Building a Clinical Foundation for Value-Based Care

Executive Summary

The role of the physician advisor (PA) has become essential to healthcare organizations today, especially with the need to build an infrastructure that supports the movement toward Value-Based Care. Keeping up with changes to policies and regulations from CMS and managed care payers require the kind of time and attention that would be difficult for most clinical professionals. Physicians who can assist their peers and other hospital personnel in these matters are more essential than ever today. While this role began about twenty years ago with a focus on Medicare compliance, utilization management and review functions, reversal and management of denials, and billing status determinations, the physician advisor role has in some organizations expanded beyond these functions. To support the move towards value-based care, the roles are expanding to include the support of care progression, the appropriate level of care placement, management of length of stay (LOS) through leading practices, appropriate utilization of clinical resources, clinical documentation improvement, payor contracting, revenue cycle, ongoing physician education, clinical quality improvement and safety/risk management when the opportunity presents itself.

Physician advisors should be involved in all of these areas if the organization is going to accomplish the largest return on investment from this role. A physician advisor's typical day may consist of attending various multidisciplinary meetings with care management and clinical documentation teams regarding identified concerns, while ensuring compliance, seeing that quality care is being provided, and staff is communicating effectively.

A Model to Support Care Management, Clinical Documentation and Value-Based Care

Cherye Morgan LLC conducts detailed Physician Advisor (PA) Assessments compiled through PA interviews and Care Management leadership for client organizations. Included in this assessment is the identification of key leading practice roles for a successful PA model; an example of the hospital's current practices; and recommendations for specific changes. We often recommend that the current models of our client hospitals be expanded to include up to sixteen (16) critical roles and responsibilities instead of the four (4) roles inconsistently covered.

The following table illustrates these expanded roles and responsibilities:

	PHYSICIAN ADVISOR LEADING PRACTICES
1	**Communication and Team Support** - Physician Advisors (PA) encourage productive communication and align their work to support the Value Based Care organizational goals as well as specific Care Management (CM) departmental goals.
2	**Admission Decisions** - PA evaluates admission decisions when CM believes inpatient criteria are not met and if the patient meets criteria for inpatient admission. If not, PA discusses the appropriate level of care with the admitting physician, provides evidence of criteria requirements and facilitates discharge with or without supportive services. The PA is called to conduct a second level review when admission criteria is not met due to the current medical record documentation.
3	**Observation Status** - PAs are knowledgeable about Observation status and are capable of advising medical staff and CM in the management of level of care decisions. This knowledge includes detailed understanding of the criteria for levels of care associated with MCG screening criteria and leading practice guidelines so that they are capable of educating the medical staff to ensure appropriate use of observation status and support CM as needed.
4	**Discharge Planning** - Early identification of patients requiring post discharge services is critical, and CM should collaborate and negotiate patient's hospital stays to seek opportunities for cost effective care that does not compromise clinical and efficiency outcomes. PA's must provide additional clinical support for patient's diagnosis and care plans in consultation with the medical team. While it can be challenging to facilitate next level of care planning for patients who are uninsured or underinsured without support from the entire team. PA's need to assist in this process by establishing good working relationships with community providers.
5	**PA's Role with Complex Patients** - Complex patients require a multidisciplinary approach to care. PAs and case managers must collaborate with the entire healthcare team to determine the best approach to resolve barriers and assure the development of a clear plan of care that includes the patient's complexities. The PA and the CM should assure that the plan of care incorporates the support of the appropriate disciplines required to manage the complex case in a timely manner.
6	**Early Identification of Post Hospital Needs and Resources** - PAs should be called when potential needs are identified by the CM, but there is a lack of agreement with the patient's attending physician. The PAs may intervene by reviewing the medical record and having a discussion with the attending physician. Discharge to another inpatient setting requires effective communication between all parties. The multiple facets necessary to effect a discharge to a long term acute care hospital, SNF, inpatient hospice or other inpatient setting requires time to coordinate. Cases that include consulting physician teams, in addition to primary care teams, require close communication between the team members.
7	**Denials Management** - First line appeals in the denials management process should fall to CM. They should then review the medical record for additional information to support whether patients meet medical necessity for the level of care and then refer questions to the PA. The PA then should assist the CM in approaching attending physicians with probing questions that are not currently answered within the clinical documentation of the medical record. This affords CM the opportunity to learn more about the condition in question and what documentation would be required to meet medical necessity. If CM encounters difficulty with receiving the necessary additional information to provide to the payer during the appeal process, the PA should approach the attending physician for a peer to peer review of the medical record. The PA can when necessary then coach the attending physician about documentation requirements to support the need for the patient to be in the hospital at an acute level of care.
8	**Utilization Management** - In a value based world of healthcare, physicians should be critically assessing the appropriateness of resources being used. This means that diagnostic tests and therapies should only be ordered or utilized if they are going to help provide additional diagnosis that will be treated in the acute care setting or help the patient improve their clinical status while in the hospital so that they can be discharged to a lower level of service. Testing and therapies should be avoided in the inpatient setting if they are inappropriate because they are not required for the inpatient diagnosis or could be safely done in the outpatient setting after discharge.
9	**Clinical Documentation Improvement** - PAs engaged in clinical documentation improvement perform ongoing medical record review to ensure that documentation matches the clinical picture of the patient. Since CDI is the primary driver for a hospital's case-mix index, as well as for its risk-adjusted mortality rate, which depends on accurate coding of serious medical conditions, such as sepsis, a good documentation program will ensure that documentation is accurate and captured at the point of service, that it reflects the acuity level of the patient, drives appropriate coding for accurate reimbursement, meets standards for clinical documentation, reduces risk to the organization from incomplete or unclear documentation and supports high quality care.
10	**Consultation and Counseling on the Plan of Care** - PAs should be used as a key resource in providing direction on the plan of care decisions to help achieve the best outcomes for patients, as well as the desired goals of the CM department and the hospital.
11	**Physician Education and Management of the Difficult Physician** - When physicians display poor behavior to CM and others on the clinical team, PAs should approach the issue from a professional conduct standpoint. There should be a zero tolerance policy that applies to all staff members. The PA and director for CM need to have the authority to bring issues to the Medical Director of the medical specialty, HR or legal department for intervention as necessary.
12	**Care Management Department Education** - PAs acting in true partnership with CM should provide regular educational in-services to keep CMs apprised of trends and patterns observed through the PA role. Other educational topic examples that can be useful include total parenteral nutrition, percutaneous endoscopic gastrostomy, or referrals to palliative care or hospice.
13	**Conflict Resolution and Encouraging Collaboration** - Inherent to any partnership is the ability to work collaboratively and resolve conflicts and difficulties that might arise. Good communication is predicated on respect and openness to other's ideas. PAs may be instrumental in role-modeling good communication techniques for CMs to use with attending physicians and vice versa. Both PAs and CMs should work to build trust through positive dialogue with the medical staff. As a team, this group should work to eliminate any sense of distrust or adversarial relationships and develop ground rules that allow the team to identify how to resolve conflicts and reach consensus.
14	**Improving Patient Care** - PAs and CMs should identify as a team, opportunities for improving clinical practice, reductions in inefficient resource utilization and agree on actions to prevent conflicts that delay appropriate decision-making. They should assist physicians by providing options that meet expectations and improve patient outcomes.
15	**Quality Improvement** - PAs and CMs should team up to provide physician education related to care management that achieves optimum results for patients, as well as regulatory requirements that may enhance physician's awareness of current trends and issues needing immediate attention. Examples of such topics include present-on-admission required documentation, severity adjusted DRG's and those clinical diagnoses that represent the highest opportunity for standardization in order to reduce costs of care.
16	**Resolving Outliers** - There should be a standardized process in place to review patients with extended LOS or complex situations that may inhibit the discharge process. There should also be a forum for addressing outlier patients and medical necessity should be reviewed. The list should contain cost/case estimates in addition to current medical status and pending discharge plans. For patient's that no longer meet medical necessity, reviewing the patient's needs and then creating an approach to develop a complex discharge plan will provide a different perspective and may result in a new approach that will result in improvement.

Once these assessments are completed, recommendations are implemented in collaboration with the organization's clinical team in concert with leadership direction. Without such an expanded implementation, it is nearly impossible to execute a comprehensive Clinical Effectiveness Strategy. Most current physician advisor models in hospitals today weaken the hospital's infrastructure for successful implementation of clinical effectiveness initiatives and the preparation of value-based care to support risk-based arrangements. This is without strong interdependent processes of care management, utilization management and physician advisory services, they lack the strong foundation needed for ensuring that the patients are placed in the appropriate levels of care for the right amount of time and the services that they need.

Cherye Morgan LLC often recommends expanding the current models by *1) conducting an industry-wide search for appropriately credentialed PAs (by both the American Board of Quality Assurance and Utilization Review Physicians (ABQAURP) and the American College of Physician Advisors (ACPA). These roles are filled with physician resources* ***working full-time with no other organizational responsibilities;*** *or 2) by selecting and growing a few own internal medicine or hospitalist physician resources who are well respected by the organization; culturally interested in the implementation of value-based care; willing to take on this role full-time as their primary function within the organization; and have the personality to be successful.*

These physicians must also have the required training, certification, and work full-time with no other organizational responsibilities.
Outsourcing the physician advisor function for night/weekend/holiday/vacation coverage is another option but is not highly recommended because these PAs perform only the second level status review function and will not have the relationships with physicians and clinical staff that an internal credentialed resource will have. For this reason, an expanded outsourced option for program coverage is most often not recommended. Included in the assessment are the "pros and cons" for the three (3) options described here based upon each organization's situation.

Employed physician advisors can perform many more critical functions for a hospital than they are currently performing. Many organizations hire specialists part-time to support each of the medical specialties. However, because it is difficult to find the physicians to cover these responsibilities, Cherye Morgan LLC often recommends that client hospitals utilize Medical Directors from each medical specialty as a specific resource for full-time PAs in their review of specialists and make this part of their expectations and compensation as being the Medical Director. With time, the full-time PAs will also be able to build relationships with leading practicing physicians within each medical specialty as ***"go to"*** resources to learn and better understand how to make specific recommendations to outlier specialty physicians.

The expanded role of the physician advisor would also focus on issues related to clinical documentation. Educating and coaching physicians to improve their documentation assists with optimal reimbursement for the appropriate assigned DRG; thus, reducing underpayments and even denials. They would be readily available to hospital coders, clinical documentation specialists (CDS) and the medical staff as they navigate through various coding challenges, such as the identification of various pneumonia types, and definitions as it relates to sepsis and respiratory failure. The physician advisor will provide his or her expert opinion in relation to

clinical validity assessments; and, furthermore, the development of clinically robust and appropriate queries.

The chain of command that supports the PA in their roles and responsibilities; however, should follow the medical staff bylaws and recommended roles and responsibilities of the medical staff committees, beginning with the Utilization Review Committee and then, when necessary, the involvement of the Medical Executive Committee and ultimately, the Board.

Selecting the Ideal Advisor

The selection of the physician(s) is the most important step in establishing an effective physician advisor program. The main attributes a physician advisor must have include:

- Broad internal medicine or hospital-based clinical knowledge base;
- A knowledge and willingness to build a "Value-Based Care" organization;
- Knowledge of CMS regulations and contractual compliance;
- Respect/credibility from the medical staff;
- Ability to effectively communicate with physicians and non-physicians; therefore, willing and able to have "difficult conversations";
- Committed availability that comes with full-time resources committed to working on-site 8 to 9 - hour days with on-call coverage for nights and weekends; and
- Members/credentialed by the American College of Physician Advisors and American Board of Quality Assurance and Utilization Review Physicians.

The selection process should have significant involvement by the Care Management and CDI staff, and not be left solely up to senior management, ensuring that they are able to provide feedback at a minimum on internal candidates. It is suggested that the Care Management and CDI team screen applicants and submit a list of preferred candidates to senior management.

Hospital and health systems preparing for value-based care often do not realize that the basic framework and infrastructure for managing care is missing in their organizations. Without a solid infrastructure for managing care within the hospital setting and across the continuum, risk-based arrangement contracts are written without the capabilities of efficiently and appropriately managing clinical costs. Care Management working together with an appropriately designed and integrated PA process is a required foundational infrastructure. Cherye Morgan LLC has clinical improvement consultants and physicians that can help your team.

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