severity of illness
    - Risk of mortality
  - Medicare predominance
  - Education (medical staff/physician advisors)
  - Limited-focus quality reviews (mortality, PSIs, HACs, etc.)
CMS Shift to Value-Based Care

- Move away from payment for volume
- Improve care coordination
- Promote alignment of financial and other incentives to increase the quality of care and lead to better outcomes

Goals: increase % of Medicare provider payments linked to quality outcomes and Alternate Payment Models
- Quality: 2016 85% → 2018 90%
- APMs: 2016 30% → 2018 50%

HHS Secretary Burwell
Posting January 2015
## Pay-for-Performance Creates Disruptive Change

### Category 1
**Fee-For-Service: No Link to Quality & Value**
- **A** Foundational Payments for Infrastructure & Operations
  - Traditional FFS
  - DRGs not linked to quality
- **B** Pay for Reporting
- **C** Rewards for Performance
- **D** Rewards & Penalties for Performance
  - Hospital P4P
    - HVBIP
    - HACRP
    - HRRP

### Category 2
**Fee-For-Service: Link to Quality & Value**
- **A** APMs with Upside Gainsharing
  - DRGs with rewards for quality performance
  - DRGs with rewards & penalties for quality performance
  - FFS with rewards for quality performance
- **B** APMs with Upside Gainsharing/Downside Risk
  - Episode-based payments for procedure-based clinical episodes with shared savings only
  - Primary Care PCMHs with shared savings only
  - Oncology COEs with shared savings only
  - EPMs
    - GHR
    - SHFT
    - AMI
    - CABG

### Category 3
**APMs Built on Fee-For-Service Architecture**
- **A** APMs with Upside Gainsharing
- **B** APMs with Upside Gainsharing/Downside Risk

### Category 4
**Population-Based Payment**
- **A** Condition-Specific Population-Based Payment
- **B** Comprehensive Population-Based Payment
  - Population-based payments for specialty, condition, and facility-specific care (e.g., via an ACO, PCMH, or COE)
  - Partial population-based payments for primary care
  - Episode-based, population payments for clinical conditions, such as diabetes
  - Integrated, comprehensive payment & delivery system
  - Full or percent of premium population-based payment (e.g., via an ACO, PCMH, or COE)
  - Population-based payments for comprehensive pediatric or geriatric care

Source: Recreated from Alternative Payment Model Framework, HCP/LAN, 2016

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### Quality Payment Program

#### Timeline on payment adjustments

<table>
<thead>
<tr>
<th>Year</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
<th>2025</th>
<th>2026 on</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee Schedule Updates</td>
<td>0.5% annual baseline updates</td>
<td>No annual baseline updates</td>
<td>0.25% or 0.75%</td>
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<tr>
<td>MIPS</td>
<td>Max Adjustment (additional bonuses possible)</td>
<td>4%</td>
<td>5%</td>
<td>7%</td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
<td>5% bonus</td>
<td></td>
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<tr>
<td>QPs in Adv.</td>
<td></td>
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Adapted from QPP, CMS.gov
Not “Just a Hospital Problem” Any Longer!

Pay for Performance

Reputation and Reimbursement

Star Ratings

HRRP

HACRP

HVBP

Quality Payment Program

Cost

Quality

Advancing Care Information

Improvement Activity

Episode Payment Module

Advanced APM

Population

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Collaboration and Expansion of CDI

- Payer
- Specialty focused
- Quality
- Utilization and status
- Professional charge capture
- Outpatient services
- Risk adjustment
- **PATIENT CARE?!?!**
National Quality Strategy: Triple Aim

- Optimize health outcomes by improving quality and transforming the healthcare system

<table>
<thead>
<tr>
<th>Three Aims</th>
<th>Six Priorities</th>
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</thead>
<tbody>
<tr>
<td>1. <strong>Better Care</strong>: Improve the overall quality of care by making healthcare more person-centered, reliable, accessible, and safe.</td>
<td>1. Make Care Safer by Reducing Harm Caused in the Delivery of Care</td>
</tr>
<tr>
<td>2. <strong>Healthier People, Healthier Communities</strong>: Improve the health of Americans by supporting proven interventions to address behavioral, social, and environmental determinants of health, and deliver higher-quality care.</td>
<td>2. Strengthen Person and Family Engagement as Partners in Their Care</td>
</tr>
<tr>
<td>3. <strong>Smarter Spending</strong>: Reduce the cost of quality healthcare for individuals, families, employers, government, and communities.</td>
<td>3. Promote Effective Communication and Coordination of Care</td>
</tr>
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<td></td>
<td>4. Promote Effective Prevention and Treatment of Chronic Disease</td>
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<td></td>
<td>5. Work with Communities to Promote Best Practices of Healthy Living</td>
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<tr>
<td></td>
<td>6. Make Care Affordable</td>
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Closing Care Gaps Through Meaningful Measures


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Optimal Care Is Driven by Appropriate Diagnosis Recognition
Accuracy of Data Defines Populations at Risk

Chronic Condition Prevalence

Diabetes Prevalence: State to National Ratio

Diabetes Co-Morbidity

Produced by the CMS/Office of Enterprise Data & Analytics (OEDA), January 2017

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Accuracy of Data Identifies Resource-Intensive Populations
Accuracy of Data Allows Appropriate Resource Allocation
So ... Does CDI Improve Patient Care?

**Local**
- Diagnosis specificity
- Assists providers in translating care
- Appropriateness of care
- Change in approach may lead to recognition of potentially missed conditions
- Reduction in clinical variation/cost
- High-risk populations defined
- Clinical process refinement/collaboration
- Adverse outcome reduction

**State/Region/Nation**
- High-risk populations identified
- Disease associations
- Clinically preventative strategies
- Improved outcomes/patient health
- Cost-saving interventions
- Customized care to improve satisfaction
- Streamline resources for areas of most need
- Improve effectiveness of care delivery
Physician Documentation Is a First Step to Better Care Within Any Population
Stories From You
Polling Question 2

• Do you have a story where a CDI initiative spawned a change in care delivery?
  – Yes
  – No
  – Not sure
Better Care: DVT/PE Story

- Harborview Medical Center, WA
- Postoperative DVT / PE – PSI 12
  - Quality of care and patient safety
  - CMS performance
  - Multidisciplinary collaboration
    - Executive and medical leadership
    - Physicians
    - CDI and coding
    - Pharmacy

- Documentation reflects actual event, including POA
- Diagnosis accuracy led to specific improvements in care design and delivery
  - Anticoagulation prophylaxis education and standardized use
    - Missed patients
    - Dosing schedule
    - Perioperative management
  - Sequential Compression Device compliance

**Results:**
- 21% decrease in PSI 12 events over 3 years
- 15% decrease in hospital-acquired DVT/PE over 3 years

Source: Toolkit for Using AHRQ Quality Indicators,
Better Care: Mortality Story

- Our Lady of the Lake Regional Medical Center, LA
- Targeted mortality reviews
  - Quality of care and patient safety
  - CMS performance
  - Multidisciplinary collaboration
    - Executive and medical leadership
    - Physicians
    - CDI and coding
- Documentation and coding review to establish SOI and ROM
- Hospitalist committee to identify clinical variation from standard of care, safety concerns for greater population, improve care
- Mortality peer review committee formed
- **Outcomes:**
  - *Improved documentation of risk and clinical manifestations*
  - *Identifiers to alert Rapid Response Teams in high-risk populations*
  - *Earlier palliative care team involvement*
  - *50% reduction in overall mortality rates in 7 years*
Better Care/Healthier Patients: Malnutrition Story

- Vidant Health, NC
- Collaborative to improve nutritional care of hospitalized patients
  - 1 in 3 hospitalized with malnutrition
  - Financial, morbidity, mortality, and readmission impact
- Multidisciplinary collaboration
  - Executive and medical leadership
  - Physicians
  - CDI and coding
  - Dietitian
  - Pharmacist
  - Case management
- Aligned dietitian, provider, and HIM/CDI awareness, recognition, documentation, and capture of malnutrition and its severity through a comprehensive curriculum
- Diagnosis accuracy led to specific improvements in care design and delivery
  - Early recognition
  - Consistent evidence-based intervention, including dietary, wound/infection prevention, and transitions of care
- **Outcomes:**
  - Financial accuracy and diagnosis capture
  - Appropriateness of risk associated with complications, mortality, prolonged LOS and its avoidance
    - 13% increase in expected risk of mortality (denominator) in 1 year
    - 9% decrease in Medicare LOS in 1 year
  - Clinical interventions and follow-up to prevent adverse outcomes
Better Care: The Story of Comorbidities

- Diagnosis accuracy depicts the patient story
- Understanding population segments with confounding diagnoses will reduce barriers to individual care utilization and improve health
Healthier Patients: Vascular Disease Screening

- Use NLU to change care management for abdominal aortic aneurysm (AAA) patients
- 4%-9% asymptomatic > 60 years old, increasing with associated comorbidities (age, race, tobacco, PVD, HTN)
  - Multidisciplinary collaboration
    - Executive and medical leadership
    - Physicians
    - CDI and coding
    - IT
    - Vendor/consultants
- Analyzed radiology reports (> 2M) to identify AAA patients and categorize by risk
  - Clinical protocols refined
    - Highest risk: referral to vascular surgery
    - Proactive outreach to PCP
  - Improved data quality to inform care
    - 37% missing dx on Epic problem list; added diagnosis triggers capture and care plan
    - Clinical decision support solutions
  - Health plan HCC opportunity
    - Diagnosis documented, but not reported
    - Resource allocation need
- Outcomes
  - Improved recognition, documentation, reporting, and care management, including utilization
  - Secondary risk reduction in high-risk population
  - Identified critical surgical population that was asymptomatic but required urgent intervention

* Adapted with permission from M*Modal
Healthier Patients: Pulmonary Nodule Story

- Use of NLU to screen and develop clinical care pathways for incidental and known pulmonary nodules
- Exists the need to develop effective strategies for initial evaluation and follow-up for early detection for developing malignancy
  - Multidisciplinary collaboration
    - Executive and medical leadership
    - Physicians
    - CDI and coding
    - IT
    - Vendor/consultants
- Screen patients for incidental and known pulmonary nodule findings
- Clinical pathway trigger for follow-up and diagnostic procedure(s)
  - January 2017:
    - 89 patients with pulmonary nodule $\geq$ 1 cm
      - 56: newly identified based upon radiology reports
      - 5: newly identified advanced disease
- Outcomes:
  - Improved recognition, documentation, reporting, and care management, including utilization
  - Improved clinical care pathways and clinical decision support tools
  - Early recognition of disease states and acute intervention for advanced disease

* Adapted with permission from M*Modal
Smarter Spending: The Story of Resource Utilization

- Population diagnosis accuracy drives predictive analytics
- Develop strategies around resource allocation and preventive measures to reduce cost and improve access and outcomes
Smarter Spending: The Financial Story
Smarter Spending: The Financial Story
Future of CDI: Population Clinical Informatics Team/Specialist (PCIS)

• Drivers for CDI’s future:
  – Improved diagnosis accuracy
  – Population focus
  – Data collection and exchange
  – Advancing NLP technology
  – Expansion of roles based upon defined impact
  – Growth of clinical decision support
  – Predictive analytics
  – Underpinnings for improved care coordination
The Future Is Near

*Population Clinical Informatics Team* is a collaborative to improve patient health by accurately translating clinical care for the continued advancement of evidence-based care coordination, effective and appropriate targeted resource utilization, and population outcomes, one patient at a time.

*To be continued ...*
Thank you. Questions?

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