The Evolution of Clinical Documentation

How are CDI Roles Changing and Where Do I Fit In?

ACDIS Spring Indiana Chapter Meeting
April 30th, 2016
Objectives:

- The evolution of Clinical Documentation Improvement (CDI) programs
- Why is CDI growing so rapidly within all healthcare modalities?
- The move from volume based reimbursement to value based reimbursement; the new return on investment (ROI) metrics
- Pay-for-performance, value based purchasing, patient safety indicators, bundled payments, core measures, risk adjustment, CMS funded audits
- CDI prospects for career growth
It’s a Great Time For CDI Professionals!!!

Oh the places you’ll go!

You have brains in your head. You have feet in your shoes.
You can steer yourself any direction you choose.
You’re on your own. And you know what you know.
And YOU are the one who’ll decide where to go.

-Dr. Seuss

Clinical Documentation Improvement Mission: “We assist hospitals and physicians with both concurrent and retrospective reviews of patient health records, looking for conflicting, incomplete, or nonspecific documentation. We assist in identifying clinical indicators of diagnoses and procedures that are not clearly documented, whether in an electronic or paper medical record. Utilizing queries, both verbal and written, we ask clinicians for clarification and provide ongoing documentation education. Our work results in a clear picture of the care provided to the patient and the resources utilized by the healthcare organization and clinician providing that care.”

As CDI evolves, moving into other patient-care venues, the only thing that changes: “where your feet are standing.”

“We assist all healthcare providers; organizations and clinicians…”
True or false?

• CDI programs are not appropriate in some healthcare venues due to the reimbursement system utilized by CMS and private payors.

• Clinical documentation needs to be stellar for all patient encounters, no matter the healthcare delivery model or form of reimbursement.

• For a patient to be certified for CMS hospice care, the healthcare provider must confirm the patient has a likelihood of dying within the next six calendar months. For hospice care, clinical documentation isn’t as important.
CDI Evolution: What Hasn’t Changed

• Paper record vs. EMR~ both modes of the medical record have challenges!
• Stellar medical record documentation doesn’t just “happen”. Providers continue to need assistance in accurately representing the care, treatment and outcomes for their patients.

“The primary purpose of clinical documentation should be to support patient care and improve clinical outcomes through enhanced communication.

The clinical record should include the patient's story in as much detail as is required to retell the story.”

Past~
✓ Concentration on CCs
✓ Principle diagnosis optimization
✓ Clarity of procedures
✓ Physician engagement

Current~
✓ All of the above (plus)
✓ Core Measures
✓ MS-DRGs added MCCs to our task list (2008)
✓ Clarity of complications
✓ Severity of Illness
✓ Risk of mortality
✓ Present on admission
✓ Hospital acquired conditions (HACs)
✓ Readmissions
✓ Bundled Payments
✓ Lets not forget ICD-10-PCS

Future~
✓ All of the above (plus)
✓ Pay for performance (P4P)
✓ Patient safety indicators (PSI)
✓ Risk analysis (Hierarchal Condition Categories (HCCs))
✓ Value based purchasing (VBP) Volume to Value
✓ ??? Question remains “what else, what next”???
Return On Investment

The Need For a New Definition

• “Return on investment” isn’t just about case mix index any longer.
• Multiple variables are being added into what constitutes the success and ROI of a CDI program.
• ROI will have new statistics, metrics and analytics: dependent both on traditional revenue cycle definitions and Pay-4-Performance.
• Volume to value-it’s where the starship is docked; we have to get on board NOW.
• CDI professionals career growth will be dependent on being able to transition into these new settings and environments.
Welcome to Change!

- Payment structures
- Moving from fee-for-service toward fee-for-quality
- Pay-for-Performance (P4P)
Pay-for-performance (“P4P”) is a term that describes health-care payment systems that offer financial rewards to providers who achieve, improve, or exceed their performance on specified quality and cost measures, as well as other benchmarks. Pay-for-Performance models are based on a common set of design elements:

- Performance measurement
- Incentive design
- Transparency and consumer engagement

Performance Measurement
In health care, quality of care measures falls into three categories: structure, process or outcome. Structural measures include patient access to care, use of electronic systems within and/or across practices, and patient experience of care.

Clinical process measures are frequently used given the availability of the data through claims, the reduced reporting burden to providers and the breadth of endorsed measures by the National Quality Forum (NQF). However, as important as structural and process measures are, according to a study published in the American Journal of Managed Care, payers should design P4P programs with an emphasis on measures that have high economic value, for example blood pressure (www.ajmc.com/journals/issue/2008/2008-06-vol14-n6/Jun08-3299p360-368/).
### Payment Taxonomy Framework

<table>
<thead>
<tr>
<th>Category 1: Fee for Service—No Link to Quality</th>
<th>Category 2: Fee for Service—Link to Quality</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
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</thead>
<tbody>
<tr>
<td>Description</td>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
<td>Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</td>
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<tr>
<td>Medicare FFS</td>
<td>• Limited in Medicare fee-for-service</td>
<td>• Hospital value-based purchasing</td>
<td>• Eligible Pioneer accountable care organizations in years 3-5</td>
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<td></td>
<td>• Majority of Medicare payments now are linked to quality</td>
<td>• Physician Value-Based Modifier</td>
<td></td>
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<tr>
<td></td>
<td>• Readmissions/Hospital Acquired Condition Reduction Program</td>
<td>• Accountable care organizations</td>
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<tr>
<td></td>
<td>• Bundled payments</td>
<td>• Medical homes</td>
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<td></td>
<td>• Comprehensive primary care initiative</td>
<td>• Bundled payments</td>
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<td>• Comprehensive ESRD</td>
<td>• Comprehensive ESRD</td>
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<td>• Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</td>
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### Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- **2016**
  - Medicare FFS (Categories 1-4): 30%
  - FFS linked to quality (Categories 2-4): 85%
  - Alternative payment models (Categories 3-4): 5%

- **2018**
  - Medicare FFS (Categories 1-4): 50%
  - FFS linked to quality (Categories 2-4): 90%
  - Alternative payment models (Categories 3-4): 10%

Source: CMS
Value-Based Purchasing (VBP)

- CMS, other payors quickly getting on board!
- Paid for by 1.75% decrease in DRG payment by participating hospitals.
- Funds redistributed to hospitals based on Total Performance Score (TPS)
- Hospital revenue? Less, equal or greater than 1.75% they gave up.
Total Performance Score

4 Domains:

• Clinical process of care
• Patient experience
• Outcomes
• Efficiency
Merit-Based Incentive Payment System (MIPS)

Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

- End sustainable growth
- Reward healthcare provider for quality of care
- All quality reporting into one system.

MIPS

- Sustainable Growth Rate Methodology
- Consolidation of Physician Quality Reporting System (PQRS)
- Part B providers are provided a MIPS score: 0-100

- MIPS score available to public on Physician Compare website: www.medicare.gov/physiciancompare/
- Provides transparency and specificity
Patient Safety Indicators (PSI)

- Indicators providing data on potential hospital complications, adverse events following surgery, childbirth and procedures.
- Used to help hospitals identify adverse events and plan for further study to reduce risk.
Risk Adjustment: Medicare Advantage

- Risk Adjustment Factor Scores (RAFs)
- Hierarchical Condition Categories (HCCs)
- Chronic Disease/health status
- Documentation and coding a population intensity of illness, along with SOI, ROM
- Frequency of encounters
- Quality of care
- Care coordination
What’s Needed to be Successful?

• A coming together of skill sets, a team!
• Coding & HIM
• Nursing—Clinical

It takes multiple levels of expertise to drive the “CDI Starship”
Be True to Your Skill Set

• ICD-10 diagnoses and ICD-10 PCS (The fuel that provides the data collection)

• Need to study up? Time to put your “training suit” on?

• CPT Coding- Needed for outpatient and physician office: Multiple online courses, YouTube has exceptional videos.

• Clinical knowledge: You are the expert! Areas of weakness? Study Up! Multiple modalities of study options.
Multiple types of healthcare delivery modalities:

- Outpatient hospital services
- Physician office settings
- Community based clinics
- Free standing surgery centers
- Long term acute care (LTAC)
- Skilled nursing facilities (short term and custodial care)
- Home care
- Hospice
- Emergency medical services (EMS)
- Retail medicine
- Tele-medicine

Other Areas:

- Statistical Analyst
- Community Coordinator
- Chronic Disease Coordinator
- Documentation Administrator
- EMR Documentation Administrator
- Consultant
- Payor
Many thanks for your kindness today, I hope you were able to see all the wonderful CDI opportunities as you move our profession forward~

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Today was good. Today was fun. Tomorrow is another one.

-- Dr. Seuss