

Clinical Documentation Improvement and its value in **the future of healthcare reform.**

The evolution of the fee-for-service system

Throughout our history, the fee-for-service model has been the overarching mechanism used as payment for healthcare services in the United States. From the early days that included barter, to the current fee-for-service approach, this method of payment has been a consistent theme. The evolution of the fee-for-service system is likely a direct outcome of how medicine has been viewed in the American culture. Paul Starr, in his book “The Social Transformation of American Medicine,” helps us understand more clearly how this system evolved as a direct result of how professional authority was conferred in the United States.¹ Throughout our history, authority for a provider was the result of acquiring the knowledge and skills necessary to provide care. In addition, that knowledge was controlled by the provider, which made access to it something that could be obtained by charging a fee. This is not unlike most professions; yet in healthcare, because of the complexity and the challenges of using that knowledge, the price of this knowledge could be placed at a premium. Over the years systems of payment have evolved, but the underlying premise has remained the same: we pay for knowledge or a procedure performed by those who have been trained to provide that care.

While this may have worked well for decades, the evolution of technology and understanding began to raise the price of care to a level beyond the means of most of our society. This has led to the evolution of third-party payment systems in order to rationalize cost across the population. The unfortunate reality is that the supply and demand curve that moderates a capitalist society fails under this pressure because the provider controls both sides of the equation to some degree. Inevitably because of the realities of both primary and secondary inducible demand (the ability of those with the knowledge to drive more demand/care), we have seen escalations in cost of care rise to levels significantly above most developed countries in the world. Ian Morrison, a futurist, describes in his book “The Second Curve,” how the fee-for-service approach would be considered the quintessential first curve in healthcare delivery; a fee-for-service market controlled by providers who are paid for their knowledge and technical skills.²

Like most first curves, it has worked well and produced significant wealth and technological advances in the U.S. But like most industries, it is typically technology that begins to change the dynamics. We begin to see that the first curve becomes stagnant or too costly, while a second curve that typically hinges on new technology and consumerism begins to develop, promising a new way of doing business. In most business this means a dramatic economic boom if all works well. Examples in non-healthcare industries are many; the move from mainframe computers to networked PCs has been explosive, especially with the overlay of the Internet; mobile technology as a second curve for the traditional landline “Ma Bell” phone services. These transitions were focused very heavily on the consumer and less on the means of production that typically drives the first curve.

In healthcare, high costs of access, consumerism, and transparency are drivers of a move to the second curve, and clearly, technology is the facilitator. Morrison sees the second curve in healthcare being an evolution of the current predominant fee-for-service model, to models that will be value-based. In essence, pay for performance or quality vs. pay for quantity or activity.

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1. Starr, P. (1984). *The Social Transformation of American Medicine: The rise of a sovereign profession and the making of a vast industry.* Basic Books.
2. Morrison, I. (1996). *The Second Curve: How to Command New Technologies, New Consumers and New Markets.* Ballantine Books.

Transitioning to a value-based system

To understand his premise today, almost 20 years after he published “The Second Curve,” we can look at the changing market forces in the current healthcare environment. The focus of the market is moving to value for the consumer using different payment models that incentivize efficiencies, control utilization and waste, all with additional goals of expanded access, transparency, and better quality of care for all. Morrison asserts that like in most businesses the two curves exist simultaneously, so the challenge is always how and when we move to the second curve.

Timing is important because making the move at the right time may mean overwhelming success and growth, or devastating failure if the timing is off. For healthcare, it is an even more difficult transition because of the complex cultural and cost structures built into the current curve. This means that the transition will take years not months, and more importantly because of the significant differences between the two curves, organizations will face a real strategic and operational challenge. For example juggling a current fee-for-service or volume-based system while preparing for a value-based system is a significantly risky endeavor, but one healthcare is beginning to do as we speak.

In 2013, the American Hospital Association validated Morrison’s concepts of the second curve and developed 10 “Must Do’s” through its “Hospitals in the Pursuit of Excellence” (HPOE) initiative.³ It describes what measures must be considered in order for the transition of healthcare in the United States from a volume-based to a value-based system to occur successfully. They prioritized these further and developed specific metrics around the first four Must Do’s. (See Table HPOE Must Do’s).

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3. **Hospitals in Pursuit of Excellence: Second Curve of Healthcare.** (n.d.). Retrieved November 17, 2014, from <http://www.hpoe.org/second-curve.shtml>

HPOE must-do strategies

(Bolded are areas where Nuance can impact)

Strategy one: Aligning hospitals physicians and other care providers across the continuum

- **Percentage of aligned and engaged physicians**
- **Percentage of physician and other clinical provider contracts containing performance and efficiency incentives aligned with ACO-type incentives**
- Availability of non-acute services
- **Distribution of shared savings/performance bonuses/gains to aligned physicians and clinicians**
- Number of covered lives accountable for population health (e.g., ACO/patient-centered medical homes)
- Percentage of clinicians in leadership

Strategy two: Utilizing evidence-based practices to improve quality and patient safety

- **Effective measurement and management of care transitions**
- **Management of utilization variation**
- **Reducing preventable admissions, readmissions, ED visits, complications and mortality**
- Active patient engagement in design and improvement

Strategy three: Improving efficiency through productivity and financial management

- **Expense-per-episode of care**
- **Shared savings, financial gains or risk-bearing arrangements from performance-based contracts**
- **Targeted cost-reduction and risk-management goals**
- **Management to Medicare payment levels**

Strategy four: Developing integrated information systems

- **Integrated data warehouse**
- **Lag time between analysis and availability of results**
- **Understanding of population disease patterns**
- **Use of electronic health information across the continuum of care and community**
- **Real-time information exchange**

For most healthcare organizations, addressing and meeting these four strategies will be a difficult path. The need to begin development of the strategies to move to a value-based system while still living in the fee-for-service volume-based system presents not only challenges but also real risk. Furthermore, emphasis on any one of these without understanding the impact on current financial performance could be financially regressive or even devastating.

Because it is built on volume, the current fee-for-service system carries extremely high levels of direct cost needed to maintain the ability to drive care. Transitioning that direct cost will be a significant challenge and with it, a financial hardship throughout that transition. The cost of maintaining hospital beds in large facilities is a huge burden that is only maintained by the volumes that are inherent in the current care system. But the drawdown of those costs while transitioning care is a challenge that needs multiple approaches. For example, if the average revenue from a single hospital admission were \$10,000 in the current environment, it would require approximately 130 or more office visits to equal the revenue output of one admission. Unfortunately, every CFO knows that reducing that one hospital admission is a real loss because the cost structure does not allow the hospital to reduce costs simultaneously because of the high cost infrastructure of brick-and-mortar and staff to care for all the other patients. In essence, you can't flex staff because of one less patient—in fact, the number needed in reduction of patients, therefore revenue, is significant before any meaningful flex can even occur, so most of the time, the transition represents a real loss.

It's clear that the lopsided loss of revenue with the drawdown of inpatient services in a fee-for-service world could never be matched by an escalation of outpatient volume-based care in a fee-for-service outpatient world. The reality though, is that this is exactly what needs to happen and is happening, except that promise of value-based payments lag, and at this point are not significant enough to fill the gap.

Managing that transition is perilous as long as fee-for-service is the driver of revenue, and value-based changes produce only partial financial benefit, as in Value-based Purchasing with Medicare. For hospitals or health systems to be successful they have to optimize both of these worlds during that transition. The reality of the challenges of juggling both curves is where Nuance's focus on Clinical Documentation Improvement, powered by Nuance's J. A. Thomas & Associates (JATA) clinically based strategies within the Compliant Documentation Management Program (CDMP®), will provide hospitals with a clear partner to navigate the management and transition to the second curve. Beyond Clinical Documentation Improvement is the entire array of Nuance Clintegrity 360 offerings, based on Nuance's advanced speech recognition and natural language processing technologies, the Clinical Language Understanding infrastructure (CLU) improves accuracy and efficiency. CLU-driven solutions including Computer Assisted Physician Documentation (CAPD), Computer Assisted Clinical Documentation Improvement (CACDI), Computer Assisted Coding (CAC), along with a host of best practice support offerings that could be propagated from the CLU. The optimal combination of clinical strategies and automated workflow processes position healthcare organizations to navigate and succeed through the transition.

The most important factor to understand is that Clinical Documentation Improvement can be initiated no matter where a hospital or health system is in its transition between the two curves. CDI provides the best opportunity to optimize the client's position in navigating the two curves. Without a doubt, this is one of the biggest benefits Nuance can provide as a partner in this transition.

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Clinical documentation improvement (CDI)

Clinical Documentation Improvement offers us the largest opportunity to engage health systems and hospitals at any point along their journey between the two curves. Because of the nature of the Nuance Clintegrity 360 CDI solution and the JATA clinical approach to CDI, we are able to engage a hospital that is primarily in a paper world all the way through a fully integrated electronic system of care documentation. This is vital because clinical documentation improvement is one of the largest and most important key factors in transitioning between the two curves. It allows us to optimize not only revenue in the current fee-for-service system, but it begins to develop a much stronger picture of the severity of the population that will need care in value-based payment systems in the second curve. The longer a hospital delays in focusing on this challenge, the further behind they will be in positioning themselves for success in the second curve. This basic building block needs to be a strategic imperative for every hospital and health system in the nation.

It is a strategic imperative for many reasons. First and foremost, it helps an organization decrease the reality that significant variation occurs because of the clinical documentation and coding practices in use in the U.S. The sooner an organization begins its journey to manage that variation, the sooner it will have a better understanding of the population they are caring for, along with optimization of the revenue deserved for the resources being utilized to care for that population. This is vital because of the real delays in the current ability for policymakers to access timely data. Failure to begin this process now will lead to understating the real severity of the population when the transition from fee-for-service to value-based care payments become predominant. Recognition and action is seen all too often through the implementation of Nuance's Clinical Documentation Improvement program and the JATA CDMP® approach.

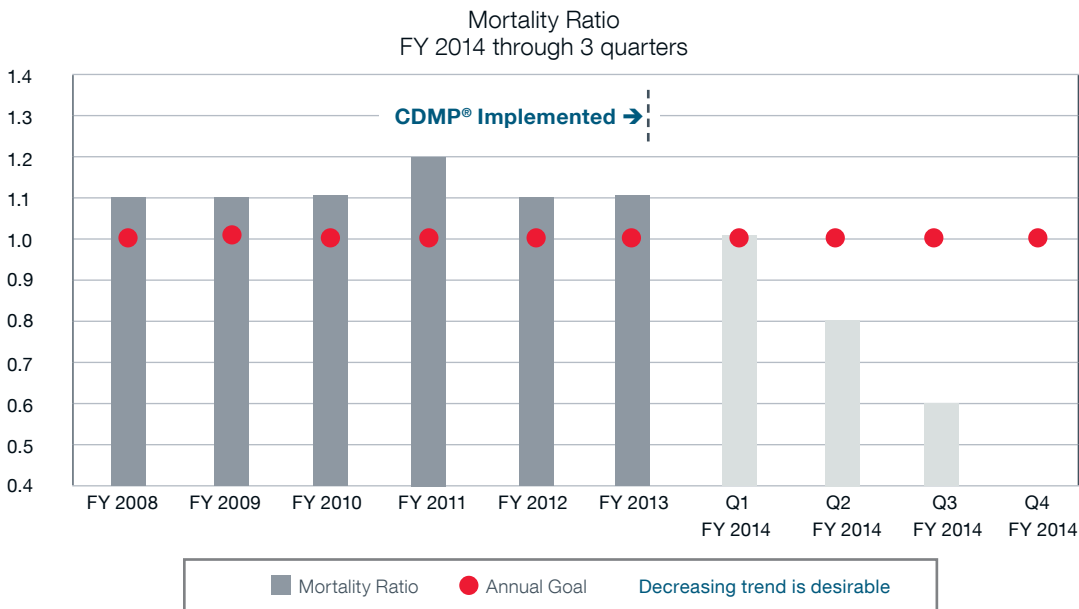
We see a consistent 4 to 8% improvement in Case Mix Index (CMI) with an implementation, even in the presence of an existing CDI program. While that purports tremendous amounts of revenue based on the size and scope of the system, it also means a significant understating of the true population severity of illness that existed prior to the implementation of the CDI program. Both of these are absolutely vital to an organization's success in managing between the two curves. The success of the Nuance CDI solution is due mostly to JATA's clinically based approach to CDI. While most CDI programs use coding software as a base, JATA approaches CDI from the clinical or physician/patient side. By understanding the clinical nature of the patient and the clinical and pathophysiological documentation by the provider, we can guide the physician's documentation through software and trained clinical documentation specialists by establishing a clinical dialogue. The resulting documentation uses the appropriate clinical language relevant to coders, so they can apply the appropriate codes that describe the patient and their illness more accurately.

While the revenue consequences of such a significant change are fairly obvious, the impact on what the severity of the population we care for looks like to the rest of the world is less obvious. What is most important for health systems and hospitals to understand is that the only way anyone outside of your hospital can analyze and evaluate the care they are providing is through billing data. While this has been used in the hospital setting for years to compare hospitals, we are now beginning to see billing data used for comparison on the outpatient and physician office-based practices as well. This is important because any payment initiative being discussed within the world of the second curve has some relation to outcomes either in base payment or in bonus payment/holdbacks for quality outcome performance.

Only a clinical focused CDI program fully engages physicians in a way that optimizes revenue in the fee-for-service system and develops a stronger picture of severity of the population needing care in a value-based payment system.

It is clear that improving clinical documentation and helping providers understand the differences existing between the clinical world and the coding world is imperative to optimizing the understanding of the overall severity level of the population that is being cared for. Whether it be the MS-DRG system or the APR-DRG systems on an inpatient side or Hierarchal Condition Categories (HCC) on the outpatient side, the outcome is the same; if we don't translate clinical documentation appropriately to accurate and compliant codeable documentation, we will understate the severity of the population we care for. This is apparent over and over again through the real outcomes seen when measuring severity-adjusted performance at organizations where Nuance's Clinical Documentation Improvement programs have been implemented using the JATA approach. Some examples of the improved outcome performance secondary to the implementation of the CDI program are shown below.

Clinical Quality

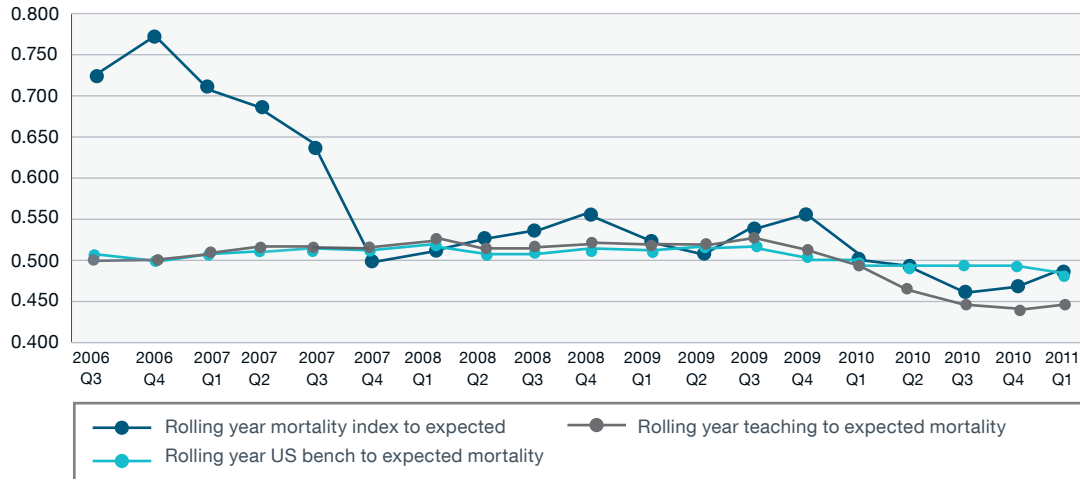


In this case we see that after implementation of a CDI program in the first quarter of fiscal year 2014, the organization experienced a 40% improvement in risk-adjusted mortality over the next three quarters. This is significant both from a reputation standpoint and also in the realities of the pay-for-performance world. More importantly, the fact that the organization's performance was that much better compared to previous years is concerning because there was no change in the care being delivered. However, the rest of the world saw them as performing worse than expected rather than significantly better than expected, which was the reality of the care being delivered at that organization arguable at all the time periods measured before implementation.

Another example of an organization where similar findings occurred at two of their hospitals is shown below.

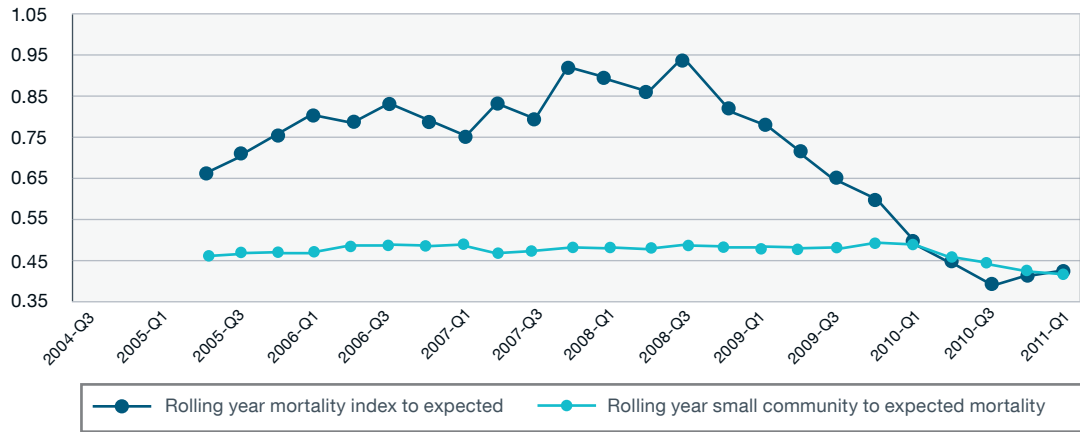
Hospital A implemented Jan 2007

Hospital A mortality risk adjusted rolling year by quarter

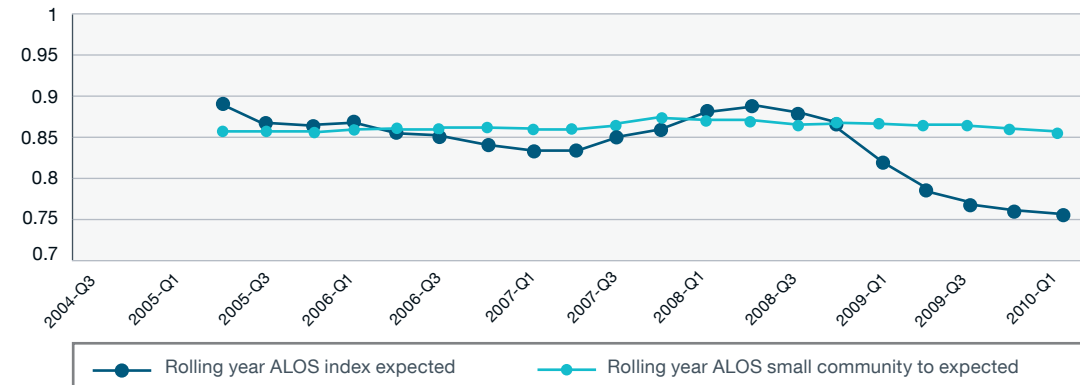


Hospital B implemented Oct 2008

Hospital B mortality risk adjusted rolling year by quarter

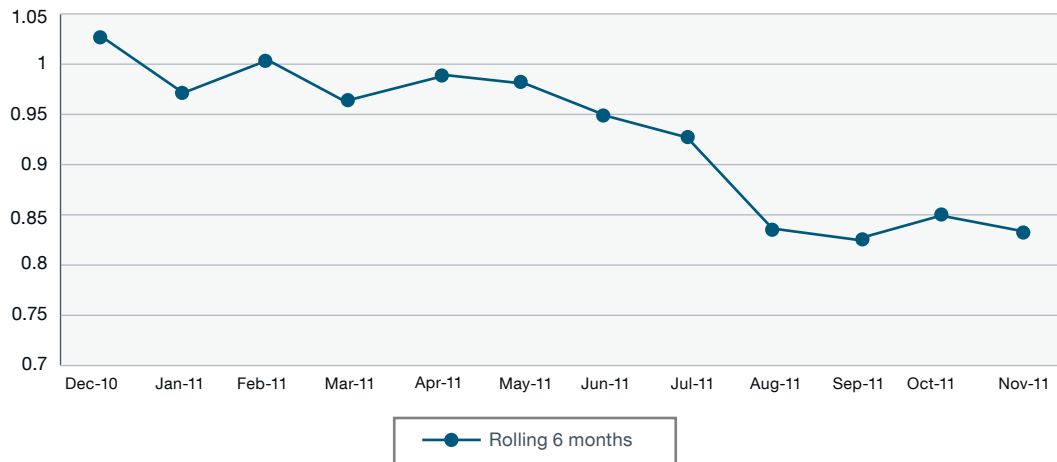


Hospital B average length of stay severity adjusted rolling year by quarter



The example below shows another hospital that implemented the Nuance CDI program using the JATA clinical approach, replacing a CDI program that had been in place for 3 years.

Conversion from previous documentation program to Nuance JATA



The realities of these outcome changes cannot be understated. More importantly, the Nuance CDI program powered by JATA is a vital strategic initiative that all hospitals and health systems should be undertaking. The implementation of the Nuance CDI program creates an environment in which a hospital can maximize current revenue in the fee-for-service world while establishing a stronger and more realistic severity adjusted view of the population they are caring for. It is the view of this population that will set the reimbursement levels in an ACO or population-based payment system of the future.

Nuance's Clinical Documentation Improvement program helps transition between the two curves, allows hospitals and healthcare systems to survive the exit from the fee-for-service first curve and ensures success in the value-based economy of the second curve.

To learn more about how Nuance can help you improve financial performance, raise the quality of care, and increase clinician satisfaction, please contact us at 888-350-4836 or visit www.nuance.com.

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