

Tines on the Same Fork: Supporting Physician Engagement in Ambulatory CDI Through a Dyad Partnership

Purvi K. Shah, MD

Medical Director, Population Health – Complexity Capture and Post-acute Care
NorthShore University Health System
Evanston, IL

Sarah J. Hartley, MHA, RHIA, CDEO, CRC

Director, Ambulatory Risk Adjustment and Clinical Documentation Integrity
Northshore University Health System
Skokie, IL

Presented By



- **Purvi K. Shah, MD**, is a primary care internist and medical director, population health – complexity capture and post-acute care at NorthShore University Health System in Evanston, Illinois. Her focus is on improving complete and accurate documentation in the ambulatory setting and improving transitions across the continuum of patient care while ensuring appropriate use of post-acute services. She is passionate about improving quality without increasing clinician workload. Shah attended Vanderbilt University School of Medicine and completed her internal medicine residency at Northwestern University prior to joining the professional staff at NorthShore University Health System in 2009. She is a member of the ACPA CDI Committee and ACDIS Leadership Council.

Presented By



- **Sarah J. Hartley, MHA, RHIA, CDEO, CRC**, is the director of ambulatory risk adjustment CDI at NorthShore University Health System in Evanston, Illinois. Hartley has more than 22 years of experience in healthcare and has served in roles such as HIM director, inpatient and outpatient CDI director, and coding director. She has also been an adjunct instructor within the HIT/HIM department at her local community college and Fisher College in Boston, Massachusetts for the last 10 years. During her career, she has been responsible for initiating CDI programs in both the inpatient and outpatient settings, developing education, provider engagement facilitating the ambulatory CDI efforts through multi-discipline collaboration to improve the quality and completeness of documentation and hierarchical condition category (HCC) coding.

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Learning Objectives

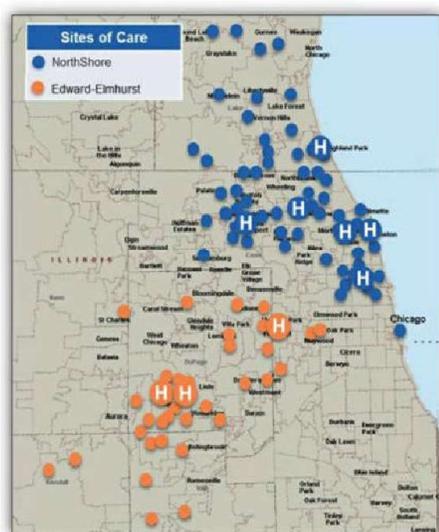
- At the completion of this educational activity, the learner will be able to:
 - Define the key roles and responsibilities of members in a dyad model for ambulatory CDI
 - Describe the role of each member of the dyad in physician engagement strategies specific to ambulatory documentation integrity efforts
 - Identify strategies to “cross train” each member of the dyad to have maximum impact
 - Describe strategies to strengthen the working relationship between different members of the dyad
 - Describe strategies to break down barriers between leadership, physicians, and CDI professionals

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Overview

- Who we are and what we're solving for
- A brief review of HCCs
- Why a dyad model?
- How does a dyad work in ambulatory CDI?
- What can a dyad model tackle?
 - Ambulatory CDI process
 - Audit-based education
 - Specialty reporting and education
 - Diagnosis and documentation education
 - Tool development
 - Behind the scenes support
 - Work queues
 - Artificial intelligence

NorthShore – Edward-Elmhurst Health



NorthShore
University HealthSystem

6 HOSPITALS

1,630 BEDS

77,000
ADMISSIONS

17,000
TEAM MEMBERS

3,720
PHYSICIANS

~ 1350
Employed
Physicians

\$205M
CHARITABLE
CARE & SERVICES

Healthy Driven
Edward-Elmhurst
HEALTH

3 HOSPITALS
2 - Full Service
1 - Behavioral Health

737 BEDS

44,000
ADMISSIONS

7,700
TEAM MEMBERS

1,900
PHYSICIANS

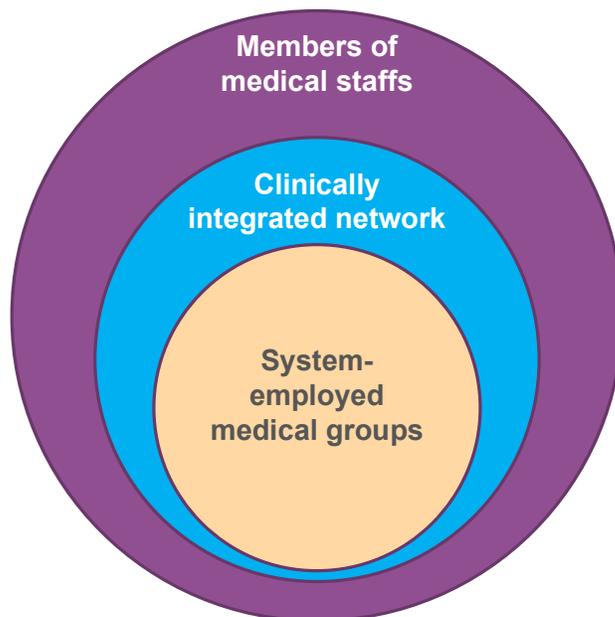
~ 350
Employed
Physicians

\$123M
COMMUNITY
BENEFIT (2020)

FORWARD TOGETHER.

NorthShore | Edward-Elmhurst
HEALTH

Physician Enterprise: Interrelationships and Opportunities for Growth



Physician Enterprise Strategy Will Meaningfully Drive System Goals



The Basics of HCCs...

- CMS measures illness severity by **HCCs**
- Must be **documented every calendar year, during a face-to-face visit.**
- A payer can only “see” the complexity of our patients by **HCC diagnoses** on a claim → risk adjustment factor (RAF) score
- This is a reflection of the **quality** of care we provide

If a condition is **H**appening **C**urrently or **C**hronically, include it as a visit diagnosis and document on it!

Monitor

- Signs & symptoms
- Disease progression and/or status
- Diagnostic tests ordered/performed

Evaluate

- Response to treatment(s)
- Test results & diagnostic conclusions

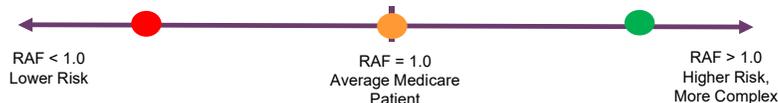
Assess

- Statement of definitive diagnosis
- Intervention taken
- Referrals to specialist
- Counseling, education, discussion provided to patient

Treat

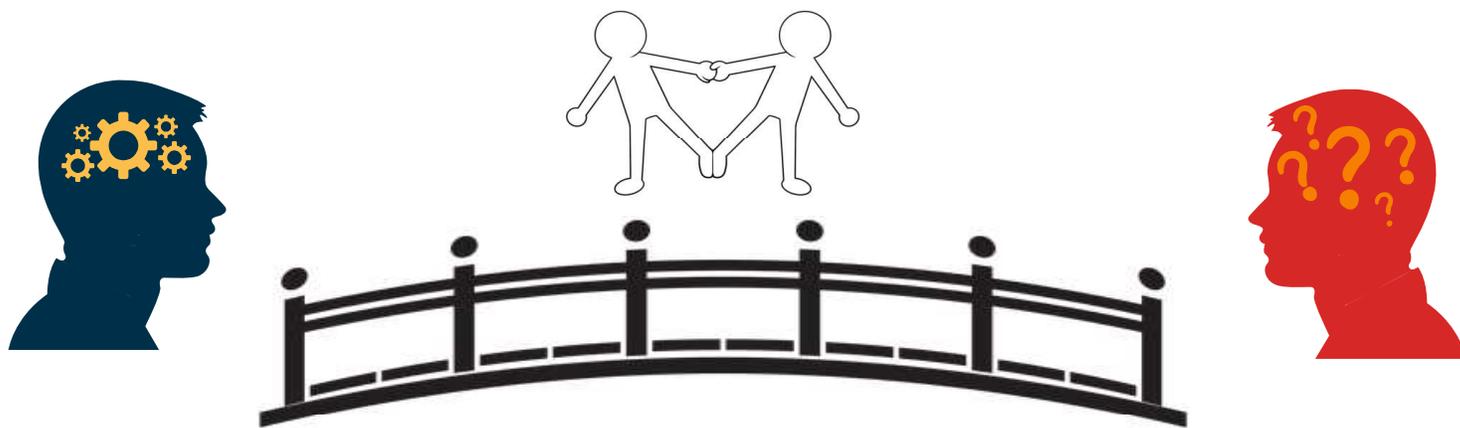
- Medications
- Therapies
- Diagnostic/therapeutic plan

- The average Medicare patient has an average RAF score of 1.0
- RAF scores below 1.0 are indicative of a lower risk patient
- RAF scores above 1.0 are indicative of a higher risk/more complex patient

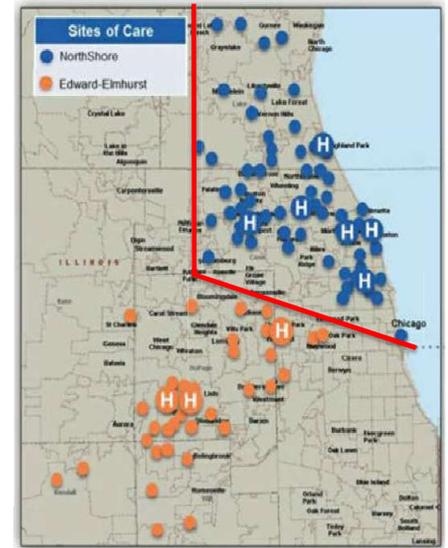
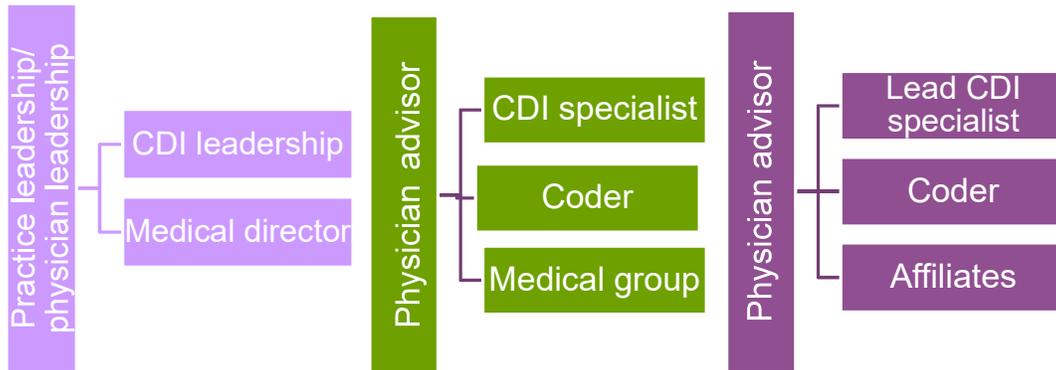


Bridging the Gap

Coding guidelines do not always align with clinical practice



Dyad Structure



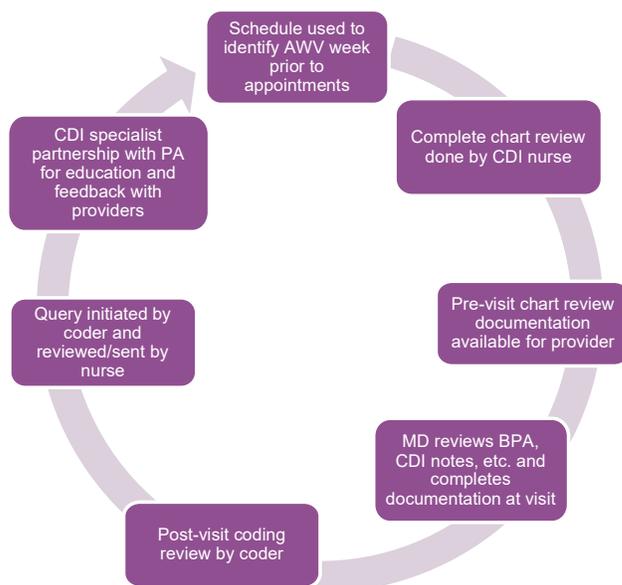
The Brains Behind the Dyad



The Details Behind the Work



Ambulatory Clinical Documentation Integrity Workflow



- Office-based CDI process:
 - Start in primary care
 - Aim is to increase number of accurately captured HCCs and documentation
 - Pre-visit query
 - Post-visit query
 - Attend monthly business meetings (Dyad)
 - Share practice level, pilot-specific scorecards
 - Share information re: documentation opportunities and education
 - Work with physicians on workflows or using Epic tools
 - CDI specialist provides clinical support in the reviews and feedback from coding
 - Weekly Dyad Meetings with coders/CDI specialists
 - Discuss coding topics, documentation tips, audit results

Dyad Support

Legacy medical group/Employed providers	New medical group/providers	Specialty Providers	Affiliates
<p>Central</p> <ul style="list-style-type: none"> Practices <ul style="list-style-type: none"> Three offices 20 providers ~5k lives Dyad <ul style="list-style-type: none"> CDI specialist/nurse, CRC coder, and physician advisor <p>North</p> <ul style="list-style-type: none"> Practices <ul style="list-style-type: none"> Four offices 24 providers ~9k lives Dyad <ul style="list-style-type: none"> CDI specialist/nurse, CRC coder, and physician advisor <p>East</p> <ul style="list-style-type: none"> Practices <ul style="list-style-type: none"> Four offices 36 providers 12,182 lives Dyad <ul style="list-style-type: none"> CDI specialist nurse, CRC coder, and physician advisor 	<p>New medical group</p> <ul style="list-style-type: none"> Practices <ul style="list-style-type: none"> 18 offices 60 providers ~2k lives Dyad <ul style="list-style-type: none"> CDI specialist/nurse, CRC coder, and physician advisor 	<p>NSMG and SMG specialists</p> <ul style="list-style-type: none"> Practices <ul style="list-style-type: none"> By specialty Dyad <ul style="list-style-type: none"> CRC coder and physician advisor (cardiologist) 	<p>Affiliates</p> <ul style="list-style-type: none"> Practices <ul style="list-style-type: none"> 17 providers 1,989 lives Dyad <ul style="list-style-type: none"> CDI specialist/nurse, CRC coder, and physician advisor

CDI Assessment Form in Epic

- All CDI process tools interact with HCC BPA
 - No workflow changes needed
- Suggested diagnoses populate BPA for clinician review and inclusion
- CDI notes reflect problem list cleanup and support medical decision making

Hcc, Six D.
 Female, 70YO, 10/11/1952
 MRN: 540000810
 CSN: 324009069
 Code: Not on file (no ACP docs)
 NorthShoreConnect: Pending
 CONFIRM HCC's - Gap: 1.442

COVID-19 Vaccine: Unknown
 Isolation: None

Drexler, Mark A., MD
 Ref Provider (PCP)

Allergies: **Not on File**

Delay NSC Result: None

PRIMARY CVG
 Medicare Part A & B/Medicare P...

Behavioral Health Story

DAILY MEED
 None

Next Imm Due: 10/11/1958
 Next Appt: 02/06/2023
 Travel Screening-Risk Response:
 <restricted>

2/6/2023 ESTABLISHED VISIT
 No vital signs recorded for this encounter.

LAST 3YR
 FM, IM
 Imaging (1)

HM ALERTS
 HCV Screen

Welcome to the Pre-Charting workspace, where you can get a head start on your work for this visit! This screen shows your full toolset. Here are some other helpful tips:

- Any notes that you write before the patient checks in are accessible to only you and other clinicians who work in the same department.
- Any notes or orders that you don't sign, and communications that you don't send, are deleted by the system system deletes them and copy those notes forward to a visit within that time frame.
- Any orders that you sign are carried out regardless of whether the patient arrives for the scheduled appointment.

Med Management **BestPractice** Patient Instructions
 evaluation, or treatment.

Lymphoma in remission (CMS-HCC) Assessment & Plan Note Search
 Add Visit Diagnosis Do Not Add Resolve Problem
 ✓ Lymphoma in remission (CMS-HCC) is already on the Problem List

Rheumatoid arthritis (CMS-HCC) Assessment & Plan Note Search
 Add Visit Diagnosis Do Not Add Resolve Problem
 ✓ Rheumatoid arthritis (CMS-HCC) is already on the Problem List

Hydrocephalus (CMS-HCC) Assessment & Plan Note Search
 Add Visit Diagnosis Do Not Add Resolve Problem
 ✓ Hydrocephalus (CMS-HCC) is already on the Problem List

CDI Suggested Dx **Thrombocytopenia (CMS-HCC)** Assessment & Plan Note

Reason for suggestion:
 Labs 11/30/2022 platelets of 130. In your clinical opinion is there a diagnosis related to those findings?
 Source:
 From Internal Review, noted Dec 02, 2022

Other (2)
 HCV Antibody Screening

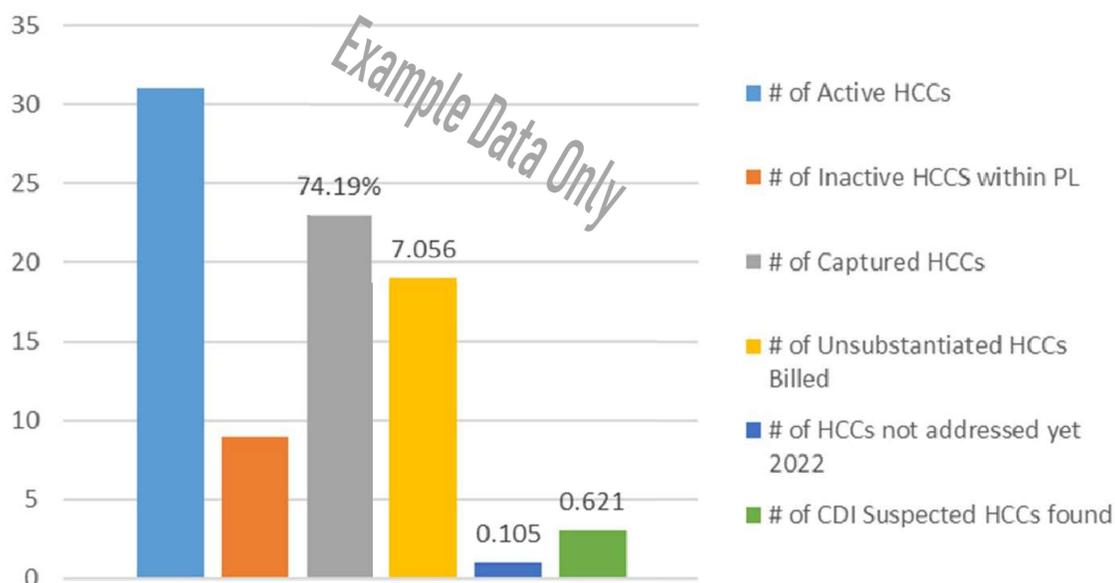
Audit-based Education

Coding audits give a sense of which practices need additional education

Comprehensive audits done by CDI specialists (10 charts per clinician)

Presented by CDI team, then physician advisors share individual results with clinicians

Audits Demonstrate Opportunities for Documentation Improvement



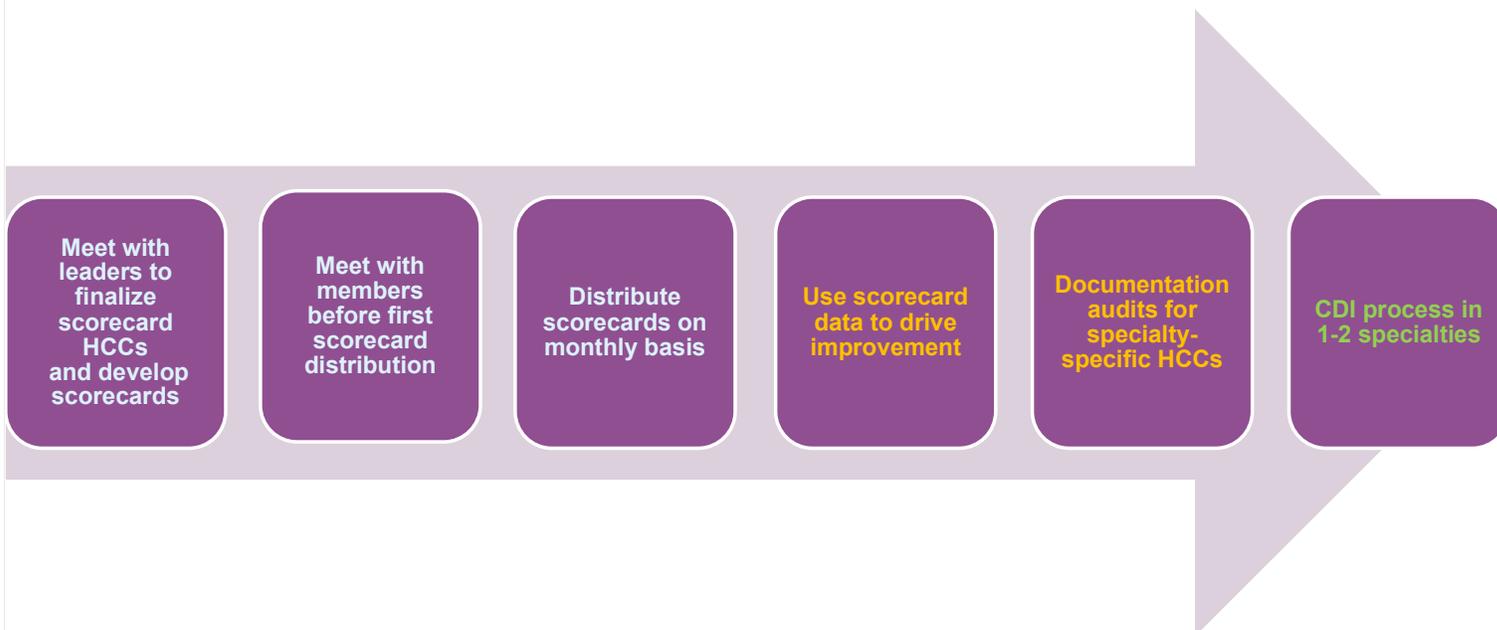
Specialty Reporting and Education

- Focus the effort of specialists into coding and documenting on HCCs they manage in their daily practices
- In addition to specialty-specific HCCs, specialists are expected to address:
 - Group 22: Morbid obesity
 - Group 21: Protein-calorie malnutrition
 - Group 18: Diabetes without complications
- Most large specialties have specific targeted groups of HCCs they are expected to address

Specialty Reporting and Education

- Phased rollout of reports, based on impact on RAF score:
- Divisions with specialty-specific reports:
 - Cardiology
 - Neurology
 - Hematology-oncology
 - Gastroenterology
 - Orthopedics
 - Ophthalmology
 - Pulmonary
 - Endocrinology
 - Rheumatology
 - General surgery
 - Surgical oncology
 - Neurosurgery
 - Infectious disease
 - Dermatology
 - Cardiothoracic surgery
 - Vascular surgery

Specialty Reporting and Education



Specialty Reporting and Education

Ophthalmology	Heme-Onc	Gastroenterology
<ul style="list-style-type: none"> 18 Diabetes w/ chronic complications 40 Rheumatoid arthritis and inflammatory connective tissue disease 122 Proliferative DM retinopathy and vitreous hemorrhage 124 Exudative macular degeneration 	<ul style="list-style-type: none"> 8 Metastatic cancer and acute leukemia 9 Lung and other severe cancers 10 Lymphoma and other cancers 11 Colorectal, bladder, and other cancers 12 Breast, prostate, and other cancers and tumors 46 Severe hematological disorders 47 Disorders of immunity 48 Coagulation defects and other specified hematological disorders 	<ul style="list-style-type: none"> 6 Opportunistic infections 11 Colorectal, bladder, and other cancers 27 End-stage liver disease 28 Cirrhosis of liver 29 Chronic hepatitis 34 Chronic pancreatitis 35 Inflammatory bowel disease 34 Chronic pancreatitis 188 Artificial openings for feeding or elimination

Tips of the Month

- Topics selected at system level in HCC collaborative
- Co-developed by ambulatory CDI team and physician advisor
- Sent out systemwide
- Live monthly session

HCC 134, 135, 136, 137, & 138 CKD Stage 3 to ESRD, AKI & Dialysis Status

Relevant Clinical Data:

Diagnosis	GFR	ICD10 Code
CKD stage 3, unspecified	30-59	N18.30
CKD stage 3a	45-59	N18.31
CKD stage 3b	30-44	N18.32
CKD stage 4	12-29	N18.4
CKD stage 5	<15	N18.5
ESRD (CKD stage 5 requiring Dialysis)	<15	N18.6
Acute Kidney failure/injury unspecified	Abrupt decrease in kidney function – do not continue to capture once GFR is at baseline	N17.9
Dialysis Status	Must be captured every year that patient is on HD or PD	Z99.2

**** TIP: If there is a sudden drop in GFR without 3 months of sustained decrease: Instead of changing CKD staging, consider documenting and coding AKI until the GFR returns to baseline or there are 3 months of sustained decrease for new CKD staging.****

Documentation MEAT Criteria:

Staging

Documentation should always specify CKD staging. Without staging, no HCC can be captured.

Staging CKD requires 3 months of sustained decreased GFR. For patients with varying GFR, use CKD stage that corresponds with most recent GFR.

Etiology of CKD

- Endocrine
- Renal
- Cardiac/Hypertension
- Autoimmune
- Oncologic
- Medication induced
- Multifactorial

Plan/Management

- Refer to Nephrology
- Avoid NSAIDs
- Control Hypertension/Diabetes



Examples of Documentation:

N18.32 Stage 3b chronic kidney disease

GFR has been decreased consistently in last 9 months. Most recent GFR 39. Will give referral to nephrology. Instructed to avoid NSAIDs and monitor BP. Will schedule f/u visit after nephrology consult.

N18.6 + Z99.2 ESRD on dialysis

Managed by nephrology. Continues hemodialysis 3x weekly (M/W/F schedule). No issues with fistula. Compliant with diet and medications.

N17.9 AKI

Creatinine/GFR still not at baseline per recent labs but improving. Patient avoiding NSAIDs and has adequate fluid intake. Will repeat renal function labs in two weeks. Will f/u when results available.

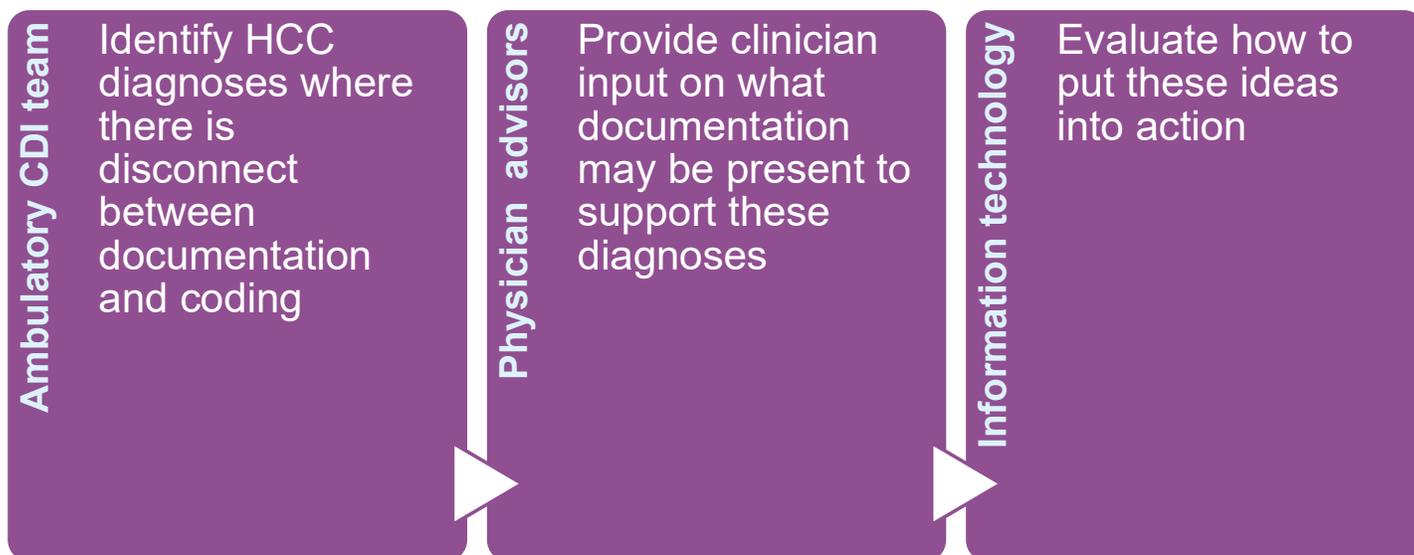
Documentation Tools

- Dot phrases
 - Co-developed between Physician Advisor team and aCDI team
 - Make it easy for clinicians to document on HCC diagnoses
 - Obesity with comorbidities
 - Diabetes with complications
 - CKD
 - Malnutrition
 - COPD
 - Depression

Work Queues

- Behind the scenes coding work to help clinicians get credit for the diagnoses they are managing and the visits where this work is occurring
 - Morbid obesity
 - Diabetes
 - Annual Wellness Visits → paired with query process and Physician Advisor support

Artificial Intelligence and HCCs



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Summary

- A dyad model is key to successful engagement in ambulatory CDI
- An ambulatory CDI process, education, and documentation tools are all more successful with physician advisor and CDI minds working together

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Thank you. Questions?

PShah3@northshore.org, SHartley@northshore.org

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