Guidehouse
Outwit Complexity

Beyond CMI: Emerging Impacts of Diagnosis Capture

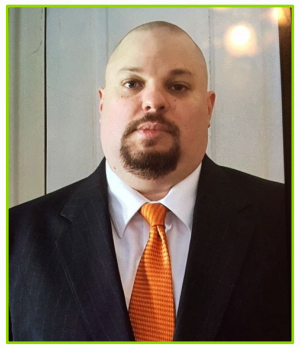
An Ever-growing Data Set Of Quality And Financial Data – Hawaii HFMA

April 7 - 8, 2022

Today's Discussion

- Introductions
- A New Approach & Solution
- Current & Future State
- What Makes This Approach Different?
- Leveraging Your Analytics
- HI Inpatient Data Insights
- Summary
- Question & Answer

Introductions



Brian Schaffer

Brian is an Associate Director in Guidehouse's Revenue Cycle Consulting practice. Schaffer has over 16 years' experience in data management, data analysis, data requirements, custom report generation, and sales. Schaffer has worked with the Clinical Integrity Team on Inpatient, Outpatient, Physician E&M audits creating custom reports, custom audit tools, and working with multiple different software systems to show results of a range of audits. Schaffer has worked with the Clinical Integrity Team for CMI, CC/MCC Capture, and LOS analysis for multiple clients creating custom reports and dashboards showing clients numerous analysis on the state of their CDI programs.

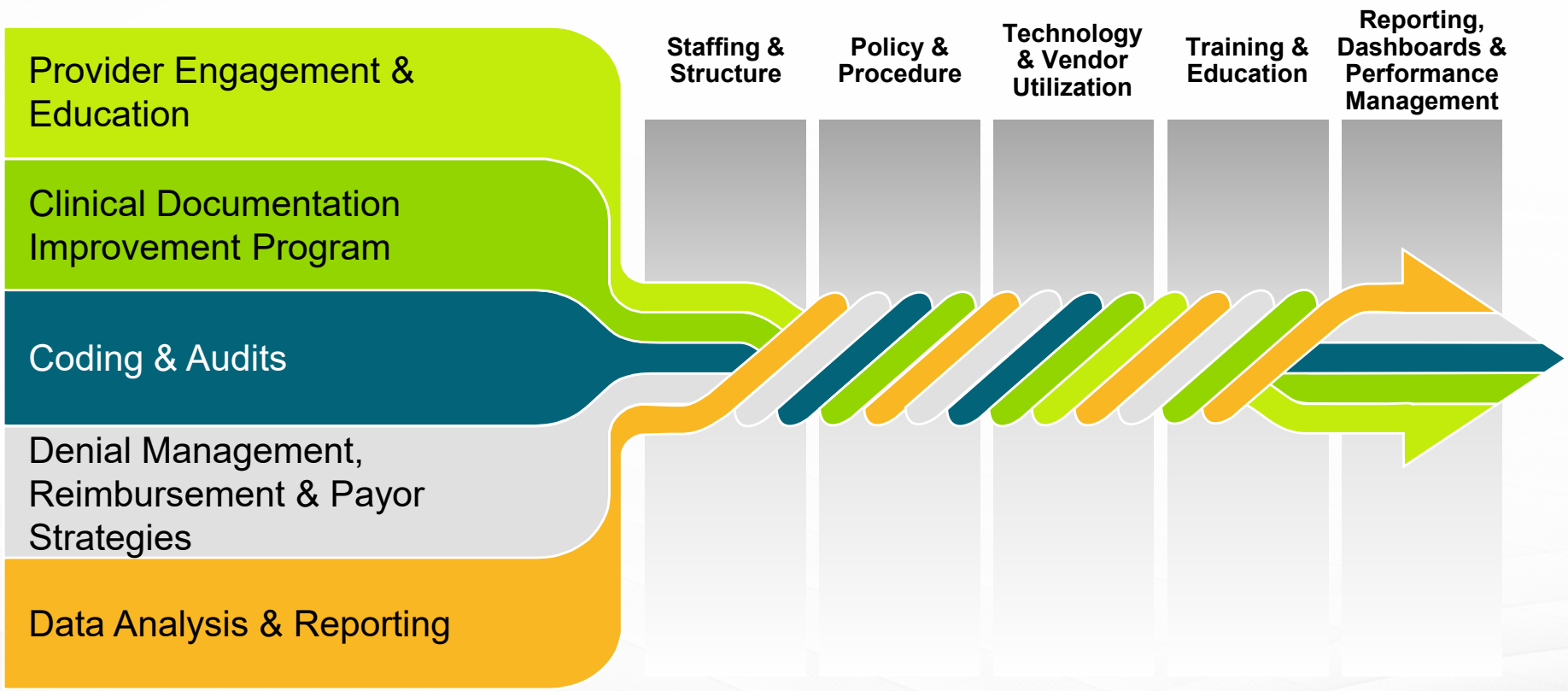
Amy Gaston

Amy's expertise includes a wide range of revenue integrity workstreams. Amy has experience in charge capture, education, documentation improvement, and technology process improvement. She is a dynamic educator focusing on documentation improvement to providers, and documentation specialist and coding. Amy has more than 20 years of nursing experience with ten years in revenue cycle. Her clinical experience in the Emergency Department and SICU has given her invaluable insight into her consulting career. Most recently she completed a charge capture project along with Revenue Cycle technology process optimization.

She has extensive knowledge of multiple technologies used in CDI programs and an extensive background in auditing and review of records for improvement and potential program growth. She also has experience in supporting implementation for hospital systems through follow-up post implementation audit, education, and continued support.

A New Approach to Clinical Integrity

Advanced Analytics & Epic Optimization



Outcomes

- Quality of Care
- Compliance with regulations
- Preparedness for changing payment models
- Comprehensive and accurate medical record
- Sustainable Model Design
- Streamlined and optimized process and workflows
- Improved efficiency and productivity
- Improved communication and transparency between providers and key functional areas
- Performance and Actionable Data
- Appropriate reimbursement
- Improved provider engagement

Clinical Integrity Approach

Program Development for managing acute & chronic conditions via CDI program

EHR Optimization
Patient Problem Lists, Specialty-based Smart Phrases/SmartTexts and Embedded Workflows

Comprehensive documentation approach and accuracy across the continuum of care

Custom & Tailored Provider Education
Performance tracking and reporting

Medical Record Audits, data trending, and predictive condition modeling

Focused process improvements in Documentation, Charge Capture, CDI, Coding and Denials

Pay for Performance

Medicare Incentive Payments

Value based purchasing provides additional payments for:

- Outcomes/Complications/Quality
  - Hospital Acquired Conditions
  - Patient Safety Indicators
- Mortality
  - DNR/Palliative Care populations
- Readmissions
- Lengthy of Stay
- Bundled Payments
  - Managing cost of care, preventing readmissions and reducing length of stay*
- Cost of Care/Resource Utilization
- Chronic conditions
  - At least 40% of HCC chronic conditions are usually reportable on inpatient stays under RAPS

Mortality

Achieving Appropriate Observed vs. Expected Mortality Rates

- Why is mortality important?
  - Risk adjusted
  - Publicly reported
  - Financial implications
- Value vs. Prevalence
  - Often highest value coefficient diagnosis are captured
  - Identify high volume with lower value coefficient
    - Educate providers/CDI on these diagnosis
- Mortality Review
  - Engage CDI/coding in post mortality review to optimize secondary diagnosis capture
  - Leverage data sources to understand directional needs of mortality review

HCC 84-Acute Respiratory Failure

Examples of Quality Impact

- HCC 84 is a risk adjustment trigger which can improve scores for the following quality metrics:
  - Myocardial Infarction 30 Day Mortality
  - COPD 30 Day Mortality
  - COPD 30 Day Readmissions
  - Pneumonia 30 Day Mortality
  - Pneumonia 30 Day Readmissions
  - Heart Failure 30 Day Mortality
  - Heart Failure 30 Day Readmissions
  - Heart Failure Payment Measure
  - Excess days in Acute Care Heart Failure

Prioritization and Sequencing

A claim form only allows 24 diagnoses (837I)

*The UB 04 only allows 17

Make sure you prioritize the things that matter in those top slots:

- MCC/CC
- HCCs
- PSI/HACs
- SOR/ROM
- CMS Readmission/Mortality/*Complication **EXCLUSIONS**
- CMS Readmission/Mortality/Complication **RISK ADJUSTERS**
- ***Conditions that overlap with Elixhauser/Vizient/Premier key drivers**
    - **Correct Present on Admission status is of critical importance**
- Social Determinants of Health

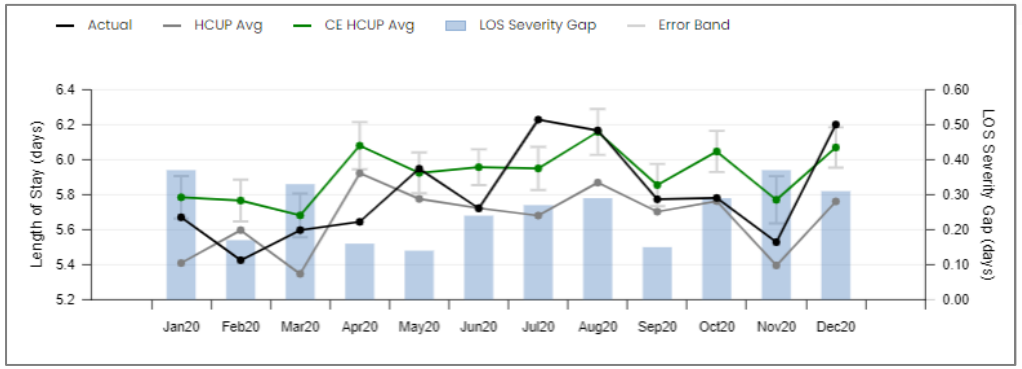
Length of Stay

Are you tracking length of stay outliers?

Be aware of problem areas

- Long length of stays with low weight DRGs with short GMLOS
- Short lengthy of stays with high weight DRGS or long GMLOS
- All single Tier Sign and Symptom DRGS
    - Syncope/Chest Pain/Psychosis/Hand procedures/GYN procedures

- Is your utilization correct for your patient population?
- In hospital deaths per thousand:
    - Observed
    - Expected



Denial Prevention and Management

Completing the Circle of DRG Downgrades and Clinical Denials

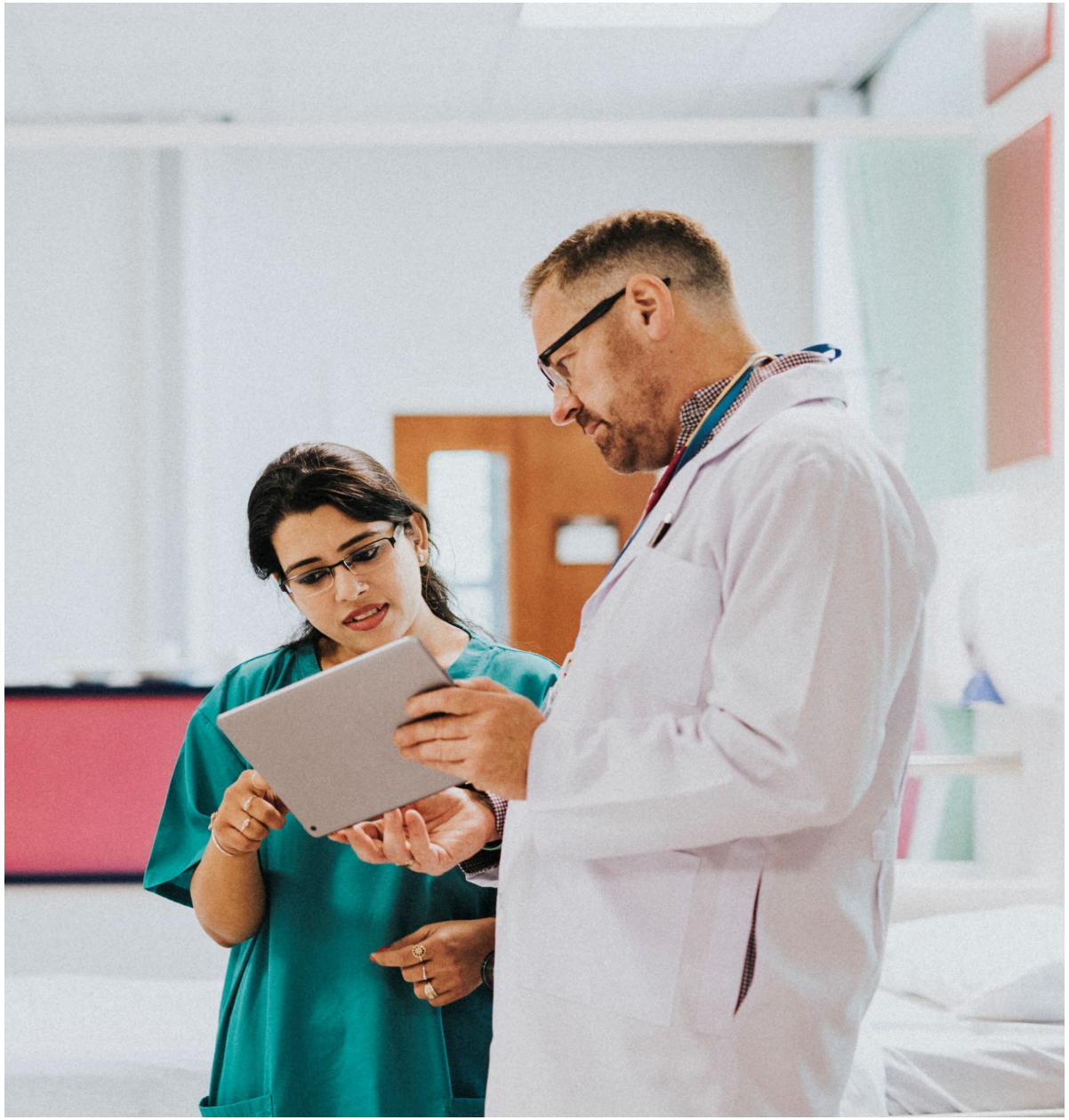
CDI has an active role in Denial Management as well as Denial Avoidance

- Roles in Denial Management of Medical Necessity, DRG Downgrades, Diagnosis Carveouts, RAC
  - Triage denials for appropriateness of potential appeal
  - Support/draft appeal letters incorporating clinical criteria and best practice documentation
- Roles in Denial Avoidance
  - Clinical Validation
  - Understanding payor definitions and documentation requirements
  - Track and trend denials and root cause for denial prevention

Documentation Drives More Than Just CMI and DRGs

The success of failure to report specific clinical conditions impact multiple hospital initiatives

Picture The Current & Future State of CDI



Clinical Integrity – Transforming Approach

Current State – Traditional CDI Programs

Benchmarks based on Static Measures

- Case Mix Index or CMI is the key measure of success
- CMI is driven by identifying and documenting complicating comorbid conditions (CC) or major comorbid conditions (MCC)
- Emphasis is on review of medical record during IP stay or immediately post discharge and sending queries to physicians to get them to document potentially missing CC or MCC
- CDI programs today are evaluated and measured on number of queries, number of queries agreed to by the physician, and ultimately increase in CMI
- Relies heavily on benchmarking performance against industry standards and peer group performance
- Does not consider the impact that actual charges in patient mix will have on the CMI in any given period
- Benchmarking assumes a static patient mix and does not account for a dynamic change in patient severity
- Current technology being utilize in most hospitals drives work overflow and measures performance against benchmarks but does provide insights into true patient severity over time

Future State – Transformation to a Comprehensive Program and a Data Drive Clinical Integrity Approach

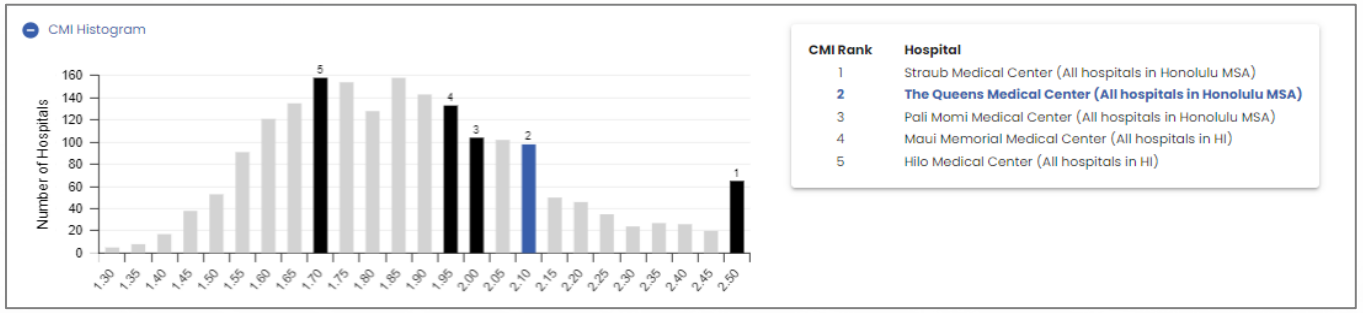
Program Scope

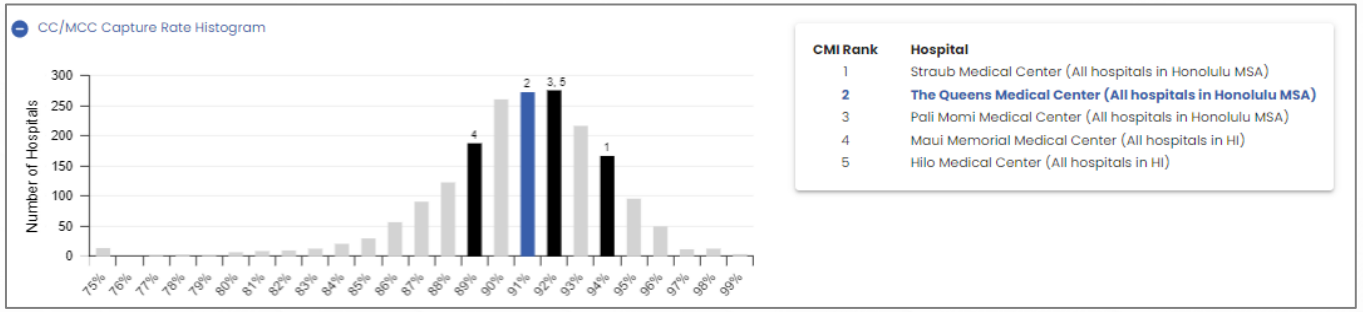
- Expand focus on comprehensive scope of services (IP, Ambulatory, Ancillary/OP)

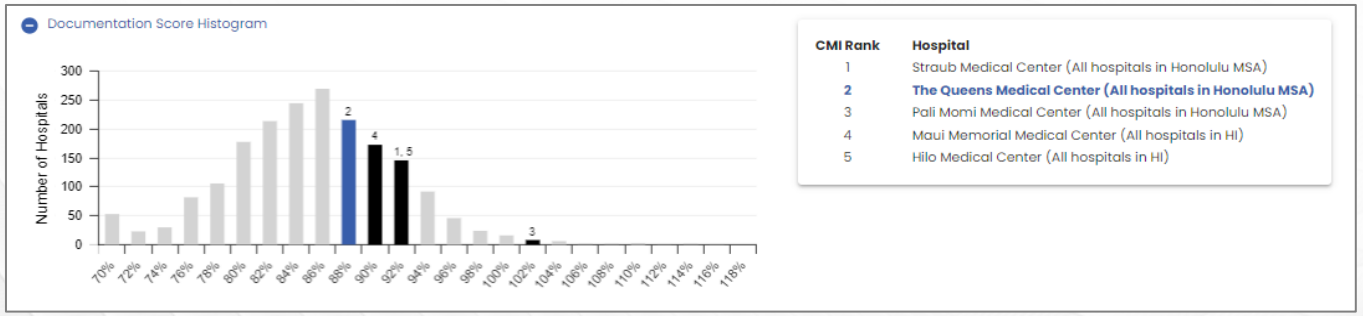
Data Driven and Predictive

- Does not utilize static benchmarks to effectiveness but instead compares performance against expected outcomes based on dynamic and changing patient mix
- Utilizes advanced predictive analytics to identify documentation gaps and area for focused intervention
- Establishes clinically expected measures for both CMI and patient severity (Documentation Score)
- Drives provider focused education to improve documentation accuracy and reduces the number of queries
- Providers can be held accountable for their documentation quality and completeness
- Provides regular dashboard reporting and actionable information on a real time basis

Why CMI can be Misleading







Key Takeaways

- Benchmarking CMI to gain insight into severity reporting under the MS-DRG billing system, or to infer opportunities to improve can be very misleading
- Capture rate benchmarking is also misleading. Capture rates are largely dependent on the DRG/DRG mix at each facility
- There is no proxy for the unique DRG mix for each hospital when choosing a cohort
- Documentation Score represents the percentage of severity reported under the MS-DRG billing system after the analysis of each facility's unique patient/DRG mix

Current State of Most CDI Programs

Benchmark Driven & Static Measures

Most CDI programs rely heavily on broad benchmarks

Most CDI programs rely on *indirect* contact with physicians

Most CDI programs cannot deliver expected measures for CMI based on patient population

Most CDI programs cannot track and adjust to specific physician behavior

Future State

Deep Dive Data Driven & Physician Focused

Hyper-targeted provider patient data - Measurements are population adjusted, rather than locked Benchmarks

CDI programs are physician-focused – direct approach

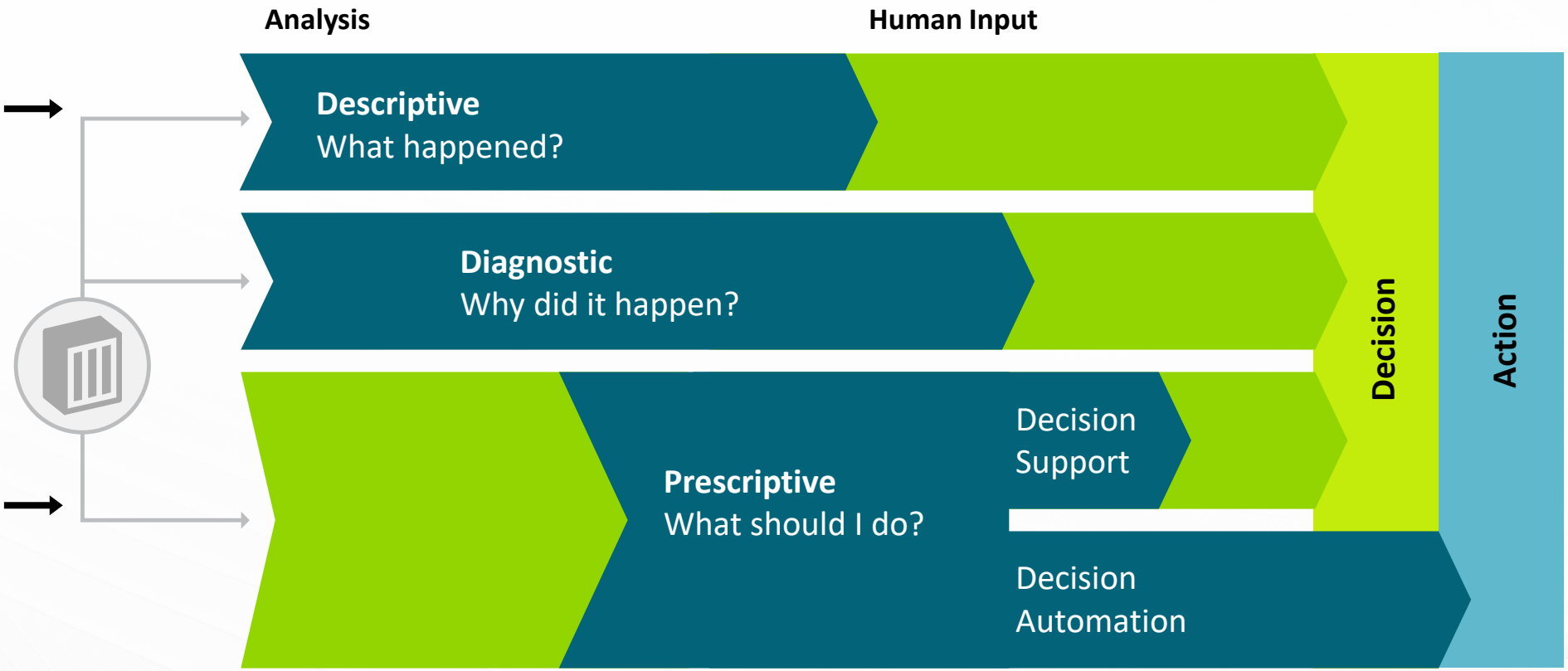
Leverages your patient data to measure current vs. expected performance

Program driven physician focused education based on their specific behavior

Converting Historical Data into Predictive Analytics

Most CDI programs still start from here:

Data driven approach allowing for an 80/20 strategy for which tangible goals can be set using performance and actionable data

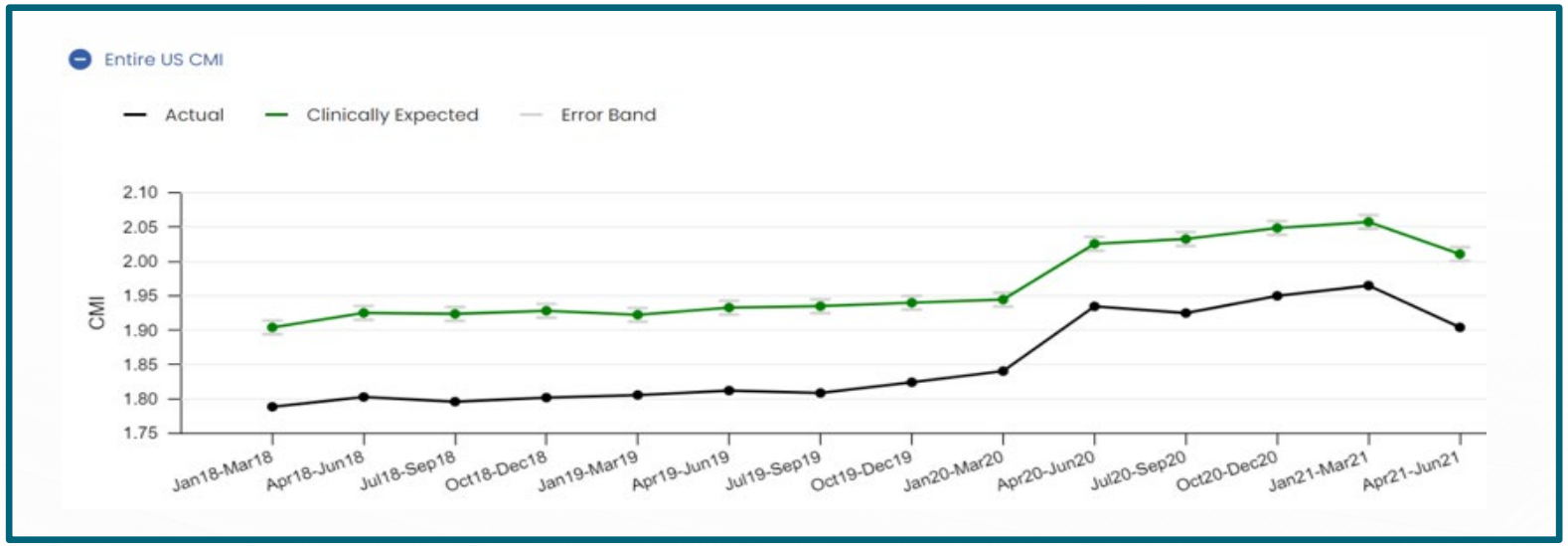


Four Types of Analytics Capability
Source: Gartner (October 2014)

Eliminating the above referenced Human Input time spent on auditing and comparing multiple reports to try and get to actionable data is a more efficient process

Prescriptive Analytics

- Custom data analytics based on your patient population
- Better metrics - expected vs actual outcomes using your data
- Direct approach to physicians equals better engagement
- Doesn’t rely on old-fashion benchmarking, better results and physician buy-in



Leveraging Your Analytics

All Services & All Payer Focus

HI Inpatient Data Insights

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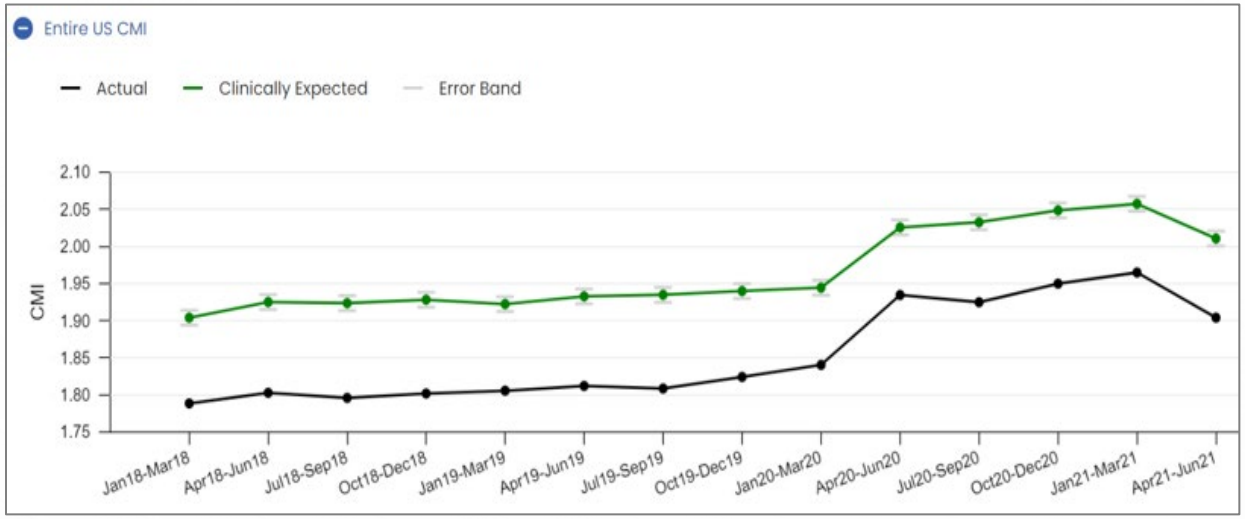

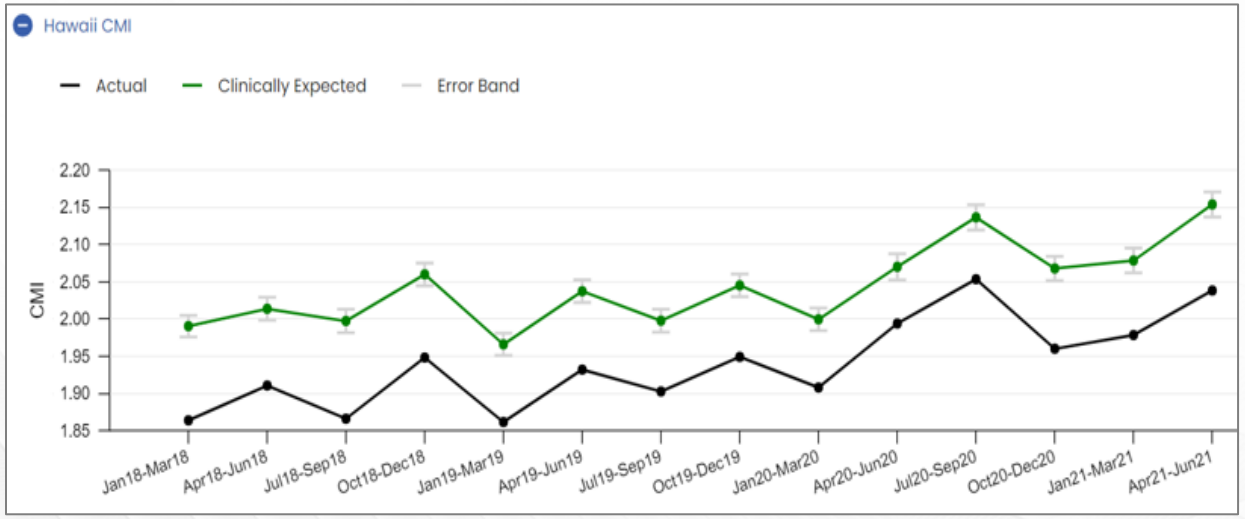

- What does the post COVID-19 CMI look like?
- Fluctuations in actual CMI can be driven by patient mix (DRG mix) volatility, even when performing optimally on severity reporting (CC/MCC reporting)
- Measuring CMI trends can be helpful, but in isolation can be misleading as a representation of severity reporting

Hawaii Clinical Conditions (Gaps affecting CMI)

Medicare discharges only, OB DRGs excluded

US Conditions with largest Documentation Gaps

Type	Clinical Condition	Jul20-Jun21	Clinically Expected	Gap vs CE
DRG	Staged Chronic Kidney Disease	15%	36%	21%
DRG	Malnutrition, mild, moderate and severe	11%	29%	18%
DRG	Acute Heart Failure	12%	19%	7%
DRG	Acute Respiratory Failure	19%	35%	16%
DRG	Heart Failure	30%	44%	14%
DRG	Severe Malnutrition	5%	8%	3%
DRG	Encephalopathy (All)	13%	20%	7%
DRG	AKI With Tubular Necrosis	3%	8%	5%
DRG	Acute Myocardial Infarction	4%	7%	3%
DRG	Quadriplegia	1%	3%	2%
DRG	Severe Sepsis	3%	6%	3%
DRG	Pneumonia (All)	14%	17%	3%
DRG	Chronic Kidney Disease	27%	32%	5%
DRG	Severe Brain Conditions	2%	3%	1%
DRG	Specified Nontraumatic Cerebral Hemorrhage	1%	2%	1%
DRG	Severe Pressure Ulcers	1%	3%	2%
DRG	Specified Shock	5%	8%	3%
DRG	Drug Induced Pancytopenia	1%	1%	0%
DRG	Sepsis, Severe Sepsis and Septic Shock	3%	5%	2%
DRG	Specified Encephalopathy	11%	13%	2%

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DRG	Specified Shock	6%	9%	3%
DRG	Drug Induced Pancytopenia	1%	1%	0%
DRG	Acute Pancreatitis	1%	1%	0%
DRG	Quadriplegia	2%	3%	1%
DRG	Severe Pressure Ulcers	1%	4%	3%
DRG	Sepsis, Severe Sepsis and Septic Shock	3%	5%	2%

Hawaii Clinical Conditions (Largest Gaps)

Medicare discharges only, OB DRGs excluded

US Conditions with largest Documentation Gaps

Type	Clinical Condition	Jul20-Jun21	Clinically Expected	Gap vs CE
EX	Metastatic cancer	4%	17%	13%
EX	Congestive heart failure	29%	40%	11%
EX	Weight loss	9%	17%	8%
EX	Renal failure, moderate	19%	25%	6%
DRG	Staged Chronic Kidney Disease	15%	36%	21%
EX	Dementia	13%	23%	10%
EX	Solid tumor without metastasis, malignant	6%	11%	5%
EX	Deficiency anemias	25%	35%	10%
EX	Coagulopthy	9%	15%	6%
DRG	Malnutrition, mild, moderate and severe	11%	29%	18%
EX	Cerebrovascular disease, paralytic sequela	0%	8%	8%
EX	Drug abuse	2%	7%	5%
EX	Depression	15%	29%	14%
DRG	Acute Heart Failure	12%	19%	7%
DRG	Acute Respiratory Failure	19%	35%	16%
EX	Pulmonary circulation disorders	7%	12%	5%
DRG	Heart Failure	30%	44%	14%
EX	Psychoses	5%	9%	4%
EX	Liver disease, mild	6%	9%	3%
EX	Cerebrovascular disease, on admission	2%	6%	4%
DRG	Severe Malnutrition	5%	8%	3%

Hawaii Conditions with largest Documentation Gaps

Type	Clinical Condition	Jul20-Jun21	Clinically Expected	Gap vs CE
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EX	Depression	6%	28%	22%
EX	Dementia	15%	24%	9%
EX	Solid tumor without metastasis, malignant	8%	12%	4%
EX	Cerebrovascular disease, paralytic sequela	0%	8%	8%
DRG	Heart Failure	27%	44%	17%
EX	Chronic pulmonary disease	20%	25%	5%
EX	Psychoses	3%	8%	5%
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EX	Pulmonary circulation disorders	6%	12%	6%
EX	Coagulopthy	12%	15%	3%
DRG	Acute Heart Failure	12%	19%	7%
EX	Seizures and epilepsy	3%	7%	4%
EX	Cerebrovascular disease, on admission	2%	6%	4%

Your Guides

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