Elevating CDI Performance

Presentation for HFMA

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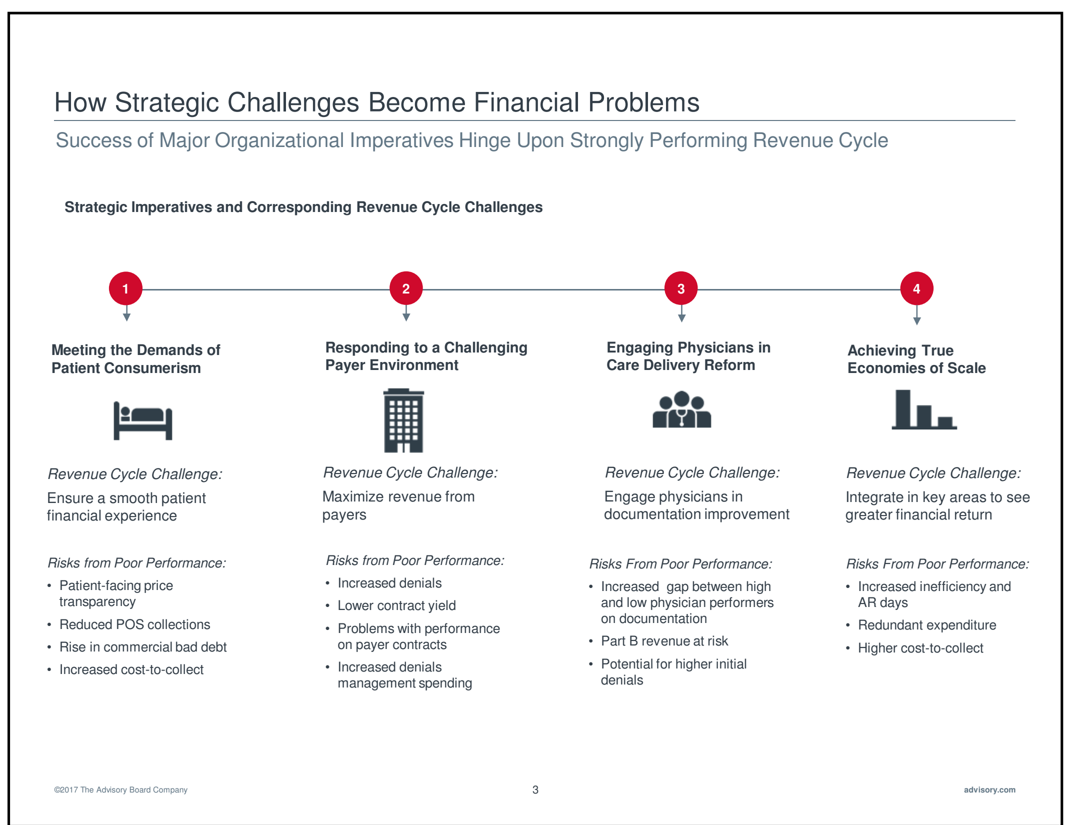
How Strategic Challenges Become Financial Problems
Success of Major Organizational Imperatives Hinge Upon Strongly Performing Revenue Cycle
Strategic Imperatives and Corresponding Revenue Cycle Challenges
1
Meeting the Demands of Patient Consumerism
Revenue Cycle Challenge:
Ensure a smooth patient financial experience
Risks from Poor Performance:
• Patient-facing price transparency
• Reduced POS collections
• Rise in commercial bad debt
• Increased cost-to-collect
2
Responding to a Challenging Payer Environment
Revenue Cycle Challenge:
Maximize revenue from payers
Risks from Poor Performance:
• Increased denials
• Lower contract yield
• Problems with performance on payer contracts
• Increased denials management spending
3
Engaging Physicians in Care Delivery Reform
Revenue Cycle Challenge:
Engage physicians in documentation improvement
Risks From Poor Performance:
• Increased gap between high and low physician performers on documentation
• Part B revenue at risk
• Potential for higher initial denials
4
Achieving True Economies of Scale
Revenue Cycle Challenge:
Integrate in key areas to see greater financial return
Risks From Poor Performance:
• Increased inefficiency and AR days
• Redundant expenditure
• Higher cost-to-collect
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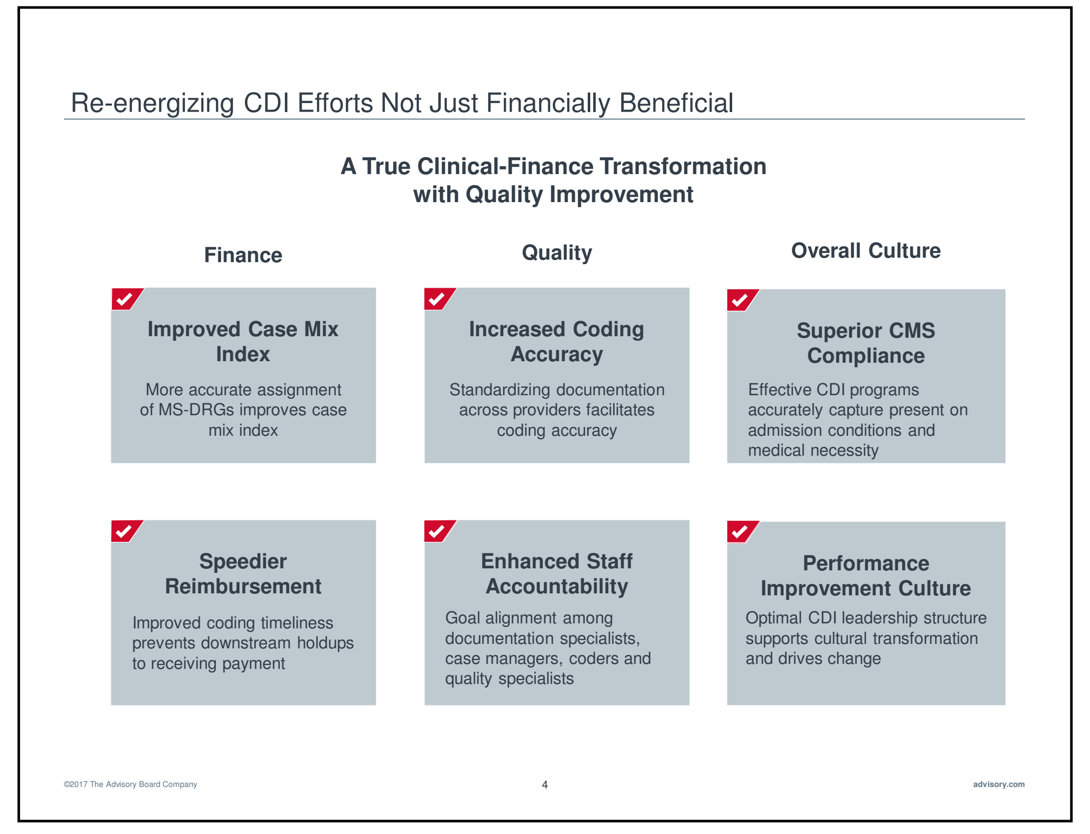
Re-energizing CDI Efforts Not Just Financially Beneficial
A True Clinical-Finance Transformation with Quality Improvement
Finance
Quality
Overall Culture
Improved Case Mix Index
More accurate assignment of MS-DRGs improves case mix index
Increased Coding Accuracy
Standardizing documentation across providers facilitates coding accuracy
Superior CMS Compliance
Effective CDI programs accurately capture present on admission conditions and medical necessity
Speedier Reimbursement
Improved coding timeliness prevents downstream holdups to receiving payment
Enhanced Staff Accountability
Goal alignment among documentation specialists, case managers, coders and quality specialists
Performance Improvement Culture
Optimal CDI leadership structure supports cultural transformation and drives change
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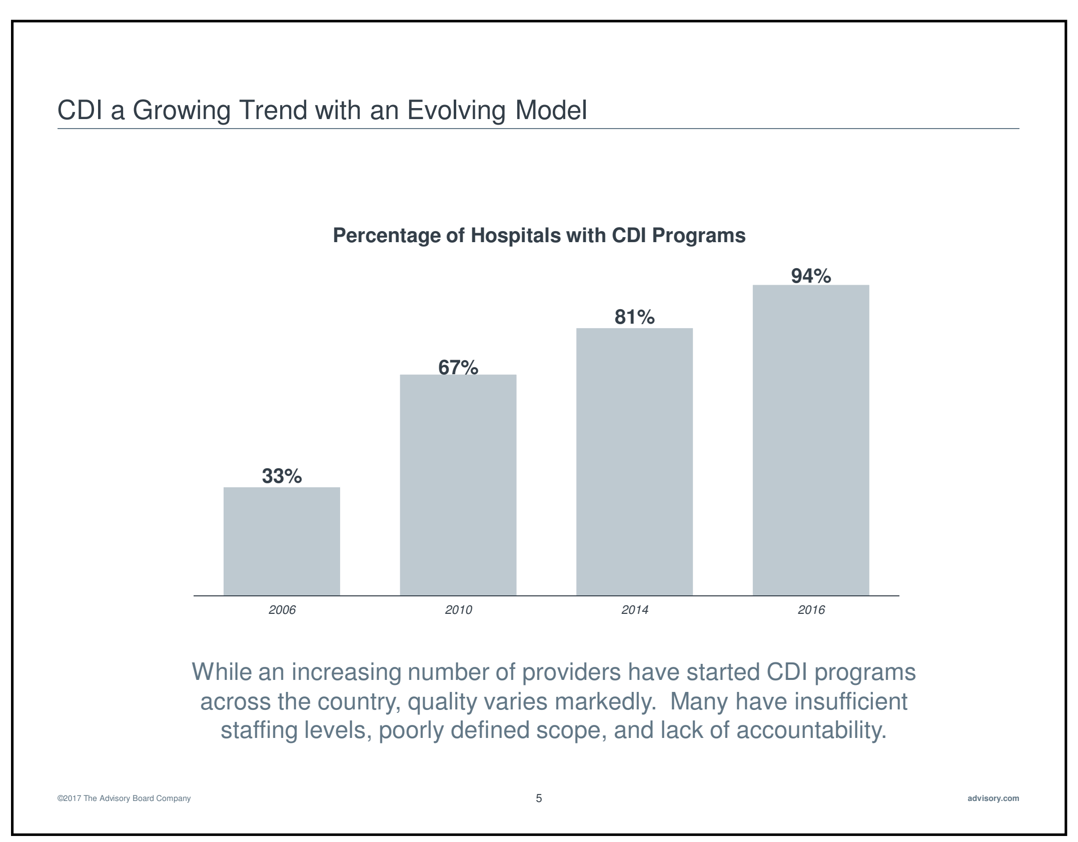
CDI a Growing Trend with an Evolving Model
Percentage of Hospitals with CDI Programs
33%
67%
81%
94%
2006
2010
2014
2016
While an increasing number of providers have started CDI programs across the country, quality varies markedly. Many have insufficient staffing levels, poorly defined scope, and lack of accountability.
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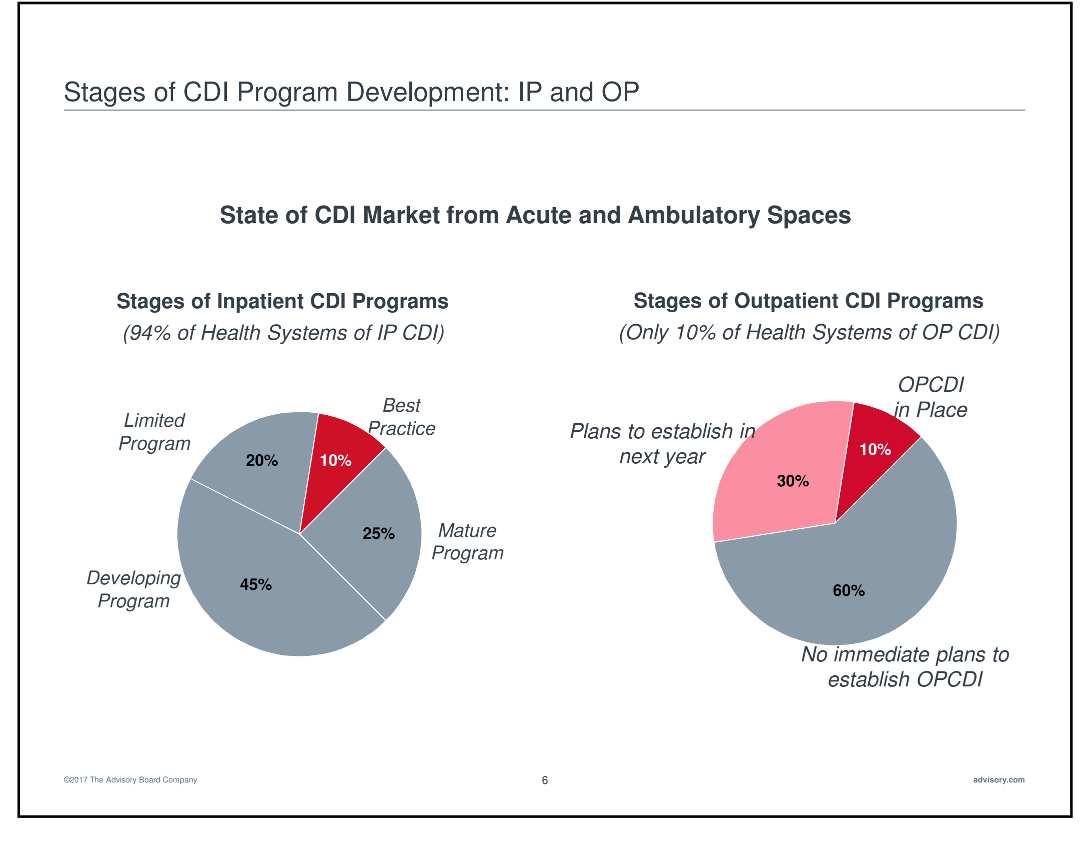
Stages of CDI Program Development: IP and OP
State of CDI Market from Acute and Ambulatory Spaces
Stages of Inpatient CDI Programs
(94% of Health Systems of IP CDI)
Limited Program
20%
Best Practice
10%
Mature Program
25%
Developing Program
45%
Stages of Outpatient CDI Programs
(Only 10% of Health Systems of OP CDI)
OPCDI in Place
10%
Plans to establish in next year
30%
No immediate plans to establish OPCDI
60%
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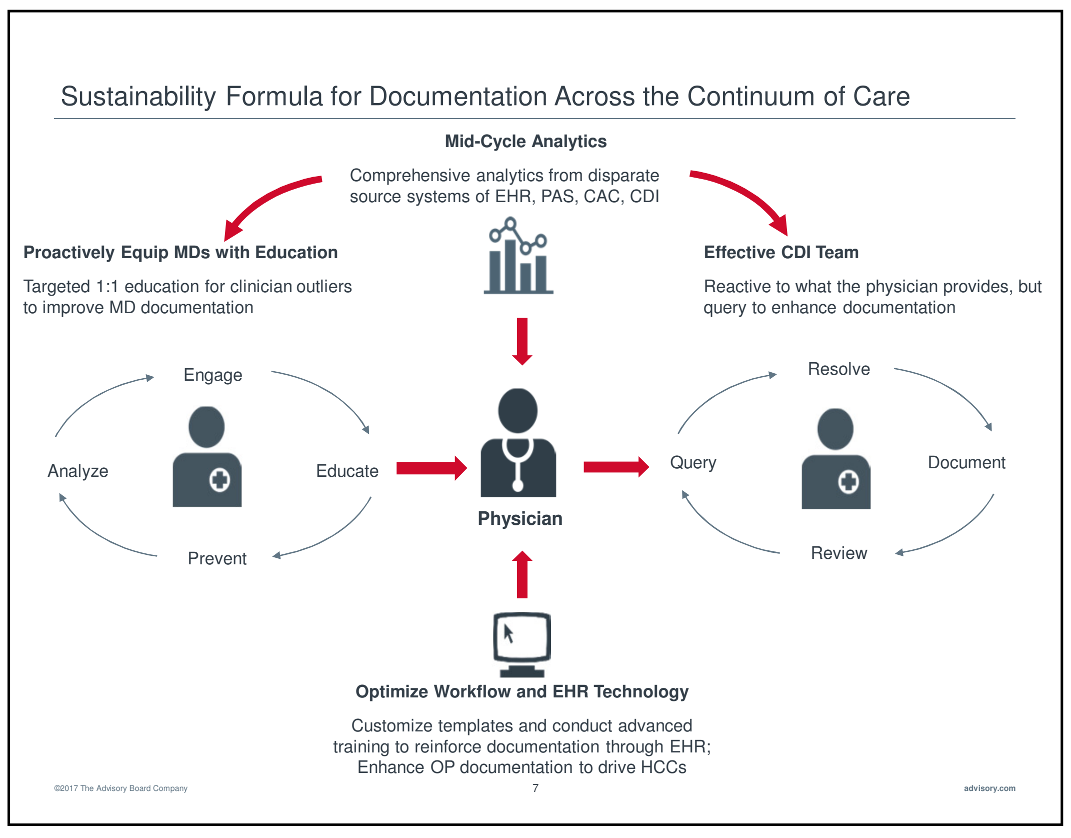
Sustainability Formula for Documentation Across the Continuum of Care
Mid-Cycle Analytics
Comprehensive analytics from disparate source systems of EHR, PAS, CAC, CDI
Proactively Equip MDs with Education
Targeted 1:1 education for clinician outliers to improve MD documentation
Effective CDI Team
Reactive to what the physician provides, but query to enhance documentation
Engage
Educate
Prevent
Analyze
Physician
Resolve
Document
Review
Query
Optimize Workflow and EHR Technology
Customize templates and conduct advanced training to reinforce documentation through EHR; Enhance OP documentation to drive HCCs
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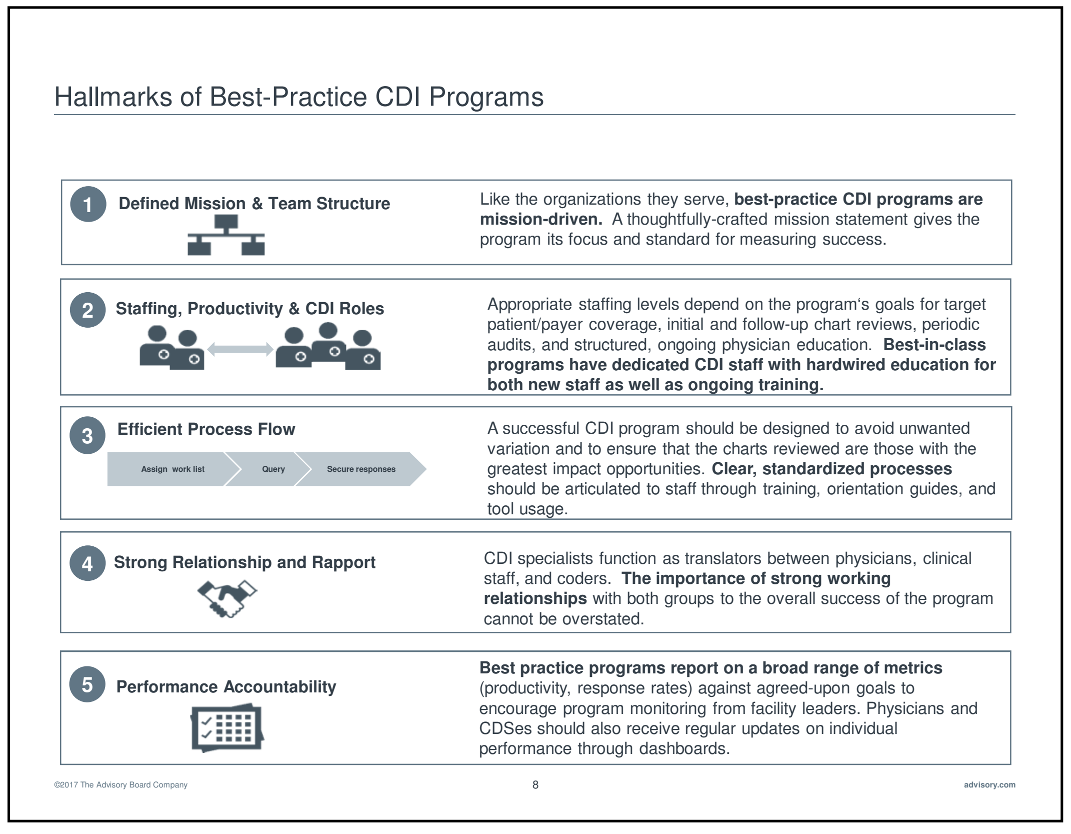
Hallmarks of Best-Practice CDI Programs
1 Defined Mission & Team Structure
Like the organizations they serve, best-practice CDI programs are mission-driven. A thoughtfully-crafted mission statement gives the program its focus and standard for measuring success.
2 Staffing, Productivity & CDI Roles
Appropriate staffing levels depend on the program's goals for target patient/payer coverage, initial and follow-up chart reviews, periodic audits, and structured, ongoing physician education. Best-in-class programs have dedicated CDI staff with hardwired education for both new staff as well as ongoing training.
3 Efficient Process Flow
Assign work list
Query
Secure responses
A successful CDI program should be designed to avoid unwanted variation and to ensure that the charts reviewed are those with the greatest impact opportunities. Clear, standardized processes should be articulated to staff through training, orientation guides, and tool usage.
4 Strong Relationship and Rapport
CDI specialists function as translators between physicians, clinical staff, and coders. The importance of strong working relationships with both groups to the overall success of the program cannot be overstated.
5 Performance Accountability
Best practice programs report on a broad range of metrics (productivity, response rates) against agreed-upon goals to encourage program monitoring from facility leaders. Physicians and CDSes should also receive regular updates on individual performance through dashboards.
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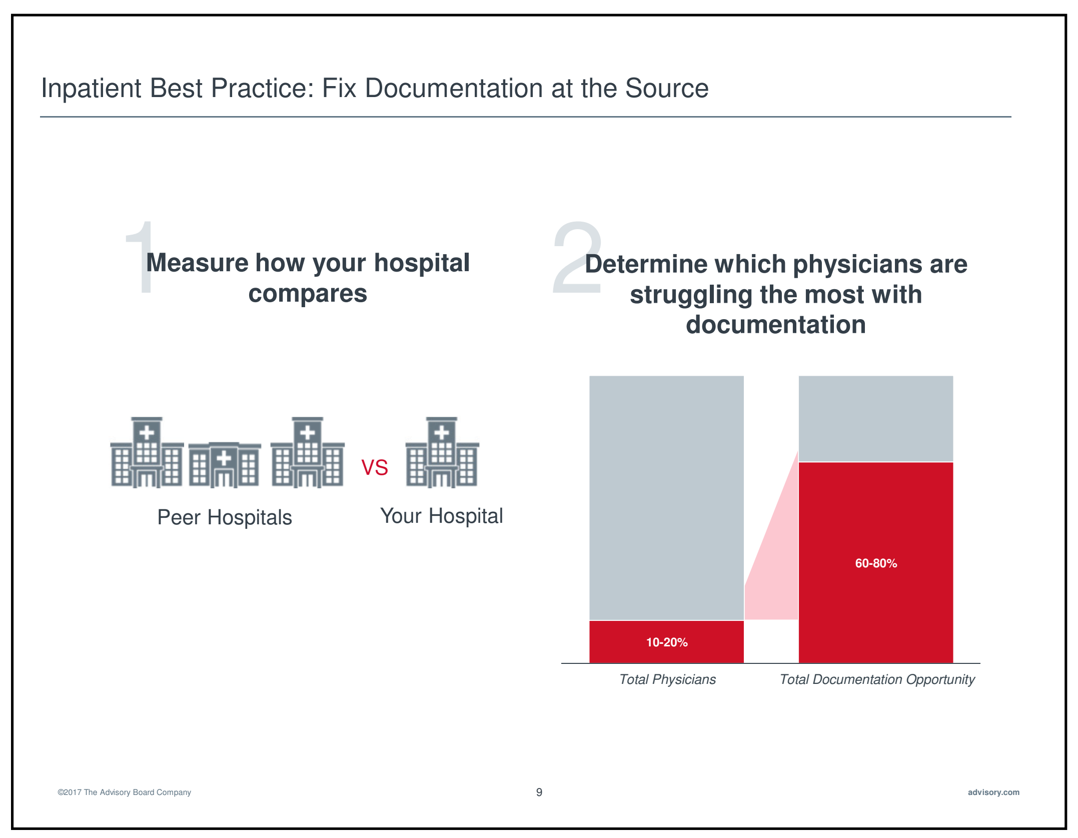
Inpatient Best Practice: Fix Documentation at the Source
1
Measure how your hospital compares
VS
Peer Hospitals
Your Hospital
2
Determine which physicians are struggling the most with documentation
10-20%
60-80%
Total Physicians
Total Documentation Opportunity
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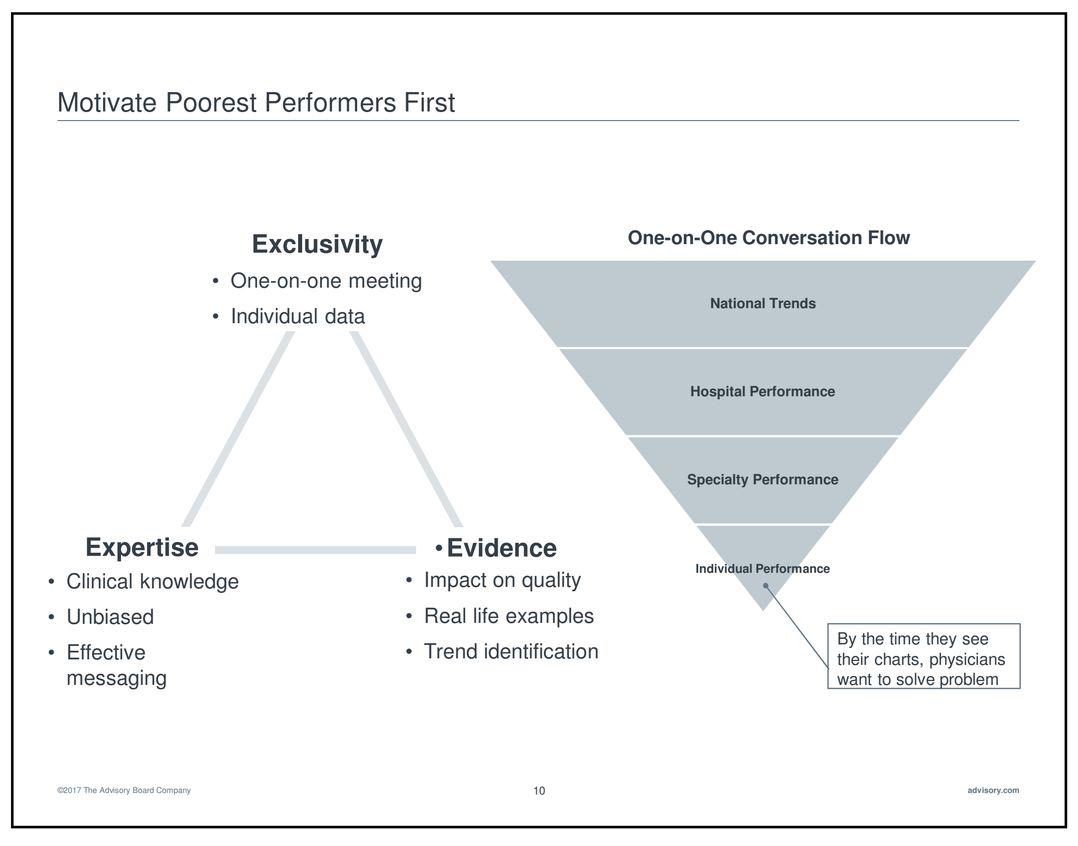
Motivate Poorest Performers First
Exclusivity
• One-on-one meeting
• Individual data
Expertise
• Clinical knowledge
• Unbiased
• Effective messaging
•Evidence
• Impact on quality
• Real life examples
• Trend identification
One-on-One Conversation Flow
National Trends
Hospital Performance
Specialty Performance
Individual Performance
By the time they see their charts, physicians want to solve problem
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Key Differences of Inpatient and Outpatient CDI

Inpatient

- Decreasing volume
- Fewer variables
- Financial focus on DRG and CMI
- Pay for performance
- Less provider interaction
- Multiple employment/ contractual agreements with providers
- Single setting
- Less focus on changes
- Efforts always concurrent

Outpatient

- Increasing volume
- Constant change
- Financial focus on HCCs
- Quality focus on PQRS
- More provider interaction
- Less opportunities to influence provider behavior
- Charge description master (CDM)
- Disparate settings
- Efforts both concurrent and retrospective

Added Complexity

Professional

- Hospital-owned
- Private Practice

Facility

- Ambulatory Surgery
- Emergency Department
- Diagnostics
- Clinics
- Skilled Nursing, Long Term Care and Rehab

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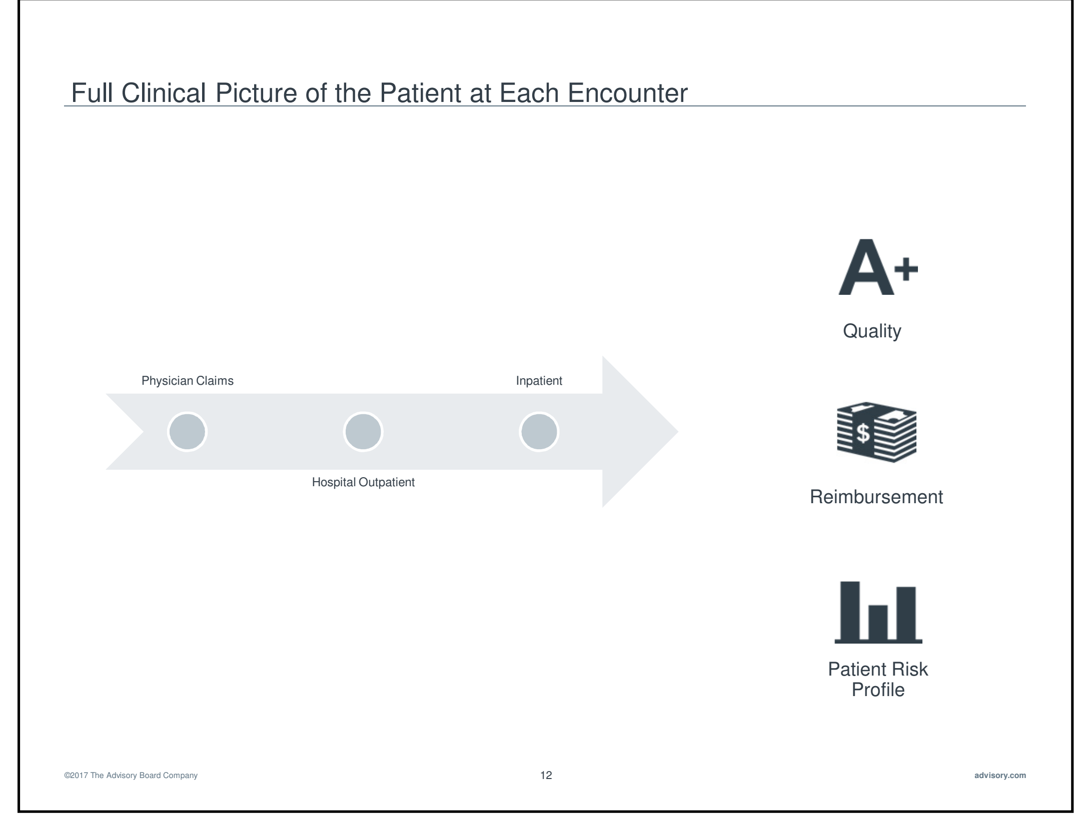

Multiple Areas of Potential Focus for CDI Reviews

Potential CDI Program Objectives & Focus Measures

CDI Program Objectives	**Optimize Payments**	**Protect Payments**	**Quality Payments & Quality Profiling[1]**
CDI Program Measures	MS-DRGs APR-DRGs Medicare Annual Wellness Visits	2nd CC/MCC: "RAC-proof" Charts	**HACRP** *(PSI#90) Risk* **HVBP** *Mortality Risk* **HRRP** *Readmission Risk* **HCC** *Hierarchical Condition Categories*

Fee-for-Service → ***Quality-Based Payments***

1. Hospital-Acquired Condition Reduction Program; Hospital Value-Based Purchasing Program (HVBP); Hospital Readmission Reduction Program (HRRP)

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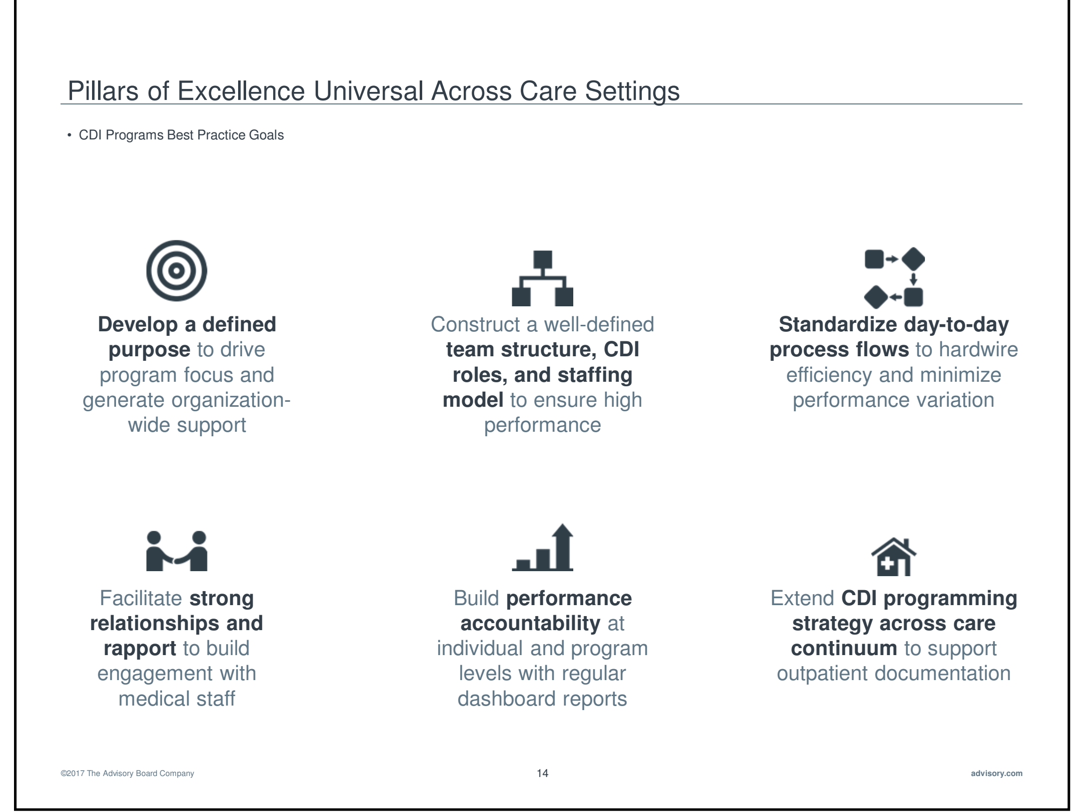

Start with Program Infrastructure

- Align Mission an Goals with Broader Organization Goals

Strategic Factors **Operational Factors**

Establish mission for outpatient CDI should be clear and succinct and mirror organizational goals

Build governance process to enfranchise critical stakeholders in ambulatory arena

Set specific goals for CDI should be step-wise, enfranchise staff, and have clear success measures

Start compliance program to ensure regular audits of documentation accuracy

Communicate effectively to physicians and practice managers on purpose and execution of CDI program

Hardwire ongoing education mechanisms ensure all staff up to speed on goals and expectations

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Tackle Outpatient Documentation Basics First

Incomplete and Insufficient Documentation

- Infusion start and stop times
- Missing clinical conditions
- Lack of specificity
- Failure to document links between various conditions
- Date of service errors
- Failure to capture components required for quality reporting

Incorrect Coding

- Insufficient coder skill and experience
- Limited communication with provider
- Missing clinical conditions
- Inappropriate use of modifiers
- Untimed codes
- CDM errors

Lack of Medical Necessity

- NCD/LCD noncompliance
- High-cost medications
- Exceeding defined service frequencies such as units per day or yearly limitations
- Excessive medication units

Billing Errors

- Failure to capture and submit all service codes
- Unbundling
- Incorrect units
- Differences between order and billed medication units
- Place of service errors
- Authorized service changes

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Standard Clinic Visits Hold Significant Opportunity

- Most common elements in Evaluation & Management (E&M) visit documentation insufficiently documented or missing altogether

1 Chief complaint

Even if the nurse clearly documents this, the physician must re-state this in their documentation or else it is invalid.

2 Review of Systems (ROS)

This MUST be in every chart. If the nurse does not include this, then it is your responsibility as the physician to complete.

3 History of Present Illness (HPI)

Even if the nurse includes the HPI, you must also include this in your own words in the progress note

4 Counseling or Coordination of Care >50% of Visit

In visits where consultation or coordination of care takes >50% of time, time is the driver of E&M, and the precise amount of time spent must be clearly documented.

5 Supporting Ancillary Test Orders

One must document the association between every test and the diagnoses or potential diagnoses.

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Set Clear Documentation Expectations for all Staff

For Physicians…

- ✓ Focus on first on comprehensiveness
- ✓ Facilitate easy and accurate ICD-10 diagnosis code selection
- ✓ Maximize time for Medical Decision-Making and patient Assessment and Plan

For Clinical Staff…

- ✓ Decide which parts of the encounter support staff can own
- ✓ Get physician buy-in for documentation support
- ✓ Maximize opportunities for documentation outside of the patient visit

For Billing Staff…

- ✓ Ensure regular communication routes with the providers
- ✓ Design ongoing education strategy
- ✓ Hardwire standard audits for code and diagnosis selection

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Turn Focus to Existing Revenue Opportunities

- Documentation Improvement Supports Current Fee-for-Service Models

Medicare Annual Wellness Visits

Under the Affordable Care Act, Medicare covers annual wellness visits (AWVs) completely, if the services meet specific criteria for information-gathering, assessment, and counseling

Right now, only 14% of Medicare beneficiaries receive an AWV. For a 100-provider practice, the additional revenue can total as much as $3 million annually

Hierarchical Conditional Codes

Hierarchical Conditional Codes (HCCs) are CMS's methodology for determining capitated payments for the Medicare Advantage program and other Medicare programs

HCC codes allow payments to be risk-adjusted based on patient complexity by using a patient's documented 12-month diagnostic coding history to predict future financial utilization and risk

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Considerations for University of Kentucky

What to think about for OP CDI engagements

1. Do you have a best practice outpatient CDI program established?
2. What is the structure and composition of your physician network?
3. Are your owned physician practices on a unified electronic medical record?
4. Do you have a well-established governance structure for your Ambulatory EMR?
5. Have you negotiated any risk contracts with their network physicians?

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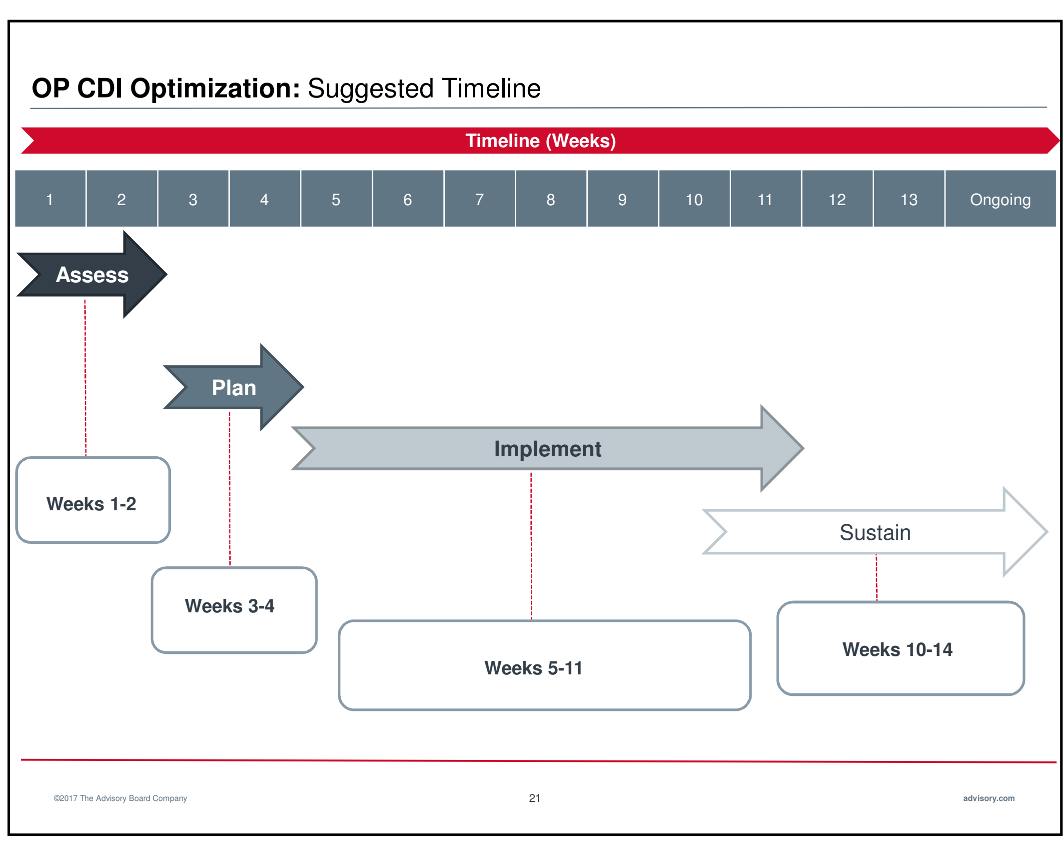
OP CDI Optimization: Suggested Timeline
Timeline (Weeks)
1
2
3
4
5
6
7
8
9
10
11
12
13
Ongoing
Assess
Plan
Implement
Sustain
Weeks 1-2
Weeks 3-4
Weeks 5-11
Weeks 10-14
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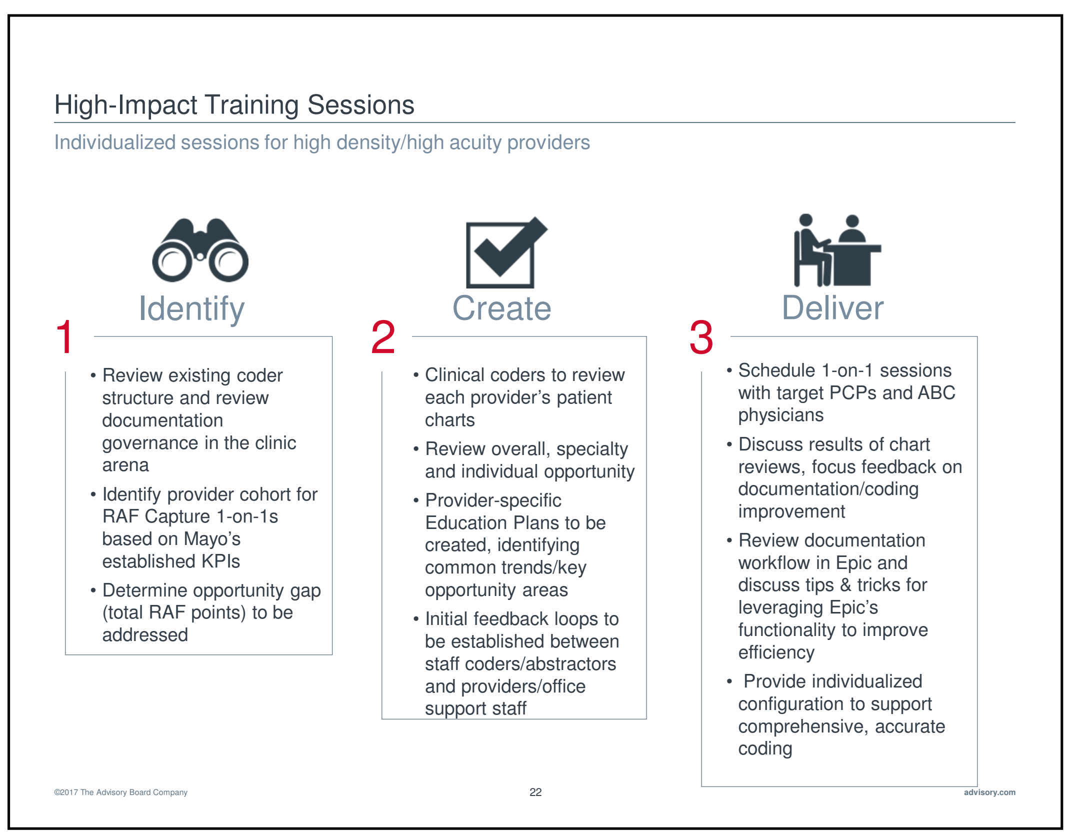
High-Impact Training Sessions
Individualized sessions for high density/high acuity providers
1
Identify
• Review existing coder structure and review documentation governance in the clinic arena
• Identify provider cohort for RAF Capture 1-on-1s based on Mayo's established KPIs
• Determine opportunity gap (total RAF points) to be addressed
2
Create
• Clinical coders to review each provider's patient charts
• Review overall, specialty and individual opportunity
• Provider-specific Education Plans to be created, identifying common trends/key opportunity areas
• Initial feedback loops to be established between staff coders/abstractors and providers/office support staff
3
Deliver
• Schedule 1-on-1 sessions with target PCPs and ABC physicians
• Discuss results of chart reviews, focus feedback on documentation/coding improvement
• Review documentation workflow in Epic and discuss tips & tricks for leveraging Epic's functionality to improve efficiency
• Provide individualized configuration to support comprehensive, accurate coding
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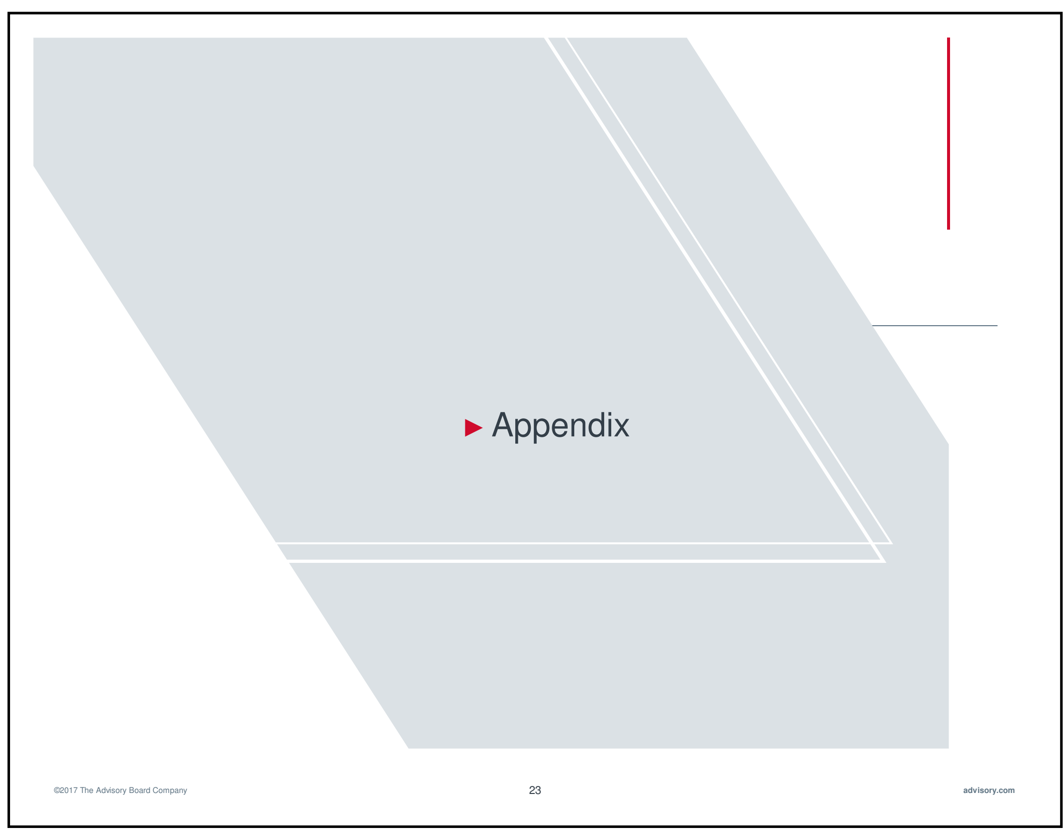
Appendix
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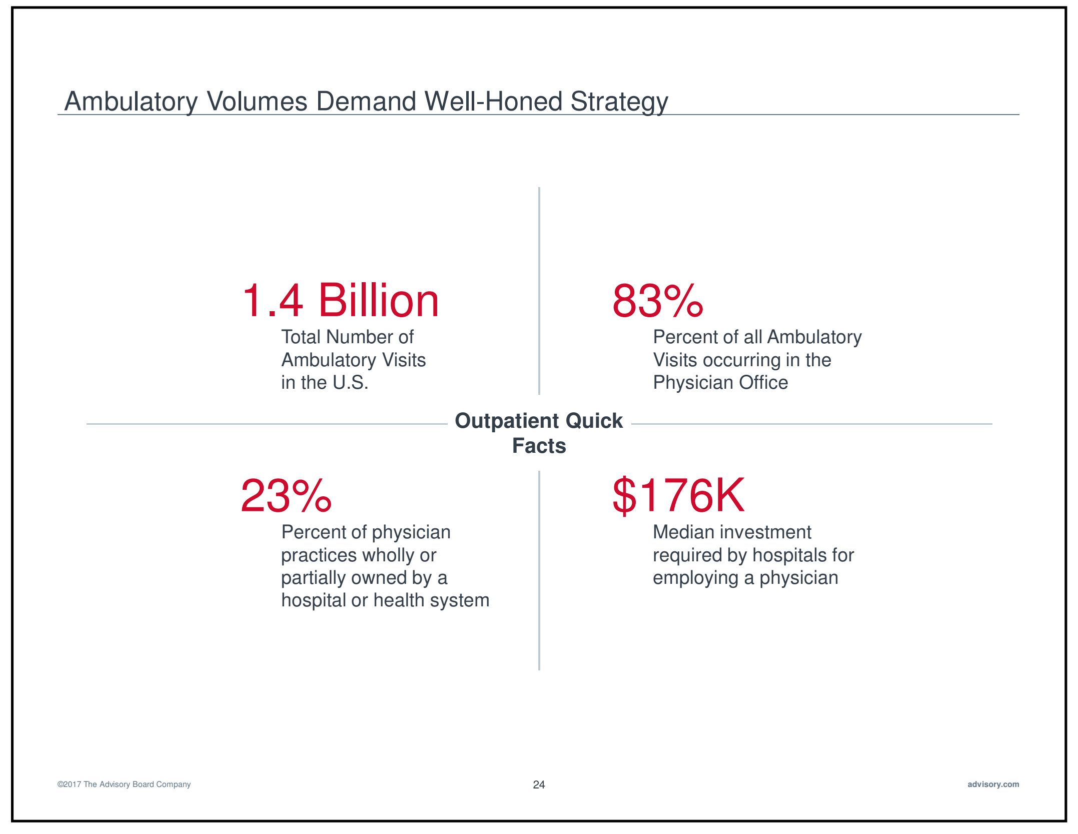
Ambulatory Volumes Demand Well-Honed Strategy
1.4 Billion
Total Number of Ambulatory Visits in the U.S.
83%
Percent of all Ambulatory Visits occurring in the Physician Office
Outpatient Quick Facts
23%
Percent of physician practices wholly or partially owned by a hospital or health system
$176K
Median investment required by hospitals for employing a physician
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Understanding Details of AWVs

1 Initial AWV Components

Applies first time beneficiary receives an AWV service (CPT G0438)

- Acquiring beneficiary information including the health risk assessment, histories, and current provider list
- Conduct assessment, gathering required elements e.g. BMI, blood pressure, etc.
- Counsel beneficiary on screening schedule, relevant risk factors, and appropriate program referrals

2 Subsequent AWV Components

Applies to all AWV services after first time a service is received (CPT G0439)

- Update beneficiary information including the health risk assessment, histories, and current provider list
- Conduct assessment, gathering required elements e.g. weight, blood pressure, etc.
- Counsel beneficiary on updated screening schedule, new and old risk factors, and appropriate program referrals

!

Dollars on the table for AWVs:

47. 9 million
Medicare Part B beneficiaries

86%
Number of beneficiaries **NOT** receiving an AWV

$7 billion
Total revenue opportunity for AWVs

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Next Step: Optimize your Ambulatory EMR

EMR Optimization Components

One of the most important elements of outpatient CDI program is the successful deployment and utilization of an EMR. Maintenance is an evergreen issue and physician champion groups should remain intact post go-live.

Establish Governance

- Identify clinical and administrative leaders
- Set accountability processes

Build System Collaboratively

- Consider broader impact of structured data fields
- Connect IT with clinical leaders to ensure optimal layouts and prompts

Provide Ongoing Education

- Clearly explain documentation standards and expectations
- Establish route for communicating changes and performance

Proactively Maintain

- Formalize process for addressing ongoing concerns and updating architecture

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