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CDI IN BLOOM | **acdis 2023**

**MAY 8–11, 2023**



## How to Get the C-Suite to Work for You

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## Presented By

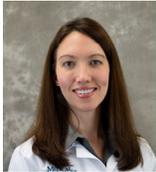


- **Julie Kolinski, MD, CHCQM-PHYADV**, is a physician advisor for Froedtert Hospital in Milwaukee and an associate professor at the Medical College of Wisconsin. She practices as an internal medicine and pediatric hospitalist. As a physician advisor, she helps oversee utilization management, denials, and CDI. In 2021, she became the enterprise associate chief quality and patient safety officer, focusing on patient safety and the mortality review process, clinical standardization/stewardship, and transitions of care.

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## Presented By



- **Carrie Alme, MD**, is a physician advisor for Froedtert Hospital in Milwaukee and an associate professor and internal medicine hospitalist at the Medical College of Wisconsin. She has been a physician advisor for eight years, focusing on utilization review and denials. She continues her 15 years as a hospitalist specializing in advanced heart failure and enjoys advocating for patients.

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## Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
  - Display how to translate utilization review to leadership to guide focus
  - Highlight how to create a business proposal that allows for CDI expansion
  - Discuss how, through internal processes and data tracking, you can work on the ultimate goal of contract improvements

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## Observation, Inpatient: What Does It All Mean?

- C-suite leaders are often under the impression that
  - Status is something we "control"
    - "We need to fix our Observation rate, it is too high!"
    - "What is the industry standard observation rate?"
    - "The patient was in the ICU so how can they be Observation?"
  - Governed 100% by the 48-hour cut-off
  - Status can be manipulated
    - "Just make everyone an inpatient if we get paid more"
    - "Just leave them Obs if they are in the Obs Unit"
    - "Flip them to inpatient, they need to get into an LTACH/Rehab"

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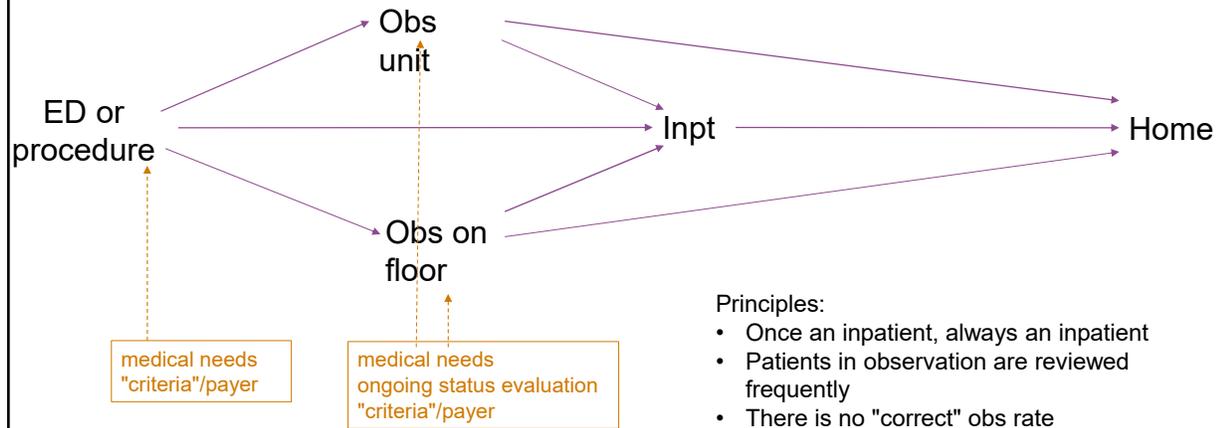
## Observation, Inpatient: What Does It All Mean?

- Status (as you know) is determined by...
  - Medical illness/the community of people you care for
  - Payer criteria (and how each payer/medical director interprets their own criteria)
  - Contractual agreements
  - Length of stay
  - IPO list

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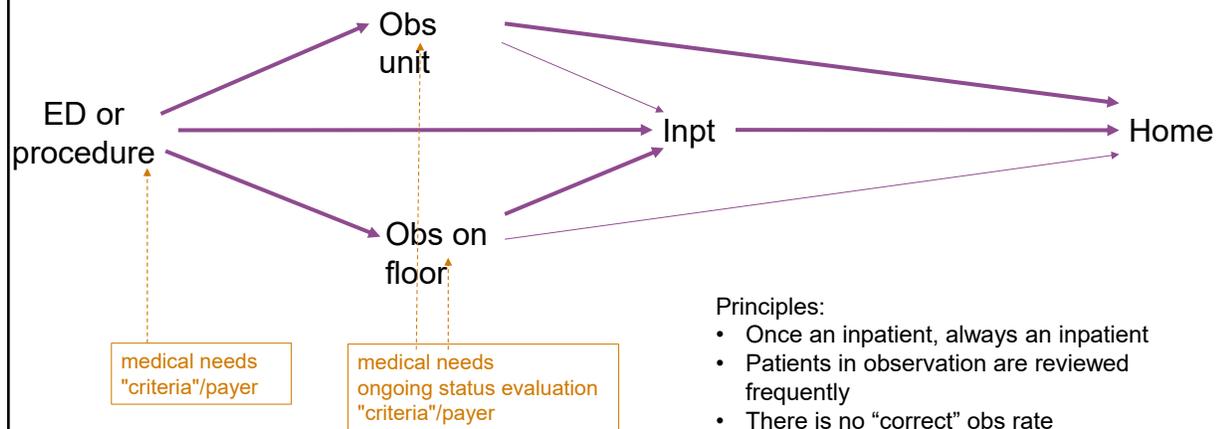
## Pictures Help: KSO Diagram



Principles:

- Once an inpatient, always an inpatient
- Patients in observation are reviewed frequently
- There is no "correct" obs rate

## Pictures Help: KSO Diagram



Principles:

- Once an inpatient, always an inpatient
- Patients in observation are reviewed frequently
- There is no "correct" obs rate
- **Preferred pathways**

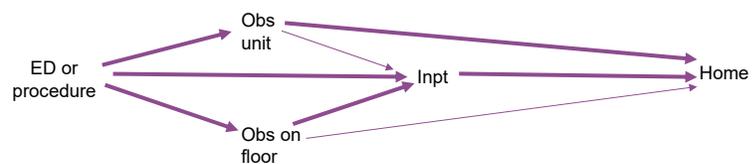
## Use Case: Observation Unit: Good or Bad? Could Be Either!

- What's your goal?
  - Faster throughput?
  - Protocolized care?
  - Staff optimization?
  - Improved standard of care?
  - Resource management?
- How seamlessly do you transfer between units?
- Can any patient go to your Obs unit?
  - RN competencies
  - Specialty cohorting (improving or worsening?)
  - Space restrictions (equipment, regulations, proximity to other departments, tele)
- Bed turnover too frequent?

## Use Case: Observation Unit

- Are the preferred pathways optimized?
- Is your unit near capacity consistently?
- Have you achieved your goals?

If yes, you are set!



## As a Result

- This level of detail will give C-suite leaders the talking points they need to make informed decisions
  - What they do need: Basic info/the why
  - What they do not need: Understanding of payer criteria/denials nuances/exceptions to the 2 MN rule, etc.

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## As a Result

- It will show them your knowledge as a subject matter expert is what they want at the table
  - They understand who you are and what you do
  - They call you with questions
  - Affirmation of the *Conditions of Participation*/regulatory requirements
  - Avoids plans set in motion based on misinformation

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## As a Result

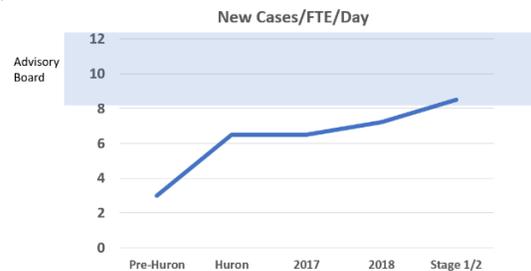
- They can/will back you to get appropriate resources
  - As census grows, your resources need to as well
  - Makes future conversations easier with a shared language
  - Opens the door to other complicated spaces you impact—Denials, DRGs, CDI, contracts, etc.

## CDI Proposal—Business Case to Increase Your Program's FTE

- The big picture is relatively simple: More charts reviewed, more gain
  - To tell the story can be complex: Focus on your audience
    - **Revenue**

## CDI Proposal—Key Aspects of Revenue

- Partner with finance
  - Look at past average CMI increases (by payer)
  - Be realistic
- Use benchmarks
  - But also take the opportunity to tell whole story of CDI impact
    - Quality metrics
    - Physician support
- Be open to a staged approach
  - Orientation takes a long time, be OK with some now and more later
  - Invest in increased efficiency in parallel (if you can)
  - Don't forget physician advisor FTE



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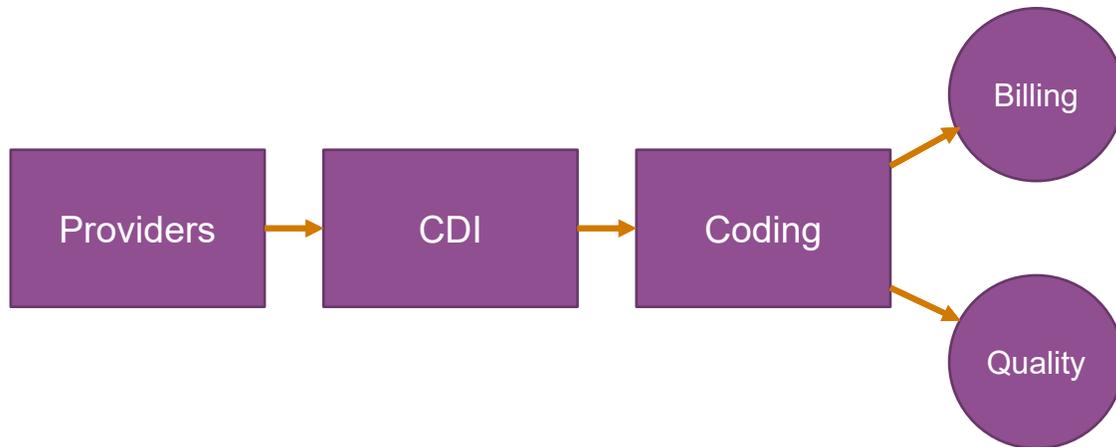
## CDI Proposal—Business Case to Increase Your Program's FTE

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    - **Quality**
    - Physician/APP support

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## Clinical Documentation



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## CDI Proposal—Business Case to Increase Your Program’s FTE

- The big picture is relatively simple: More charts reviewed, more gain
  - To tell the story can be complex: Focus on your audience
    - **Revenue**
    - **Quality**
    - Physician/APP support
- Be realistic & don’t overpromise
  - Declare caution at the onset
    - Diminishing return?

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## CDI Proposal—Key Aspects

- Staged approach

	past 2013	past 2014-2015	2017	2018	Stage 1, proposed	Stage 2, proposed
	<b>1/3 of Medicare</b>					
	All Medicare					
Inpatient concurrent reviews (CDE)			Add largest payer		Other Added payers	
					ALL payers	
New cases/FTE/day						
CDE FTE						
Physician Advisor FTE						
Provider Engagement			Epic	Epic	Epic/Direct	Epic/Direct
Vizient Mortality Reviews			Retrospective-Sporadic	Retrospective-Sporadic	Pro/Retrospective	Pro/Retrospective
Patient Safety Indicators			Passive	Transition	Active-Integrated	Active-Integrated
Projected New Revenue (M)						
New Expense (M) [CDE specialists & Physician Advisor]						

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## C-Suite Buy-In for CDI Expansion

- Comes pretty “easy” when you show a direct financial gain
- However, value to the medical staff and to the CDI specialists themselves has to be more – Show your physicians and APPs the positive impact their work has on quality
  - → Your C-Suite can help perpetuate those values

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## Physician Advisors & Contracting: Stare at Each Other for a While, It's Worth It

- They likely don't know what you do
  - If they haven't heard from you, they assume that what they are negotiating in the contract is going fine (even well!)
  - Even when they do start hearing from you, they don't understand your language
- Relationships speak louder than data
  - For us: This looked like a quarterly meeting
    - Common foes
    - Ideas of "things we always wondered about"
    - Consistent team

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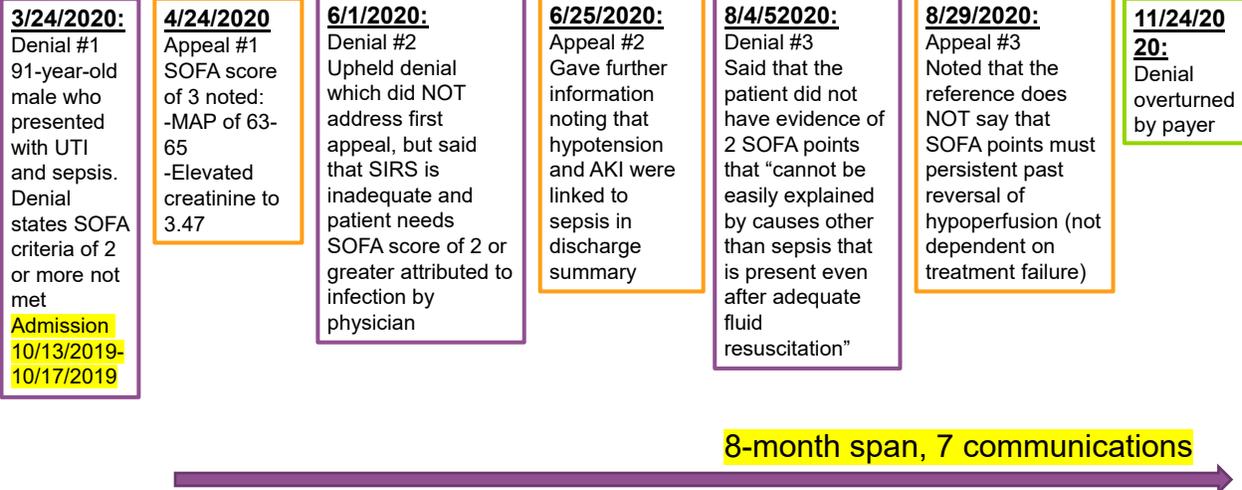
## Re-Explain as You Pivot Between Your Worlds

- Remind them where your role fits
  - Which teams do you work closely with (denials, CDI) and which teams do you not (finance)?
- Denials can feel the same to them
  - Nuances are quickly lost if not careful
  - The clinical words don't feel as relatable
  - Use timelines (highlighting administrative burden) instead
- They want to understand
  - Payer misbehavior is something they can use

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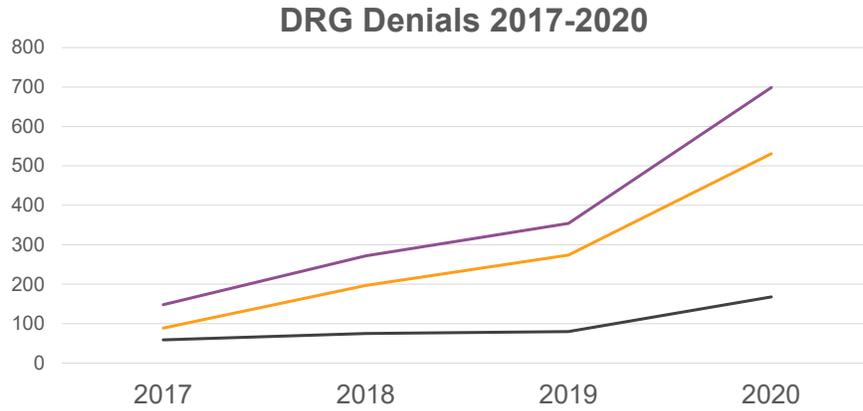
## Case Example for Contracting: Sepsis DRG Denial



## But Then Do Have Data

- Tailor your current conversation to what they are ready to hear
  - Contracts coming due for negotiation
  - Difficult payers (to them and likely to you too)
- Highlight your processes that are consistent
  - Trends
  - One-offs
- Poke holes in your numbers before you get in front of them
  - Higher volume because of a higher volume of payer discharges?
  - Different product lines within the same payer?

## Trends Can Be Simple



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## (All Numbers Made Up)

Single Payer (All Product Lines)	Percent of Total Hospitalized Patients	Percent of Hospitalized Patients Eligible for a DRG Denial*	Percent of Total DRG Denials Received	Percent of Available Cases Denied (Single Payer Denials/Total Single Payer Patients)
2019	27%	44%	77%	3.5%
2020	28%	45%	79%	<b>6.4%</b>

Payer Second Biggest	2019	1.1%
	2020	2%

Payer Third Biggest	2019	1.5%
	2020	2.5%

\*Hospitalized patients excluding Medicare A/B, Medicaid, Self-Pay

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## Hang in There

- Recognize your thoughtful highlight of payer misbehavior may not translate into change for you and your team
  - Negotiating power
  - Keep developing the storyline
  - Play the long game
- Chances are, you'll start hearing from them instead of the other way around!
  - Builds your Contracting-Physician Advisor relationship
  - Elevates your position with the rest of the C-Suite
  - Stronger position with your payers

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## Summary

1. Give leaders the building blocks of utilization review understanding
2. Teach them that CDI is more than just about the money (but still speak money)
3. Contracting is the ultimate partner but takes investment

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## Thank you. Questions?

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