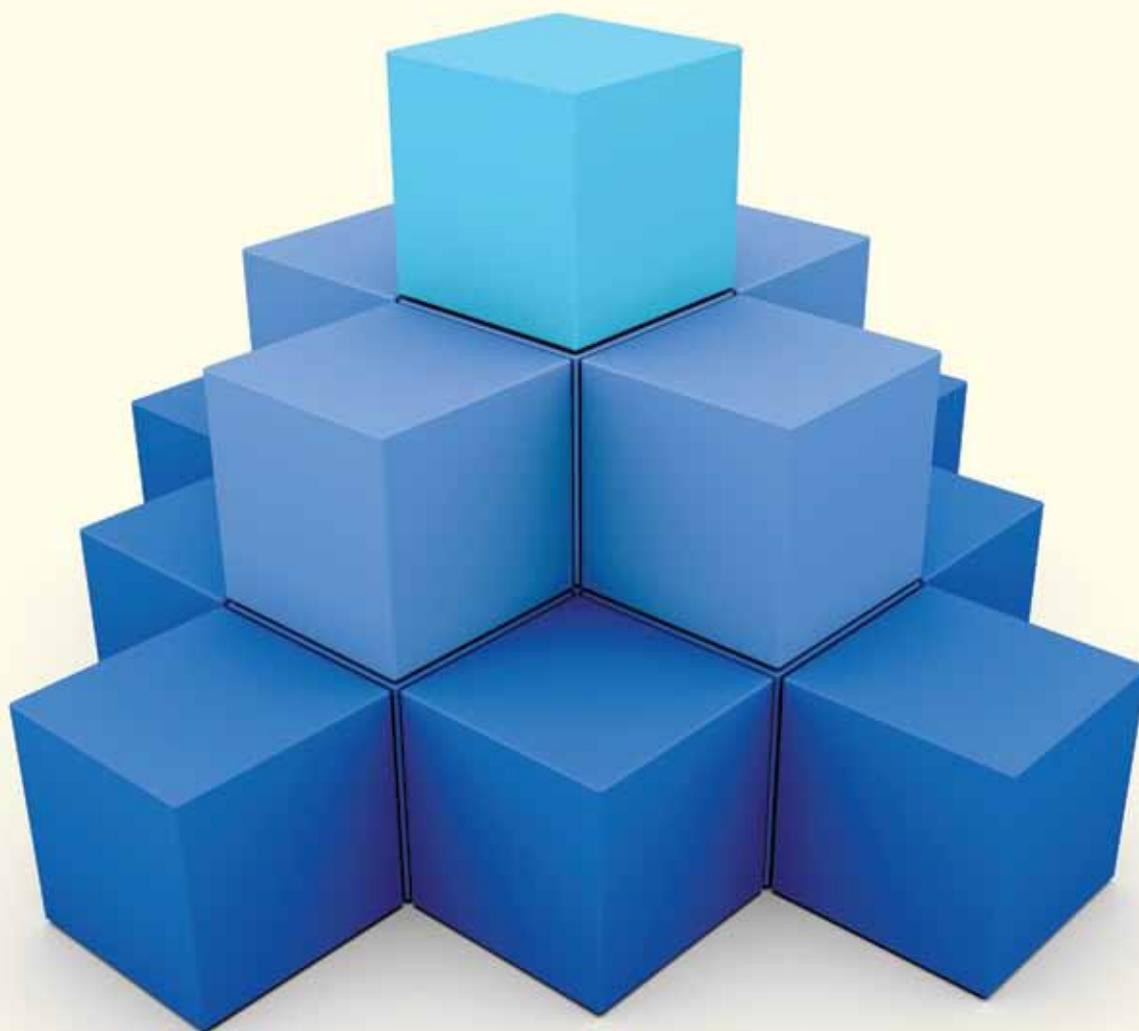hfma
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Will Your Data Support Value-Based Payment?

Capturing, analyzing, and reporting data are not new tasks for healthcare organizations. But recent changes ushered in by healthcare reform initiatives that emphasize value over volume have introduced a new aspect to such data processes: the bottom line. Whether reporting on preventable medical errors and readmissions or ensuring appropriate documentation of outcomes for pay-for-performance programs, hospitals and health systems are facing greater pressures to improve how they manage data.

Hospitals that fail to improve their processes may hinder their abilities to comply with regulations and meet the demands of payers seeking evidence of better quality outcomes. As a consequence of lacking such abilities, healthcare organizations face a greater risk of penalties and reduced fees and payment from government and private payers.

The risk of loss is no longer a distant threat, but a looming reality. Beginning this year, for example, Medicare will penalize hospitals with higher-than-expected 30-day readmission rates for heart failure, heart attack, and pneumonia. Hospitals that do not perform well in value-based payment programs either leave bonus money behind or suffer payment cuts.

To produce more-reliable data, hospitals are working more strategically with physicians, incorporating technical tools that simplify documentation and coding workflows and investing in infrastructure that integrates clinical and financial data.

In short, healthcare organizations need to ready their data processes for this new reality, which really means preparing for a tomorrow that will look a lot different than today.

Preparing the Data—Improving Documentation

Arriving at better outcomes data requires inputting better data at the beginning of the care process. Hospitals use various methods to assess and improve clinical documentation, from dedicating staff to documentation review functions to educating clinical staff.

One common strategy is manual review of patient charts, often by a clinician, such as a nurse. Generally, the nurse will compare documented services and procedures against the diagnosis to discern whether acuity levels match up—a critical factor in not only helping to ensure appropriate payment, but also providing evidence of comprehensive care.

The Medical University of South Carolina (MUSC) Medical Center, a 709-bed teaching facility in Charleston, initiated a concurrent clinical documentation improvement (CDI) program in 2005, according to Susan Pletcher, MPA, RN, director of health information and patient placement services. The program is staffed by nine nurses and one manager. The CDI nurses daily review the charts of patients enrolled in Medicare and a few select commercial insurance plans.

Pletcher says that nurses especially want to make sure that present-on-admission conditions, as well as all contributing factors to a patient's primary condition, are thoroughly documented. If a nurse finds a discrepancy between the documentation and the diagnosis—for example, a heart failure diagnosis that does not indicate whether located on the left or right side—the nurse will either write a query on the patient's chart or send an email to the physician.

The CDI staff work closely with the hospital's coding staff, each relying on the other's expertise when seeking clarification on a clinical-based or coding-based documentation issue. The CDI staff also work directly with physicians, when necessary.

Pletcher says nurses recently met with a group of pediatric intensivists to determine why clinical performance data indicated that patients had lower severity of illness and risk of mortality than would be expected for the services physicians were providing. The nurses determined that physicians were not documenting acuity levels appropriately. "Such assumptions were made because you would see something like an order for a ventilator, so you knew that the patient was in acute respiratory failure. And yet the condition wouldn't be anywhere in the patient chart," she says.

Such sessions help physicians understand how their practices affect the coding data. A coder is also present at such meetings to clearly explain coding requirements. Pletcher says that, although the meetings are held only to address specific problems, the long-term goal is to have more formal and routine educational sessions with physician groups on documentation and coding.

The Physician as Teacher

In fact, one result of efforts to improve data capture is that physicians are playing a greater role in improvement efforts. In the case of Oakland, Calif.-based independent delivery network Kaiser Permanente, physicians are taking on greater responsibility for documentation improvement at both ends of the spectrum—as educators and students.

About five years ago, Kaiser initiated its Physician Documentation and Coding Group, composed of practicing physicians from the eight regions within the Kaiser system. The physicians are also certified coders. The group addresses ways to improve documentation and coding practices, according to James Taylor, MD, CPC, medical director of revenue cycle for Colorado Permanente Medical Group, PC, a multispecialty physician group practice based in Denver that contracts with the Kaiser Foundation Health Plan to provide physician services for the Colorado area. The Colorado physician practice includes about 1,000 physicians who serve about 500,000 patients, Taylor says.

Taylor, a certified coder, was hired about 10 years ago as a kind of physician ambassador to develop a documentation/coding training program for physicians as the Colorado market shifted from a capitation-style health maintenance organization payment model structured on annual premiums to a model based largely on fee for service. Taylor notes that under the capitation model, physicians generally did not have to document their services and procedures, so when payment models changed they did not know proper documentation/coding practices. Kaiser initially developed a program in which coding experts trained physicians. "And it failed miserably," he says.

USING PERFORMANCE DATA EFFECTIVELY

Pay-for-performance programs rely not only upon having good data, but also upon having access to the data and making the data usable. Having worked within such programs for several years, Donald R. Vayr, director of strategic planning and decision support for OSF Saint Anthony Medical Center, Rockford, Ill., follows a few guidelines intended to reap the most out the hospital's pay-for-performance data.

Saint Anthony's pay-for-performance metrics, along with those of its six sister hospitals in the Peoria, Ill.-based OSF HealthCare System, are available through a portal in a dashboard-type setting. The portal enables everyone in the system to view each other's progress.

Seek standardization. To produce reliable reports, the language and terms used in the data must be consistent. Notes Vayr: "You have to have very clear definitions. What does an admission mean? What is an inpatient? What is an outpatient? You've got to have the same terminology for whoever is writing the reports. That is critically important."

During the initial stages of a systemwide performance contract, Vayr says his way of defining a direct cost was different from the way the financial term was defined at the corporate level. So the term had to be standardized across the health system; otherwise, data used on performance scorecards would be unreliable because comparisons would be based on different terms. "You have to use standard terms across the system," Vayr says.

Ensure engagement from the top down. Administrator buy-in is also essential. Key decision-makers should be able to easily access and make use of the data at their own comfort level. Saint Anthony's CEO, for example, prefers a quick read of the dashboard metrics provided on the scorecard, while the CFO prefers to delve deeper into the data by clicking on links provided within the dashboard. Administrators can then use the data to inform their decisions, such as deciding to focus on improving documentation related to a specific quality measure and raise performance scores.

Consider ease of use. Finally, tools for retrieving data and creating reports must be user friendly. "The first few dashboards that we got out were very difficult to navigate," Vayr says. So Saint Anthony's corporate informatics expert worked with data users in the field to improve presentation of the data and make the dashboard easier to use.

The reason? There has always been a disconnect between the language of the clinician—the clinical terms used by physicians when they dictate or document the patient experience—and the language of coding—the diagnostic terms used for coding, performance profiling, and compliance. Taylor says that he was able to get through to the physicians where the earlier effort stalled because he uses clinical terms in the way physicians are accustomed to using them—something that nonclinical coders could not do. These days, as payment models are again shifting—this time toward value of care delivery across the care continuum—Taylor says having a clinical background, a firm understanding of coding rules, and technical skill and knowledge makes for an ideal platform for working with physicians. "I'm like a true ambassador in that I speak both languages," Taylor says. "And I know the EMR [electronic medical record] cold."

Using Tools to Improve Documentation

Along with more frequent interaction and greater involvement by physicians and clinicians, documentation and coding processes can be simplified and accuracy improved through technology.

MUSC is using several tools that help to make the coding and documentation process more efficient, Pletcher says. One tool integrates data between the information system used by the CDI staff and that used by the coding staff to enable sharing of the data between the systems, thereby enhancing workflow. When clarifying an issue or seeking more information, for example, users do not have to switch back and forth as much between the CDI and coding systems. Having such documentation data more readily accessible enables a coder to understand how to code better by understanding documentation better, Pletcher says. Because more data can pass electronically, there is also less need for direct, face-to-face communication, she says.

The medical center is also rolling out computer-assisted coding, which automatically generates CPT and ICD codes from a text document, such as a transcription of physician notes. The coder then edits and reviews the codes for accuracy. The expectation is that eventually the tool will help

CDI nurses on the front end. The software highlights key terms in a transcript, for example, making it easier for a nurse to see if he or she has missed anything in reviewing the documentation. "That's going to be a big timesaver," Pletcher says.

Like MUSC, UW Medicine, Seattle, a five-hospital system that also includes a medical school, physician practice, and various outpatient facilities, also uses manual chart review to improve documentation. The goal, however, is to make the process more automatic, says Thomas Payne, MD, medical director of information technology services at UW Medicine.

Currently, clinical documentation specialists at UW Medicine identify the need for clarification on a patient chart. For example, if a physician orders an ultrasound of the urinary track to evaluate renal failure, the CDI reviewer can query the physician as to whether renal failure should be added to the problem list, Payne explains. If the physician affirms the query, then the reviewer adds the condition to the chart. In the future, Payne says, some of these triggers may be automated.

Although both the clinical review and the automatic triggers have the potential to improve documentation, Payne says the latter is more efficient. "With software, you're not just helping the doctor order the imaging test. You're transmitting information about the patient's problem list, which is more efficient," he says. "My goal is to avoid having to rely on a skilled clinician to read through all these notes to make the documentation thorough," he says.

Also on the horizon, says Payne, are emerging technologies, such as natural language processing and voice recognition, that can automatically improve documentation. "There is a lot of exciting work going on that would allow things to be much more automatic than they are today," he says.

One area of focus for the Kaiser physician documentation group is to develop tools to make documentation easier. For example, the group developed an interface between the clinical information system and billing information system that automatically appends CPT modifier 25 to certain services based on rules written by the group. Appropriate use of the modifier can be confusing, but inappropriate use of the modifier can lead to a loss of revenue or noncompliance issues.

WHAT MOTIVATES PHYSICIANS TO IMPROVE?

Perhaps one of the most persistent barriers to clinical documentation improvement is simple resistance: Physicians are caregivers, not coders, so they do not like to code. That is why in attempts to improve clinical documentation it is so critical to explain the necessity of proper documentation and coding and to provide physicians with a reason that may end with—but does not begin with—the bottom line.

The key to improving documentation is not focusing on crossing all the t's and dotting the i's required for full payment, but focusing on the clinical reasons for documentation.

"You have to step back for a moment and ask: 'Why are we documenting in the first place?'" says Thomas Payne, MD, medical director of information technology services for UW Medicine, Seattle, a five-hospital system that includes a medical school, physician practice group, and outpatient clinics.

For physicians, that "why" begins first and foremost with quality. Proper documentation ensures that the patient is getting the required care and that the next caregiver is up to date on the services and procedures that the patient has received.

Measuring quality, being compliant with regulations, and protecting revenue are important reasons, but proper documentation chiefly reflects proper care, Payne says.

In fact, focusing solely on documentation required for compliance or payment can be counterproductive. One of the problems that surfaces is chart bloat, Payne says. Chart bloat results when a checklist of terms, thought to be required for payment, is added to the documentation. The patient chart then becomes so overrun with phrases that it can be difficult to determine the current status of the patient or why a patient was admitted. "I hear this a lot in my role," Payne says.

A bloated chart doesn't necessarily protect revenue, either. "That may be the driver, but it really is not necessary for the financial purposes," he says.

Motivating physicians to improving their documentation requires getting physicians to understand that proper documentation aligns with a better understanding of the patient's history and current status, and this information aligns with better quality care, Payne says. "So there's a balance that's

needed here. We have to improve documentation in a way that helps all the missions of the medical record without impairing them any more than we have to."

Of course, identifying the right reason for improvement is only the beginning. Several other approaches can help garner physician engagement as well.

Physician ambassadors. Ideally, the person charged with educating physicians about proper documentation and coding should be another physician. The Kaiser Permanente health system, Oakland, Calif., uses physicians who are also certified coders to teach proper documentation and coding practices to other physicians throughout the Kaiser system.

"Physicians take direction better from other physicians, rather than accountants or the c-suite," says James Taylor, MD, CPC, medical director of revenue cycle for Colorado Permanente Medical Group (CPMG), PC, a Denver, Colo.-based multiphysician practice that serves the Kaiser system.

Peer pressure. Letting physicians see, literally, how they compare with other physicians improves performance. "Comparison motivates physicians more than anything else because you're talking about a group of straight-A students, and no one wants to be at the bottom of the class," Taylor says.

The quality measure scores, which include documentation accuracy, of physicians within CPMG, are available to view on the group's intranet. Physicians who are network providers, but not part of CPMG, can compare their scores with a blinded average of their colleagues.

"Let physicians know how they stack up against peers," Taylor says.

Incentives. Monetary rewards motivate change. Several years ago, CPMG physicians began receiving incentives for coding accuracy. Failure to include supporting documentation for diagnosis, procedure, and evaluation and management capture was considered an error. Physicians were audited at first monthly, then quarterly, as the scores consistently improved. The scores now consistently rank above 95 percent, Taylor says.

"Measure physicians on quality and then tie dollars to it, because then everyone wins," he says.

Generally, the modifier is required when an evaluation and management (E&M) service and procedure are given during the same visit. Without the modifier, the payment will cover only the E&M service or the procedure, but not both. To complicate the matter, some services are bundled into the E&M, meaning the modifier qualifies only in certain situations, Taylor explains. So automating the rules removes the guesswork for physicians. "That's the value of having clinicians who also understand the business and coding world," he says.

Managing Pay for Performance

Technology not only improves data capture and documentation processes, but it also plays a vital role in data analysis and reporting by integrating clinical documentation data with financial coding data, and by providing financial managers with more detailed information. These improvements are absolutely critical in value-based payment mechanisms, such as pay-for-performance programs.

Over the past several years, Ellis Medicine, Schenectady, N.Y., has invested considerably in IT infrastructure, including new clinical and financial information systems and an electronic health record (EHR) system, according to Daniel Rinaldi, vice president of finance and CFO for the health system, which includes a hospital, outpatient facility, women's health center, and primary care practices.

"Without the technology, data are virtually impossible to track," Rinaldi says. "I wouldn't want to be a hospital that's just starting to think about their information systems technology."

The EHR system, which Ellis is in the process of implementing in all of its 25 physician practices, will improve documentation by providing physicians with a seamless charge entry coding function. When inputting clinical information, physicians simply point and click on links, and the documentation will be automatic, Rinaldi says.

The financial system identifies at the procedural level the services that have been provided, which means that outcomes data can be more specified. "It's capturing data at the granular level," Rinaldi says. For example, with a well-baby exam in the previous system, the data would indicate only the exam, not specifying the procedures performed within the exam. To determine whether an inoculation was given

would require accessing and reviewing the medical record to see if there was a pharmacy charge, Rinaldi says. The new system will indicate whether an inoculation has been performed during such an exam.

The difference is important because infant inoculations are one of 10 quality indicators that are part of one of the health system's performance contracts with a managed care payer. The incentives-based program offers a $1 million bonus for meeting the quality targets, Rinaldi says.

The system also provides a scorecard for how well a hospital is meeting its quality goals. For example, Rinaldi says that during one quarter, Ellis could have received an additional $400,000 in bonus payments if it could support better quality scores. "I know where we're weak and can focus attention with our executive team, CEO, and medical director on those things that we need to do better," he says.

Shifting to Riskier Contracts

Managing data will become even more important as contracts move from risk-averse to risk-based structures.

Like Ellis Medicine, OSF Saint Anthony Medical Center, Rockford, Ill., a 254-bed level one trauma center that is part of the Peoria, Ill.-based seven-hospital OSF HealthCare System, has pay-for-performance contracts that are incentive-based. The hospital is not penalized for missing quality targets, such as HCAHPS scores, but receives bonus payments when it hits them.

For example, one of the hospital's three pay-for-performance contracts contains 10 quality indicators. The hospital receives one-tenth of 1 percent of payment for every quality target that is met. "So we can earn up to a 1 percent bonus payment," says Donald R. Vayr, director of strategic planning and decision support for OSF Saint Anthony.

So far, the hospital's payers have been receptive to these types of incentives-based contracts. But more risk-based models may come. "At some point, I have to believe it's going to be turning into a more punitive setting," Vayr says.

Currently, much like the decision makers at Ellis Medicine, Saint Anthony's CEO and CFO use performance data to track how much bonus payments the hospital will be receiving or how much will be left on the table if targets are not met.

ICD-10 IMPLEMENTATION DELAY: USE EXTRA PREPARATION TIME WISELY

In today's ever-changing regulatory environment, one thing is clear: Accurate clinical documentation is the foundation for appropriate reimbursement and quality reporting. Now that CMS has proposed delaying ICD-10 implementation to October 2014, healthcare organizations are reviewing their ICD-10 roadmaps to adjust timelines, budgets and workloads. "An additional year for preparation allows hospitals and physician practices to slow their implementation pace from a sprint to a good steady run," says Garri Garrison, director of consulting services for 3M Health Information Systems. "Facilities should take advantage of the extra time to improve the quality of clinical documentation and coding and look for ways to offset the anticipated impact to productivity under ICD-10."

Garrison recommends that physician education be a primary focus. "In our consulting engagements with hospitals and physician groups, we see too many physicians who are accustomed to using unspecified codes in ICD-9 and documenting with less specificity," she says. "Once ICD-10 is implemented, these physicians may have difficulty meeting medical necessity for hospital admission as well as for diagnostic tests ordered from their office if they don't understand how to document for ICD-10." Since documentation drives ICD-9 coding, initiating ICD-10 education now will help physicians adjust their documentation practices well in advance of ICD-10. The added benefit, Garrison explains, is more accurate and appropriate reimbursement under ICD-9, which can help fund the ICD-10 transition.

Another essential element is specialty-specific ICD-10 training, including changes that must be made to charge capture tools and systems. "Rather than focus on the entire ICD-10 code set and the increased number of codes, help physicians focus on specific codes for the major conditions within their specialty," says Garrison. "By using this approach to education, we'll be able to get the engagement we need from physicians to ensure a successful ICD-10 transition."

Source: 3M Health Information Systems.

Another of Saint Anthony's pay-for-performance contracts, which covers the health system and represents the medical center's largest payer, is monitored through an online portal that includes progress reports submitted by each hospital within the OSF system. Managed by the health system's informatics expert, the portal is accessible by key decision makers, such as CFOs, and quality improvement staff.

The informatics expert compiles a dashboard of metrics using clinical and financial analytics software. The dashboard provides a scorecard for the system and each hospital, and the metrics are updated every four to six weeks. Vayr says the scorecard is very easy to read. A red "X" denotes that a quality measure target is not being met, while a green checkmark denotes the target is being met.

The contract's bonus structure has four tiers measuring readmission, utilization, length of stay, patient satisfaction, mortality, and complication rates. Hospitals in the lowest tier receive no bonus payment; tier two initiates the bonus system, which pays based on the percentage of the total payment (paid, not charged) for the qualifying cases. Tiers three and four provide progressively larger bonus payment percentages up to the program performance maximum negotiated during the contracting process.

The scorecards enable hospital decision makers to easily gauge performance by seeing what exactly is required to maximize payment for a particular quality target. For example, one column will show all patients who qualify to be included in a certain indicator. Another column will show how many of these patients actually met the quality criteria. So a financial manager can see exactly how many positive scores are required to move into the next bonus tier. "It's really motivating," Vayr says. "The CFOs love it because you have enough detail to be able to say, literally, 'We're only two patients off, folks.'"

The reports also show how much money the hospitals lose when target measures have not been met, he says. "So it helps reinforce what we're doing or points out areas where we need to put in a little more time."

As an example, when the Saint Anthony process improvement team studied its readmission rates in preparation for the Centers for Medicare & Medicaid Services value purchasing program, it found that the hospital would only achieve 63 percent of the performance payment under the readmissions criteria. This highlighted the need to set up a task force to improve the readmission quality measure. The team met with key players—including primary care physicians, specialists, community physicians, and home health clinicians—and used Six Sigma process improvement techniques. "During such meetings, we get our data together and have all these players at the table so everyone can begin hammering out processes and procedures on how to transition patients from the point of service to ensure appropriate care is provided in the appropriate location," Vayr says.

Making the Link

In the end, improving performance and protecting revenue are all about making a smooth and effective transition from improving data capture to analyzing and reporting data. Preparing data processes for value-based payment, therefore, is really about linking clinical quality to financial value—a realization that will help a healthcare organization's ability to survive the coming changes.

Pletcher says that when MUSC first implemented its clinical documentation improvement program in 2005, the emphasis was financial. The goal was to determine whether the hospital was documenting acuity levels appropriately and, therefore, receiving full payment. "As time goes on, we recognize that quality and finance are linked," she says. "You really can't have one without the other."

Health Information Systems

3M Health Information Systems delivers innovative software and consulting services designed to raise the bar for clinical documentation improvement, computer assisted coding, ICD-10 implementation, mobile physician applications, case mix and quality outcomes reporting, and document management. 3M's robust healthcare data dictionary and terminology services also support the expansion and accuracy of the electronic health record (EHR) system. With nearly 30 years of healthcare industry experience and the know-how of more than 100 credentialed 3M coding experts, 3M is the go-to choice for more than 5,000 hospitals worldwide that want to improve quality and financial performance and prepare for ICD-10. With more than a decade of international ICD-10 implementation experience, 3M provides comprehensive ICD-10 tools and services to identify areas of financial risk, improve documentation, increase the efficiency of coding, translate codes and convert systems, and educate staff—solutions for a successful ICD implementation. Visit www.3Mhis.com/icd10.
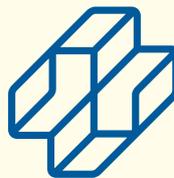
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