PASSION FOR MEASURING WHAT MATTERS

Dr. Vinik’s Case Study | By Chrissy Daniels, MS, Mari Ransco, MA, Russell Vinik, MD, Michelle Knuckles, RHIT

THE PROBLEM

Accurate clinical documentation is the engine of how hospitals get paid and the fuel of external benchmarking. Yet, many physicians treat it as bureaucratic burden. In October 2015, clinical documentation will become even more complicated with the implementation of ICD-10. Changing the documentation behavior of hundreds of physicians feels like a staggering challenge.

BIG IDEA: In the world of value-based health care, accurate and complete documentation is essential. Through a physician champion and support team, University of Utah engaged physicians in a continuous system of improvement by creating clear understanding of the measure, leveraging patient level data to identify opportunities and transforming a consistent flow of data into feedback.

Background

Physicians document and then coders translate the documentation into buckets of patient care and complexity—the codes. Codes are used by payers for reimbursement, as well as for online ratings. External organizations, such as US News and World Report, rank hospitals against their peers using outcomes on some of the thousands of codes. These external organizations prompt the public to judge the quality of healthcare.

Physicians at the University of Utah have long prided themselves as the last stop for the most ill or injured patients in the region, yet often the acuity of patients was not reflected in the outcomes listed on external benchmarking sites. For years, physicians had said that the rating data was inaccurate and did not represent what patients or faculty could expect while at the hospital.

In 2007, the hospital developed a team, called Clinical Documentation Integrity (CDI), to audit physician documentation. The CDI team would send about 100 of these notes every month to physicians, and generate $200,000 in revenue by assigning more specific codes. While the team was successful, physicians would change their documentation for individual patients instead of changing their long term charting behavior. The CDI team needed a physician champion.

The Leader

Dr. Russell Vinik, a hospitalist, had chaired the medical records committee. By 2011 he had championed the huge cultural and organizational shift from paper to a largely electronic medical record. As 2011 drew to a close, ICD-10 loomed as a major risk. He agreed to take on a physician champion role in that effort as well.
felt energized by the challenge to make coding more accessible to physicians, and at the same time, help the coding teams understand the physicians. Vinik felt that coding was a “huge, untapped void,” and that he could help fill that void.

**THE SOLUTION**

**Step 1: Understand Context**

After learning more about coding, Vinik realized that improvement was not about more documentation, but about the right documentation. Physicians would need to make extra effort. Hospital revenue was not a big enough carrot, and questioning medical staff privileges not a big enough stick to provoke sustained behavior change. Physicians would need to share the vision in order to change.

Vinik’s message was simple. Every physician cared about the quality of their respective patient care. Vinik set out to convince physicians that the published outcomes were indeed within their control through more accurate documentation. He went on the road, sharing the message at department and division meetings.

Learn about “Shock” to put coding in context, page 5.

**Step 2: Focused improvement**

Next, Vinik wanted to make it easier for physicians to document. It was not a matter of increasing documentation for all patients. Documentation needed to be improved for specific patients with specific conditions. Vinik helped break down the complexity of 14,000 codes by creating custom lists for each department. He organized around the common clinical conditions, and then gave each department a top ten list of codes used. Vinik also offered education around diagnostic criteria for each of the codes. Physicians could be more successful simply by knowing the handful of codes that applied to their patients.

**Step 3: Early wins**

The hospitalist team made the decision to focus on coding as a group. Because of the collective efforts, they saw improvement in their reported observed/expected mortality. The Group’s case mix index (CMI) increased by 11% in 1 year. Dr. Nathan Wanner, a CDI Physician Advisor and Director of the Hospitalist Group, made a deliberate effort to set an example. Through improved documentation, his CMI increased by 20% over the same time period. Leveraging their success let Vinik send the message: improvement was possible.

Learn about the importance of short-term wins, page 5.

**Step 4: Increase Data, Increase Feedback**
The inefficiency of the coding queries remained a nagging concern for Vinik. The CDI team would spend hours combing through the haystack of patient charts, looking for the needles where physician documentation could be more specific. On average, coders spent 16 hours searching for each query. Luckily, Vinik and the coding teams had patient-level data. The University of Utah had transitioned to an electronic medical record in the inpatient setting. The data was there, but Vinik needed to access it more easily. The University’s data warehouse had designed a new language-processing application for use in research. Together with Vinik’s leadership, the team developed “Warthog”, a coding specific application.

Instead of starting with the diagnosis and looking for the outliers, Warthog focused their efforts on the outliers directly. The team started with a few key diagnoses, and then would identify tests or medications for that condition to determine if the patient had the right documentation. This process turned out to be wildly successful.

**Step 4: Aligning the team**

With a new application in hand, Vinik approached the CDI team to spread the improvement throughout the system. He spent months educating the CDI team, mostly discussing why the change was necessary and how it would benefit external benchmarking. With these changes, the team’s workflow improved dramatically. Instead of 100 queries per month, the team was at 600. Average revenue grew to $2,300 per query, and the case mix index increased to 10%.

Quickly, the system improved. The team generated four times the amount of coding queries to physicians, from 100 queries per month to 400 to 500 queries. They averaged a $500,000-$750,000 in new revenue each month. In March 2014, the team hit $1.1 million.

**Step 5: Transforming Data into Wisdom**

Vinik saw that if designed appropriately, the coding queries could be a teaching tool. His goal was that comorbidity capture and CMI would be stable, and eventually the number of queries would decline. In order for this to happen, providers would need to transform the data and information requested through the queries into knowledge - and then apply that knowledge consistently. He and several colleagues spent time refining the queries and providing the accurate medical criteria for diagnosis. Problem lists were modified and streamlined quickly as physicians identified them.

**THE REFLECTION**

ICD-10 will become mandatory in October 2015. Vinik has changed organizational culture not through carrots or sticks, but through collaborative partnership. He says “We are ready. It doesn’t matter what system we use. We care about clinical documentation. As a health system we actually care about coding now.”
Key success factors have included the following:

1. A physician champion who understands the measures deeply and can connect them meaningfully to outcomes that matter.
2. Shared goal of accurately documenting complexity of care
3. Leveraging technology to increase the number and frequency of variation
4. Focusing interventions based on patient centered priorities
5. Hardwiring process changes through EMR workflow
6. Regular performance feedback.

Learn about measurement as a "Virtuous Cycle" on page 6.
Coding In Context: “Shock”

For example, patients in shock did not often receive the accurate code. Coders knew patients in shock often receive vasopressors, powerful drugs that increase blood pressure. Warthog searched for any patient prescribed vasopressors. In a seven month period, there were over 500 patients who were prescribed vasopressors but not coded for shock. Vinik remembers “This felt like a major breakthrough. We found 30 patients who were on vasopressors and already had documentation for shock which had been overlooked, and that meant $500,000 in revenue.” The rest of the patients on vasopressors probably were in shock, but needed improvement in their documentation, so there was a lot of opportunity for the new tool.

On the Importance of Short Term Wins

“Real transformation takes time, and a renewal effort risks losing momentum if there are no short-term goals to meet and celebrate. Most people won’t go on the long march unless they see compelling evidence in 12 to 24 months that the journey is producing expected results. Without short-term wins, too many people give up or actively join the ranks of those people who have been resisting change.”

Kotter – Vision, Break Down, Quick Wins, Spread “Leading Change” HBR

The Data Information Knowledge Wisdom Model

The “Virtuous Cycle” of Measuring What Matters

Many leaders of providers can pinpoint the moment when they realized that their world was changing; often it came when someone outside the organization started measuring its performance. Although few providers welcome this development, it provides context for a new breed of leaders. . . . The new leaders focus on outcomes and use performance measurement as a motivating tool to organize their colleagues and drive improvements.

The reorganization process starts with articulating the rationale and goals for change. Change is hard in any field, and medicine’s altruistic core values actually reinforce practitioners’ resistance to disturbing the status quo. . . . So the vision expressed by leaders in health care must convey both understanding and resolve. It should acknowledge the importance of what clinicians currently do, but make explicit that they have to work differently in the future. It should be direct about the measures by which they must succeed. And it should be both optimistic and realistic, expressing the beliefs that care can get better and that delivering superior care is the best business strategy. –Thomas H. Lee, “Turning Doctors into Leaders” Harvard Business Review, April 2010