The Structure and Function of a Physician Advisor Program

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Overview

- Defining program services
- Key Drivers
- Development constraints
- Program justification
- Selecting Physician Advisors
- Program leadership
- Program options
- Education resources
What Kind of Physician Advisor Program Do You Want?
Unfortunately…

- Too many programs just "happen"
  - Little or no planning or rationale
  - Lack of executive support/understanding
- Physician(s) who are most supportive of case management discover one day that they are a physician advisor
- There has been little opportunity for education or networking of new PA’s
PA Program Services

• Secondary physician review for medical necessity (status determination)
• Audit denials and appeals
• Concurrent commercial denial management
• Clinical documentation improvement education (ICD-10 conversion)
• Utilization management
  – Length of stay
  – Resource use
  – Internal patient flow (level of care transfers)
Program Services (cont.)

• Case management support
  – Manage care team rounds
  – Discharge planning
  – Family/patient conferences

• Support to quality improvement/patient safety efforts
  – Readmissions, process improvement efforts

• Support to pt satisfaction improvement efforts

• General physician and administration liaison and education efforts
Program Drivers?

• Where does the impetus for the program come from?
  – Case management
  – Medical staff
  – Administration/finance

• How well are drivers/problems understood?
  – Prioritization of needs
  – Magical thinking
Development Constraints

• Executive support and understanding
  – Critical element to long-term program success
  – No end-arounds

• Physician resources
  – Willingness to participate/time commitment
  – Skills

• Program leadership

• Financial
  – Avoid magical thinking
  – Cost vs. FTE philosophy
Development Constraints

- Silos and politics
  - Medical staff perceptions/understanding
- Physician secondary review for medical necessity determination
  - Most common driver and most expensive
  - 24/7 multi-portal coverage is often desired
  - May require greater numbers of physicians to provide coverage
  - Physician training required
Justifying the PA Program

• Financial and quality benefits
  – Proper status determinations (inpatient vs. obs)
  – Reduced concurrent inpatient commercial denials
  – Reduced pre-payment, RAC, and other audit denials
  – Reduced avoidable days
  – Reduced length of stay
  – Improved resource utilization
  – Improved HCAHPS/Value based purchasing metrics
  – Improved physician behavior/support
Although the life of a PA is glamorous and exciting, attracting candidates for the work can be surprisingly difficult.

PA’s require a unique set of skills, thus this is not a job for just anybody.

Defining the program scope is important in defining the physician needs:
- Full time vs. part time
- Generalized vs. specialized PA’s

Hiring right is a key to success.
Defining the Ideal PA

- There is no one size fits all model
- Needs to “believe” in the role
- Minimum of five years of clinical practice
  - Currently practicing vs. retired physicians
  - Team player
- Specialty vs. generalist physician backgrounds
- Internal vs. external candidates
  - Respect of and for peers
  - Leadership capability
Defining the Ideal PA (cont)

• Excellent verbal/written communication skills
  – Physician-to-physician
  – Physician to lay audience (families, non-clinical staff, administrative law judges, etc.)
  – Enjoys education

• Critical thinker, comfortable with “gray zone” issues
  – Medical necessity issues
  – Good negotiation skills
  – Willing to learn on an ongoing basis (criteria, coding and documentation rules, regulations)
Defining the Ideal PA (cont)

- Politically astute and self-secure
  - A relationship manager that must not be conflict-averse and is willing to be persistent
  - Physical presence is critical
  - Flexible and approachable
- Ability to multi-task and react to the changing demands of daily workflow
- Generally positive outlook to avoid burnout
• The case for the Physician Advisor
  – Clinical knowledge and “complex medical judgment”
  – Understanding of how clinical documentation translates into coding
  – Can more effectively turn audit lessons into physician and staff education
  – Integrate coding, documentation improvement, case management and CPOE
Program Leadership (cont)

- Turn audit lessons into clinical and documentation process improvement to improve patient care and prevent future audit denials
- Giving voice to the voiceless
  - Can call attention to importance of case management, coding, clinical documentation improvement
  - Can help bring proper resources
  - Can help drive positive culture and performance
Program Options

• The ideas discussed so far will guide the choices of how to build a program
  – Case management/UR Committee
  – In-house
  – Outsourced
  – Hybrid

• Programs come in almost infinite variety as there are almost infinite situations
Case Management/UR Comm.

• Pros
  – Traditional model that is rapidly disappearing
  – Cheap and easy to implement

• Cons
  – Limited availability and relies on local physicians for support
  – Limited local expertise or regulatory knowledge
  – Large missed opportunity cost and potential compliance issues
  – Difficult to demonstrate commitment to compliance should OIG audit
In-House Pros

• Maximum flexibility to design program to fit needs
• Familiarity with local medical staff, processes, customs and politics
  – Credibility and relationships with physicians and staff
  – Direct chart/patient access facilitates exercising “judgment”
• Can focus on physician education to reduce future dependence and improve compliance, documentation and quality
• Incentive is to reduce denials
• Cost effective for larger programs and keeps $ local
• Internal PA can support internal process improvement
In-House Cons

• Lack of internal physician resources
  – Insufficient coverage schedule
• Lack of knowledge and difficulty in maintaining ongoing training
  – Difficult to keep up with legal/regulatory changes
• PA turnover
• Quality control and inter-PA variation
• For PA’s with clinical practice – negative impact on their practice
Outsource Pros

• Primary focus on secondary physician review
  – Maximum access to external PA support
• Minimal lead time to launch program
  – Little or no internal PA support needed
  – Extensive reporting capabilities
• Better quality control with reduced variability
• Extensive expertise in audit appeals
  – Up to date legal and compliance knowledge
• Predictable cost/case
  – Can be more cost effective for smaller facilities
Outsource Cons

- Limited scope of services
- Lack of local physician relationships and knowledge of local practices
- Communication by phone and e-mail
- No physician education
  - Does not enhance local expertise
- Aggressive “statusing” may ↑ audit denials
- Need to demonstrate compliance education
- Can be extremely expensive
- Requires internal oversight
Hybrid Pros

• May combine the advantages of in-house and outsource programs
• Most practical solution for most organizations
• Can be a transitional model to a full in-house program
• Strong internal leadership required to maximize the value of the program
Hybrid Cons

• Tendency for internal and external PA programs to operate in silos limiting education opportunities for internal PA’s and medical staff
• Many of the cons of outsourcing persist
• Cost of external component may limit $ for internal PA program
Education Resources

• ACMA – American Case Management Association
• ACDIS – Association for Clinical Documentation Specialists
• AHIMA – American Health Information Management Association
• ACPE – American College of Physician Executives
• RAC Relief

Ministry Health Care
Questions?

• For additional information or to be added to the RAC Relief Listserv, please direct requests to:
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