The Physician Advisor as the National Transportation Safety Board of CDI

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Learning Objectives

- What are Physician documentation basics?
- Identify common areas for physician documentation improvement.
- Learn how to discuss with physicians in order to change behavior

The Survey Results Mentioned

- The American Hospital Association, in conjunction with Executive Health Resources, launched the inaugural Clinical Documentation Improvement Trends Survey in February 2015.

- Trends were revealed in Clinical Documentation Improvement (CDI) programs by 1,000+ CDI, coding, HIM and other hospital professionals involved in documentation initiatives across the United States.

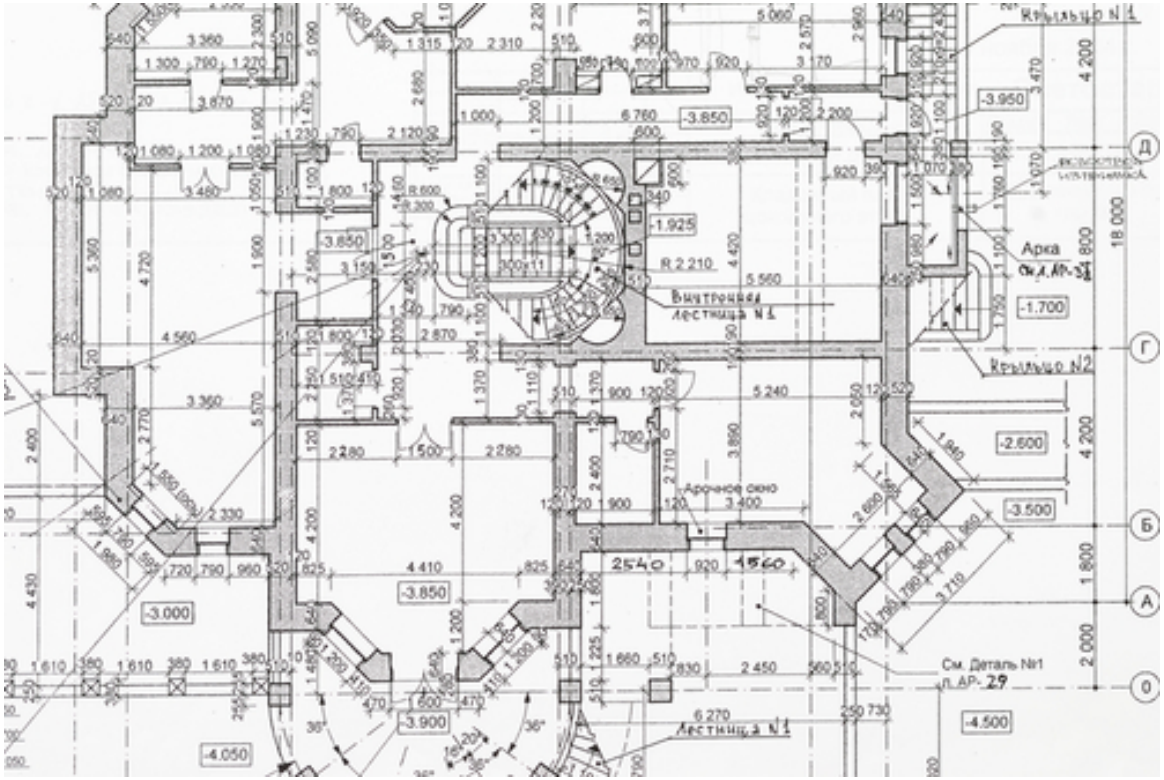
The Analogy

- Aircraft is the patient
- Pilot is the treating physician
- “Black box” is the chart
  - Cockpit voice recorder is the record of pilot decision making
  - Flight data recorder actual patient data, labs, x-rays, etc
- NTSB is CDI with **various levels of expertise**:
  - CDS and PA or physician champion
  - Investigators (CDI and PA) seek to clarify the data, make it more specific and accurate, by using queries. They also query the flight data recorder, the wreckage, to get accurate and specific data regarding the operation and performance for documentation

Today’s Documentation

Setting The Stage

What the Auditors Expect



Accuracy and Specificity

What Typically is Provided

Guidelines

Last Set of Medicare Guidelines

1997 DOCUMENTATION GUIDELINES FOR EVALUATION AND MANAGEMENT SERVICES

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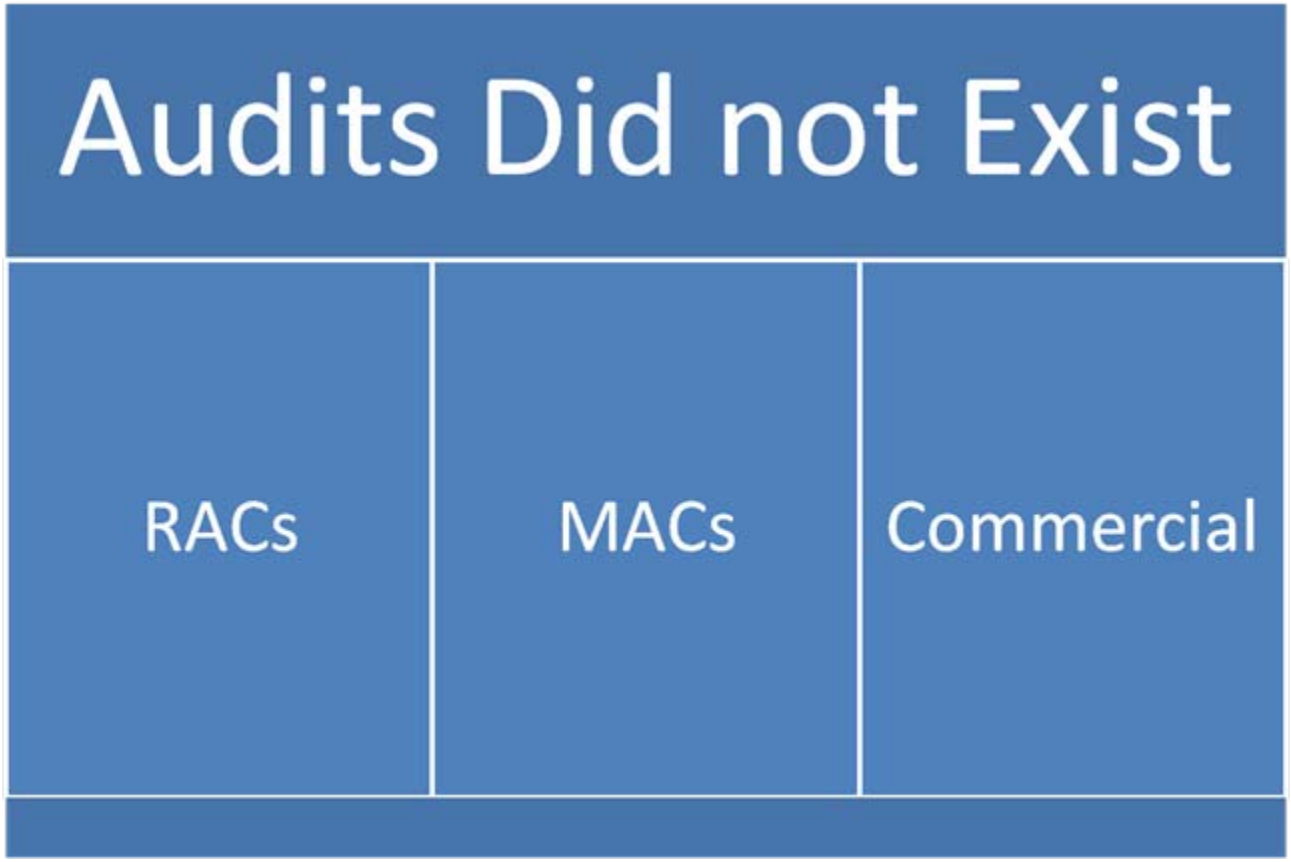
And In 1997



But Today!

Documentation Basics: Have They Been Forgotten?

Breaking Down the Chart

Some of the problems

- Physicians document for other physicians
  - Not for coders, CDI, UM, auditors
- Physicians assume that others understand
- They do not document the acuity with which patients present adequately
- The Electronic Medical Record has not been the solution

- Top **3 physician barriers** from survey:
  - 66.5% Lack of understanding of importance
  - 47.5% Lack of time
  - 38% Lack of interest

Important Chart Elements

ED Visit When Present

Orders | Certification

History & Physical

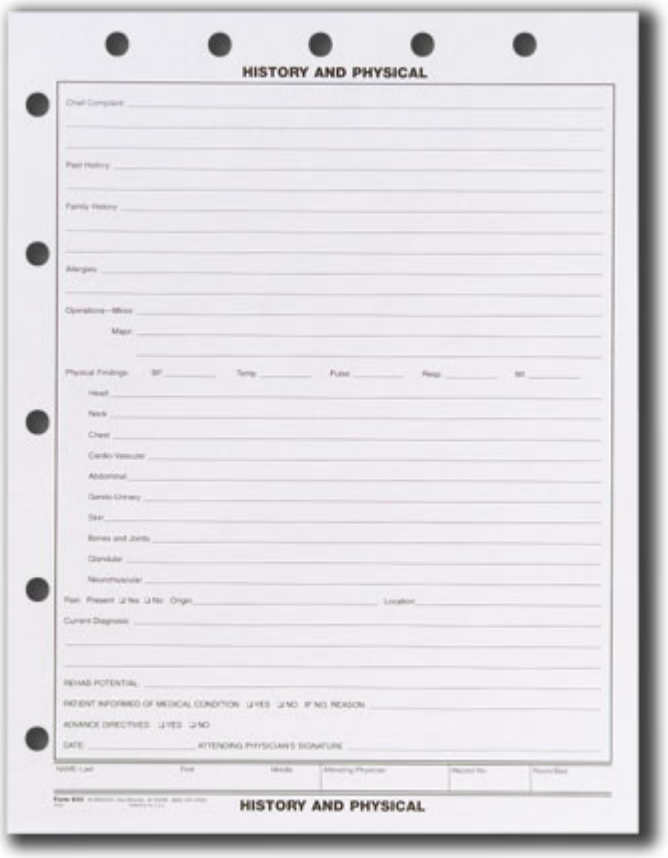
Progress Notes | Discharge Summary

Operative/Procedure Reports

Consults | Labs/Tests/EKG

History and Physical

1. Arguably one of the most important chart documents
2. Should be a stand-alone
   - The same regardless of Level of Care
3. Influential for preventing denials
   - Good for patient care

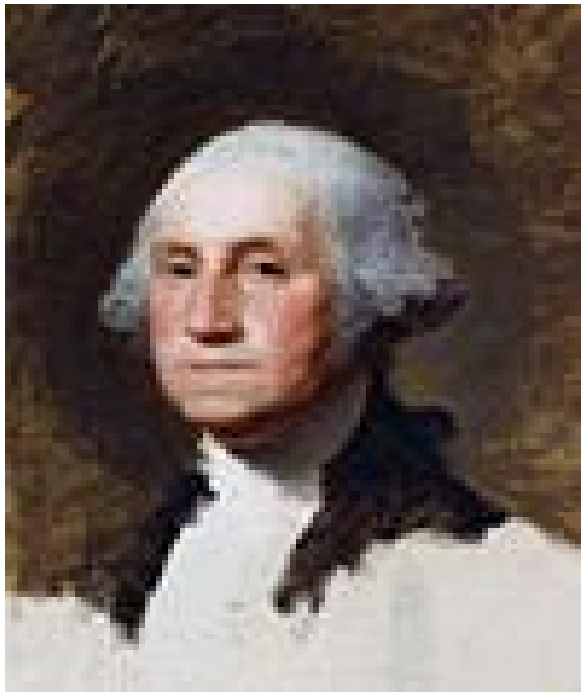


Keys to Physician Documentation

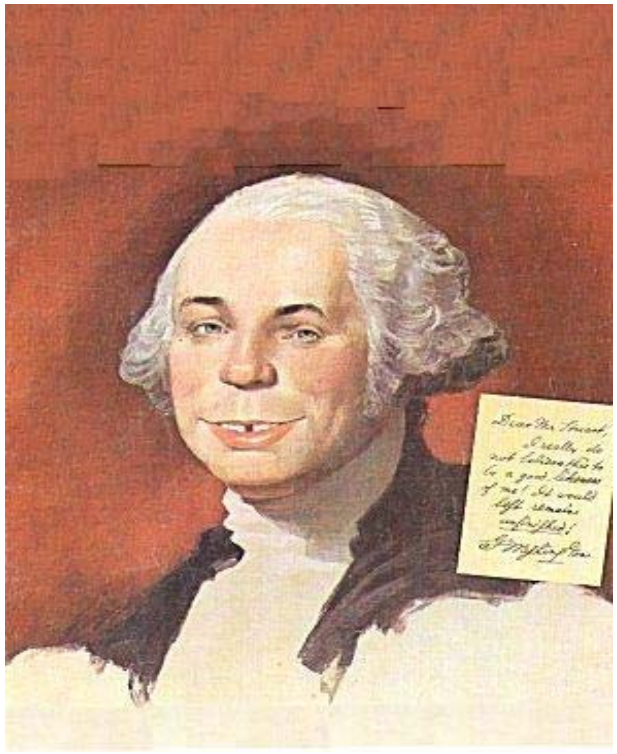
Paint the Picture Properly with WORDS

What you want…

“THIS IS SO OBVIOUS”



may not be…



what you might get

Not so OBVIOUS in the documentation

Barriers to Physician Engagement

The Norm

✓ According to the survey the vast majority **(95%)** of CDI programs struggle to engage physicians

How to E.N.G.A.G.E. Physician Cooperation

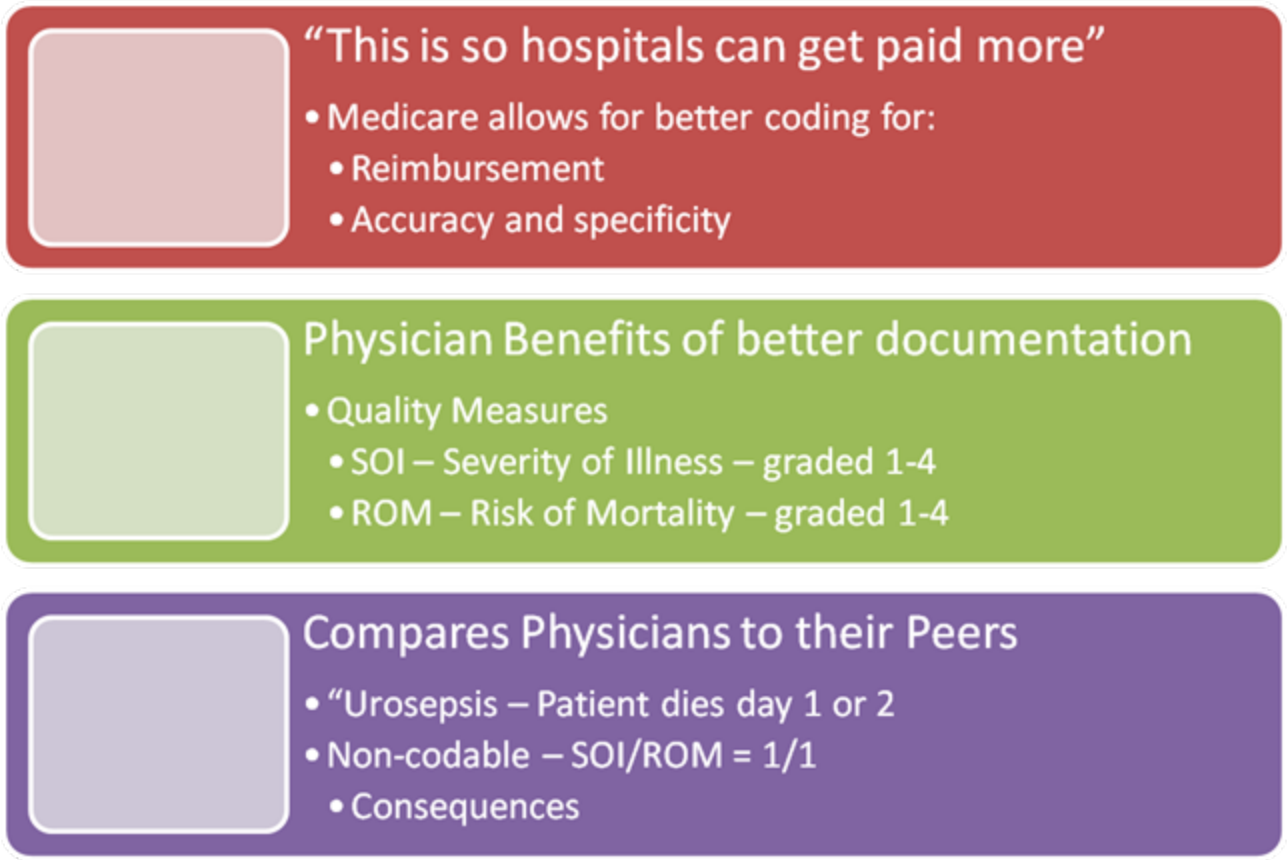
E.N.G.A.G.E.

- **E**xecutive Support
- **N**egate physician concepts
- **G**ain Cooperation
- **A**dvisors
- **G**et better documentation
- **E**ducate

Executive Support

- “But they will take their patients to neighboring hospitals”
- “That doctor does a lot of volume here”
  - A lot of DCS and other documentations are overdue
- Giving up to 30 days to complete a DCS
- Bending over backwards to make life “easier” for the physician
  - Enables poor behavior
- Don’t want to upset the docs

Negate Physician Concepts



Gain Cooperation

- Cooperation through Motivation
- WIIFM
  - What's In It For Me?
- Helping them understand their "skin in the game"
  - Quality Measures
  - Value Based Modifier (VBM)
  - Bundled Payments
  - HCC (Hierarchical Condition Categories)
  - Medicare Physician Compare, HealthGrades.com, and more
  - Potential employment effects/payer preferences
  - Medicare Spending per Beneficiary
  - POA (Present on Admission)
- Transmittal 541

Gain Cooperation

- Punish vs. Reward (carrot vs. stick)
- Depending on ownership structure various things to do
  - Physician employees vs. Not owned
  - Potential tools – hospital by-laws, policies, incentives for answering queries (not on outcomes)
- Contract metrics

Role of Quality and Value

CMS Move to Payment for Quality for Providers

- Category 1: FFS, not linked to quality or efficiency
- Category 2: FFS, linked to quality
  - Portion of payment varies based on the quality or efficiency of health care delivery
- Category 3: Alternative Payment Models built on FFS Architecture
  - Some payment is linked to the effective management of a population or an episode of care. Payment still triggered by delivery of services but opportunity for shared savings or 2-sided risk
- Category 4: Population-Based Payment
  - Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (> 1 yr)

This Data is Already being Compiled

- On 9/30/2013 CMS made 2013 Quality And Resource Use Reports available
  - https://portal.cms.gov
  - Intended to provide clinically meaningful and actionable information that can be used to plan for improving the quality and efficiency of care provided to the Medicare Beneficiary
  - There may be an increased penalty for being a high cost provider
- **In 2016 the Medicare Spending per Beneficiary (MSPB) will be included in the Total Per Capita Costs for All Attributed Beneficiaries of the Cost Composite**
  - **Expected Cost - Risk adjustment by age and severity of illness, HCC, recent long term care and MS-DRG of the index hospital**

CMI = expected cost based on what is documented in the medical record

Advisors

- Help to make sure that documentation can be supportive as RAC, MAC, Commercial Payer DRG Denials are increasing with the reason being "not clinically supported"
  (The fact that the doctor writes a diagnosis does not mean that it is supported in the chart)
- Elevates documentation practices that mitigate vague, incomplete and conflicting information from CDIS to physicians to coders
- Help queries to be more effectively and expeditiously answered as the peer to peer engagement can bridge the gap in documentation interpretation
- Serve as a clinical advisor to CDS and coders
- Aid in ongoing physician education

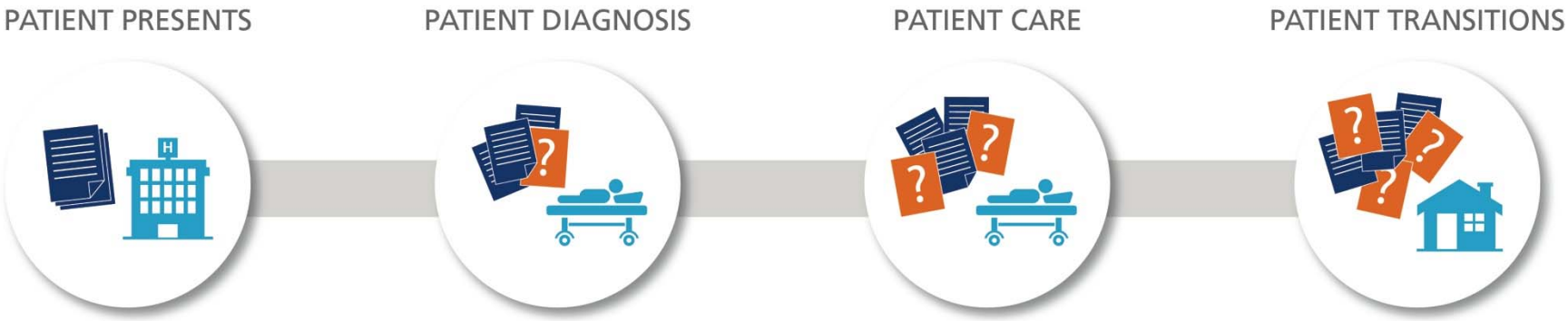
Advisors

- If trained extensively in CDI (Clinical Documentation Improvement) principles:
  - Can perform chart reviews on requested cases from the CDI team – these usually involve complex cases. If clarification is needed, can reach out to treating physician to gain clarification on the documentation
  - Physicians respond to physicians in a different way – can converse about the case as peers in a non-leading way
  - Physician to Physician conversations - serve to re-inforce solid documentation principles because physicians learn well through case – reinforcement
  - Supports the CDI program

Advisors

- The five main attributes a physician advisor must have are:
  1. Broad clinical knowledge base
  2. Respect from the medical staff
  3. Ability to effectively communicate with physicians and non-physicians
  4. Availability
  5. Broad knowledge base of clinical medicine across all specialties

Get Better Documentation



CHALLENGE: ENSURING COMPREHENSIVE PHYSICIAN DOCUMENTATION

- Gaps created with hand-offs
- Details not captured or transferred
- ED tests not logged by treating physician
- Other clinicians' perspective siloed

- Physicians don't "think in ink"
- Diagnosis and plan of care not detailed
- Key info omitted in physician summary
- Clarification sought through queries

- CDI struggles with gaps in patient story
- Plan of care and variables vague
- Key info omitted in physician summary
- Unresolved queries

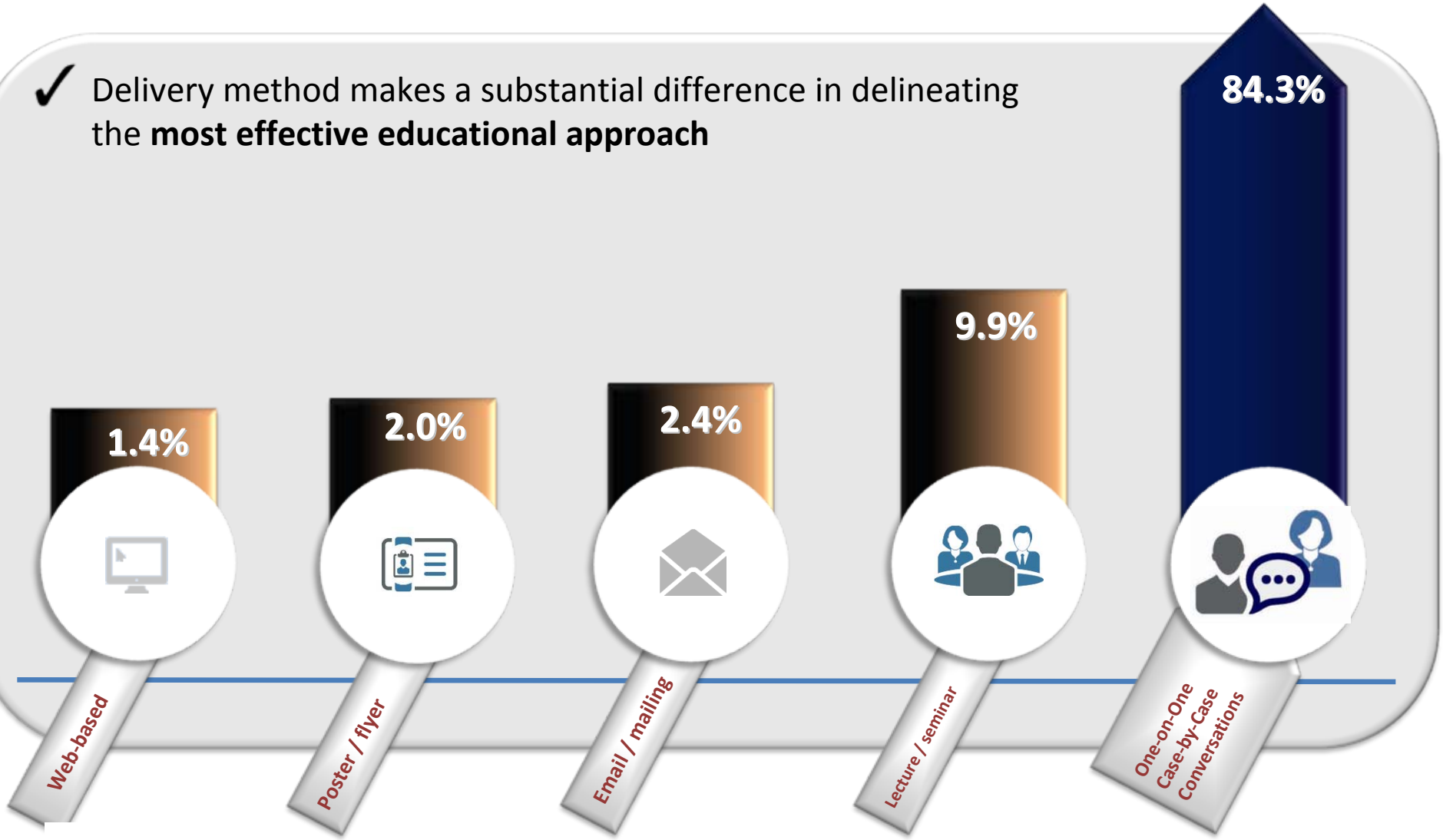
- Coding doesn't have needed detail
- Inaccurate DRG = missed reimbursement
- Weakened defensibility
- CMI and quality impacts

Educate

- **Educate physicians the way it works – not the way you've always done it**
  - **SURVEY REMINDER:** Real-time, patient specific conversations are the most effective education strategy to make physicians aware of how to improve documentation (**84.3%** of survey participants agree) and some of the most prevalent approaches hospitals use to educate physicians were deemed ineffective
- **Acknowledge the limited time that physician resources can allocate to CDI**
  - **SURVEY REMINDER:** Conflicting priorities and limited bandwidth leave hospitals seeking outside physician expertise to augment CDI program effectiveness (**83%** of physician advisors/champions spend 0-10 hours a week supporting CDI)
- **Make sure physicians know there's room for improvement across the board**
  - **SURVEY REMINDER:** Despite the expertise of your medical staff or where you're at on the CDI program stage continuum, improvement opportunities are an universal theme with **98.5%** of programs having physicians who could improve documentation practices

Education is the Answer (55.1% Agree)

✓ Delivery method makes a substantial difference in delineating the **most effective educational approach**



Best Practices Examined

✓ How an individual patient case documentation review program (with physician-to-physician discussions, as appropriate) works

Review	Substantiate	Engage	Document
• Determine if greater specificity is needed in documentation	• Clarify if a query is valid or needed	• CDI expert physician interacts directly with the appropriate treating physician to gain clarification in the documentation and provide case-specific education and feedback	• Provide a written summary of the physician conversation to the CDI specialist who can then verify the physician has appropriately updated the chart

THANK YOU.

Questions?

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