3M Science. Applied to Life.™

Redefine your KPIs and prioritize your team's work

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3M CDI INNOVATION WEBINAR SERIES

Karen

Good morning or good afternoon everyone. We'll start in just a couple of minutes. Thanks for attending today. (silence) All right, it's the top of the hour so we'll go ahead and get started. Thanks so much everyone for joining today. Welcome to today's 3M Health Information Webinar. My name is Karen and I'll be your host. In today's webinar, we'll explore how to redefine your KPIs and prioritize your team's work. Next slide, please, Julie.

I encourage you to ask questions throughout the presentation. You can do this by using the questions feature in the web meeting controls. We are recording today's presentation, and a webinar archive will be made available. Lookout for an email within the next week that includes a link to the archive. For this particular webinar, we won't be including a PDF of the presentation slides, but we have other handouts you may find helpful including information on several of our 3M webinar series afresh on our CDI Engage One solution and consulting services as well as a case study on Worklist Prioritization, which is our core topic today.

You can find all these documents right now in the handout section of your web meeting controls. We'll also provide a certificate of attendance to webinar attendees, and that will be emailed to you upon the completion of this webinar. Next slide, please, Julie.

We have two presenters today. Julie Imbrugia, Kim Conner. Julie is a 3M 360 Encompass Owner with a focus on CDI and Concurrent Coding Workstreams. Over the past five years, she has worked with product teams to continue to enhance the system to support these programs. She's recently been engaged in supporting customers in using 3M 360 Encompass CDI priority worklists for program optimization.

Our next speaker and honored guest, Kim, brings 20 years of clinical experience as a surgical ICU and burn trauma nurse at Johns Hopkins Hospital in Baltimore, Maryland, and at Brigham and Women's Hospital in Boston, Massachusetts. For the last seven years, she shifted her focus to clinical documentation integrity at South Shore Hospital and with education and support programs to maximize CDI success.

Julie will kick off our presentation today with great background information on where you might use worklist prioritization, and Kim will share her real life example of how South Shore hospital transformed their CDI department through worklist prioritization technology, before we wrap up with an audience Q&A session that we hope you'll participate in.

Before I hand it over to Julie, next slide, please. Julie, we'd like to get started with a very quick polling question that might help us tailor the conversation to this group's needs. I'm going to launch a polling question for you that you should see pop up on the screen. The question we have for you just to get started is were you aware 3M has an advanced worklist prioritization feature in 3M 360 Encompass? Please select one of the following and just one; yes, no or not sure. I'll give you guys about 15 seconds to answer that, and I will share what you have to say.

The results are piling in. All right, 10 more seconds. All right. I am going to close the poll and share those results. All right, so it looks like a decent mix, but majority of you saying yes, 32, saying no and 17 not sure. I think we'll have something for all of you if you're familiar with the tool. It may be a little bit of a refresher, but I think a really good overview and some practical examples, especially with Kim's great story she's going to share with us today. Thank you again so much for participating in our webinar today. With that, I'll hand it over to Julie to get started with her portion of the presentation.

All right, Julie, take it away.

Julie Imburgia

Thanks, Karen. Just another welcome to everyone else, thanks for joining us today. Before we get started on our main presentation on how South Shore Hospital leverages the 3M 360 Encompass CDI priority worklists, I do want to talk a little bit about what priority worklists are and why we use them. We all know that CDI teams face multiple challenges nowadays with higher patient volumes, limited time, limited

Julie
continued

resources overall. That has led to a situation where we oftentimes can't get to all of our cases, or we can't get to our cases often enough to provide good quality reviews.

We also know that our CDI teams are getting more and more engaged in the quality aspect of CDI. They're working more with quality teams to provide that critical input so that the quality teams can do their case management and utilization.

In order to help CDI programs increase their reach without sacrificing any of their core responsibilities, we have developed the CDI priority worklists. The point of the priority worklists is to surface those cases with the clinical documentation that matters most, and surface them first. The way that we do that is by leveraging our 3M technologies, and our 3M 360 Encompass systems, NLU and computer assisted CDI technologies to do that.

Let's talk a little bit about how we do this through prioritization. There is a lot on this slide. But basically, our prioritization does have an algorithm that utilizes and analyzes the unstructured data that we do get from the clinical documentation. We analyze this through our natural language understanding and processing technologies to identify different types of high priority cases, and that's what you see here in the middle of the screen.

We try to identify DRG opportunities, which may be cases for which there are multiple principal diagnoses or cases without a CC or MCC. We try to identify cases that can be grouped to a specific organization focused DRG. These may include like bundle payment DRGs. We try to identify cases that have automated queries or the physician CAPD queries on them. We also have ways to prioritize cases where we have evidence of clinical indications, but the condition is not yet documented. Those are our clarification queries. We also have new technologies through the use of our M Modal integration that allows us to prioritize by specific clinical conditions or clinical opportunities.

We have ways to prioritize by quality indicators. If your program is quality focused, you can use our technologies to surface cases where quality indicators are raised in your HACs and your PSIs. We also have ways to raise cases to the surface if the length of stay maybe doesn't correlate with the patient's severity of illness or risk of mortality. That's our LOS, SOI and ROM category that you see there.

For case status, if you have discharged cases with pending queries, that's another case that might have some impact that we could surface high in a prioritized worklist. Then we also have ways to surface cases when new documentation is received. The example that we share here is with an OP report. Sometimes they're sending in a medical case, we like to set our follow up two days out, because we're waiting for that OP report. Well, we don't want to have, to have that manual intervention, we want the system to tell us when that OP report comes in. We have ways to do that with this prioritization feature as well.

The solution in the prioritization solution is flexible, and it does allow you to prioritize based on your organizational goals. As the industry shifts towards quality, you may choose more of a quality focus in your prioritization. If you're focused on specific DRGs for maybe denial management, you can set up your prioritization to focus on that.

The prioritization, again, is adjustable and flexible. It's also real time and continuous. As new information comes in on an account or as information is changed by user on account, the case and its position and a prioritized worklist will adjust accordingly.

Now, I just want to give a sneak peek of what this looks like in our system. What we're looking at here in the center with the green box around it is a case from our CDI priority worklist, and we're highlighting the score on this case because it has a number of factors, and those factors contribute to their score, which is what puts it in its place on the worklist. What we're seeing in this example is a case from a CDI program that is really more quality based.

We see a lot of factors for quality indicators, which are driving the priority on this particular account. But we can also see that the NLU is picking up a possible pneumonia condition as well. You can see

Julie continued

that as the second class factor in that list. Before beginning a prioritization journey, we do recommend first, establishing your program growth goals, and baselining your KPIs against those goals. We also recommend expanding your CDI coverage to include all payers if you haven't already done so. With the use of prioritization, you should be able to cover most of the payers. Then lastly, you'll leverage your worklist and priority setup to support the goals that you've identified for your program.

If you need more help, or more information on CDI prioritization, we do have information available on the 3M Support site, and it is under Answer ID 11157. To provide some additional ideas and concepts for how to leverage priority worklist to support your organization and program goals, we will provide a case study from Kettering Health Network on their use of CDI prioritization. Then, of course, we have Kim with us today to provide her story on how her organization leverage priority worklists to realize both quality and financial gains.

Before we turn it over to Kim, I believe we do have one more polling question, and then we'll hand it over to Kim.

Karen

Absolutely. All right, thanks, Julie. Karen, again, your host, like Julie said, we'll have one more polling question here to get started. The question we have for you, teeing up Kim a little bit is what is the number one KPI your organization tracks for CDI success? We know there could be multiple, of course, but if you could just let us know what seems to be the most important one in your organization, just select one of the following; query response rates, SOI or ROM, CMI Change, readmission rate, new or re-review chart reviews per day? Again, I'll give you guys about 20 seconds or so to answer the poll.

Really appreciate your input on this, and I think you'll find that Kim's organization really understood this very clearly, and that really helped, I think their success in using the tools because while we can provide, I think tools that complement these goals, they really have to go hand in hand. We wanted to hear from you about your top goals to help you out in the future.

All right. I'll give you five more seconds and then we'll close the poll. Okay. All right. Here is what you said. We have really quite a spread, it sounds like, with query response rate at 29%, SOI, ROM at 13%, CMI Change, 31%, readmission rate 5% and new or re-review chart reviews per day at 22%. All right. Well, thanks so much for your feedback on that. Kim, feel free to get started next with your portion, sharing your example. Thank you.

Kim Conner

Thank you, and thank you very much for having me, and letting me share my team's story today. Next slide, please. Really, as I was introduced, I just want to make a slight correction here. I actually have been at CDI for seven years, but I've been at South Shore Hospital for about a year and a half. Prior to that I worked for a private company, who made sure I was extraordinarily well trained.

I am from Boston, I have a wicked Boston accent, I've been told. If anybody doesn't understand something that I've said, please don't hesitate to ask because when I was at Baltimore, half the time, they couldn't understand what I was saying. If you go to the next slide, please.

Our agenda today is really about how we morphed and how we changed and the extraordinary efforts made by my team in conjunction with the tools that we were provided from 3M, and this went hand in hand. Never does a computer program take the place of experience, common sense and a human being because there's so much to CDI. Really, what we're going to talk about today is how we change those program goals, how we implemented our new workflows, what our metrics were based on our program goals at the time, and how we use 3M reports and prioritization to get there. Follow up and follow through with the CDIs themselves with providers, with administration, how important that factor is as well, and how you can pull a lot of that information from 3M.

Education, education, education, I cannot stress that enough, and I will probably be saying it all throughout my presentation that that's a big one for every element of CDI, and then our ability to measure and monitor outcomes for success. Next slide, please. This is the shortlist, guys. When I came to South Shore, kind of our background, this is where we were. By the end of this, you'll be able to see where we were and where we are now in comparison, and it is quite remarkable.

Kim
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I arrived in 2019, mid-March to this almost 400 bed hospital. I had seven CDIs, five of them were nurses, two of them were coders. They were all experienced in CDI, but they were a little misdirected. Really, we had a little bit of our work cut out for us. Within the first couple of weeks, one of my CDIs had handed me a resignation. So, we were then down to six. To try to cover all of these beds presented a challenge and how do we pick our right cases?

We had a brand new physician advisor, Dr. Dolan who is amazing, but he was really new to CDI and the coding world too. So, believe me, he was ready to do anything and he is the perfect partner to help us branch out. But again, it was some education in the beginning. When I came, our case mix was pretty low. He has low revenue impact. The medical surgical staff was really not well educated on the hows and whys of what CDI did.

One of the biggest challenges we came across initially, when I first came on and started talking to physicians was, what do you think? What are your ideas? The top two things I heard consistently was, we don't know what we're being asked, and we don't know why we're being asked. There was a lot of work to be done on that front.

There was not great communication between the CDIs and the providers. There was not great communication between the CDIs and coding, and that element in particular, is huge to the success of your program. CDI and coding needs to be on the same page. A few months later, we got a brand new coding manager, who I work incredibly well with. As a team and united, we've been able to really foster a much better environment for communication. Again, we got very lucky there.

Using query templates only. I'm not a fan of the templates, I got to say. Really, what had happened here is that not only were they the 3M templates, but they were the 3M templates that then got adjusted, and they were so non-leading, they were obtuse and vague and I could understand why the physicians at that point were saying, "We have no idea what we're being asked." So, we had to make that change.

We had no denials or denial prevention program, only the coders at the time were doing all of the denial appeals and that included the clinical ones. If they came back a second time, we really weren't arguing a second time. That was a place we needed to focus on pretty quickly. Program goals really were not well established. We had no HAC or PSI reduction program, and we had no clinical validation process for highly denied diagnosis.

We know that they target the big five, which is sepsis, metabolic encephalopathy, AKI, ATN, malnutrition. Really, to try to bring this all together would have been a very difficult task without the help of 3M. Next slide, please.

This poster is actually on my wall, in my office at work and on my office wall at home, because it does remind me that even though we may be experts in some aspects of things, some people are still beginning. Just because something is my experience doesn't necessarily mean that somebody else is in it, it doesn't matter how experienced you are, it really is about understanding, you have to go back. When I looked at this program, and came home and thought I made the biggest mistake of my life, I really had to sit back and say, well, what do we do?

This was either I make small incremental changes, or I toss the grenade, blow it up, and we start all over again. To my team chagrin, we tossed the grenade. The second week, I was actually at South Shore Hospital, 3M had come in, so we could implement the 3M prioritization. At that point, we had to play with it a little bit, but the CDIs would changed their process as well. Each one of them got assigned specific floors. One medical, one surgical, we wanted to keep it even, even if somebody had ortho, they still had a good selection of surgical cases.

We did this for a couple of reasons, just to see where people would fit. It was really what do you like, what do you not like? What are you going to excel at? It also gave people the opportunity to have a different changing approach on a monthly basis. What I had found was that first week, the CDIs, just getting their feet wet and trying to get righted in the saddle, and the second week, they gained some traction, third and fourth week, they did great. Then it was time to rotate again.

Kim
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It actually gave them some time to be proficient as well. With the prioritization, they were able to go to their units, pick their patients and then put it on their swim lane. Then once they were in the swim lane, they could see what surfaced to the top and what they needed to prioritize. We also had to make adjustments within the prioritization based on what we needed. We had to tweak some things as well.

Again, it was very important to be able to move forward with this so we could get the most that we possibly could. We outlined program goals and metrics using the 3M reports, which I will show you later. We use the 3M prioritization on the assigned floors. We initiated a lunch and learn sessions with the providers. The first lunch and learn we did we had 13 people attend and then word got out that I brought really good food. At this point in time, I have standing room only, pre-COVID actually, and now we are initiating a webinar lunch and learn and we'll have lunch sent into these guys and they can just listen to me talk for an hour.

We worked with opposition champion to help fill in some gaps between CDI and the providers. He continues to do an amazing job at this. But this was a physician who had worked at South Shore Hospital for 20 years, he's very well known, very respected. It really made a difference to have that key element there as well. We also began to work with the quality department, which is something I don't think there was a big connection there. Really, our first big project, what [inaudible 00:27:25] us together, we have an amazing quality department. Like any quality department, did stretch pretty thin, too.

Whatever we can do on our end to work with them in real time to help some of these quality metrics, we are there. We did initiate a HAC and PSI reduction program. We picked one big PSI, which is PSI 03, which is the pressure ulcer. The biggest HAC that we have, which was [inaudible 00:27:54] that they really wanted to focus on this year. We had done some things to really move that forward, as well.

We also named the team leader, and she is actually my perfect complement. She is my opposite in every way, which is a very good thing. She championed the PSI 03 reduction. I'm good at wounds, she's great at it. She's very detail oriented, and she's made several saves this year based on documentation and appropriate documentation. We're not asking people to say something that doesn't belong there, but really has been instrumental with that as well.

We created swim lanes specific to diagnoses to assist with bundle identification and targeted PSIs and HACs and I can go through, and I'll show you a screenshot of that as well. That's something I fell into. I'd like to say I was a genius on developing swim lanes based on codes versus DRGS. But it was a conversation that we had with 3M and our quality people, and we were asking for all these different things, because quality we kept trying to get up and running on 3M as well. This was the last question and I'm like, no way they're going to be able to say yes to this. The woman on the phone said, "Absolutely, that's easy. All you have to do is this."

Really, it opened more doors for us to really hone in on things that we wanted to do. Again, I wish I could say I was a genius, but it was really the quality department and I tripped over it, and that's where we are. We then developed targeted swim lanes for specific DRGS. Really, the advice I had received was small gains. Start small, maybe get some HAIs or ATNs and that on a smaller scale, but of course I had to go bigger or go home and so I picked the hardest two, which is sepsis and pneumonia to really focus on and really provide a lot of data and feedback on those two things to see some improvement.

Next slide, please. Setting CDI program goals is truly essential to success. Really, the first step was let's provide some structure and what are our goals? We didn't really set small goals here. Every program is going to be different and where you are in your program is going to be different. Some programs are in their infant states and CCs and MCCs only. Some programs are a little bit more involved and they deal with APR cases; SOI, ROM.

Some programs are really fine tuning the littlest things now because they've done so well through the years. Again, what are your program goals? Then, how do you measure those outcomes? These will continue to change and evolve as your program evolves. I can say today, everybody does 20 reviews a day, but down the road, that might change. If we're branching out into quality, and we're taking on

Kim
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projects with other departments, well, that takes time away from what we're actually doing with reviews. That metric's probably going to get lowered.

If all you're doing is record reviews all day long, then that metric would stay the same. Again, these are the things that you have to decide for your program. Again, they will ebb and flow, depending on the evolution of your program. South Shore hospital, our initial CDI goals, we obviously want, case mix was a big one, we wanted to increase that case mix. But what we had in our patient population and we treat various patients. We are a hospital system, we're not just a little community hospital anymore.

Really, we're not showing that we had really sick patients on paper. We wanted to increase CC and MCC capture. Our cover reports really indicated that. Increase appropriate revenue on our capture. We just don't want to leave it on the table if it was there. Improve clinical validity for audit, reduce CSIs and HACs in real time. We targeted specific DRGS, again, sepsis and pneumonia were our top two.

Next slide, please. These are our specific metrics when we started. Our number of reviews was 15 to 20. We had a hybrid program prior to COVID. We were in the office part-time and we were working home part-time. The expectation of the remote days was that these were higher production days because there was no distraction. The query percentages, we wanted those to come up to 25% to 30%. We wanted appropriate financial capture at a minimum of 150,000 per month.

I think when I first announced that, every single one of my guys looked at me like I was crazy, and you should look at them go now. Increase case mix, which was set by administration for fiscal year 2020 of 0.05. Increase capture of complex pneumonia and MCC capture for simple pneumonia. This was a big issue. We had a lot of... 194 DRGs. We weren't really maximizing those cases. We wanted to reduce sepsis denials by 25%, and our overall team metrics were shared with the CDI team, and then I would meet with each individual monthly and go over their individual metrics, none of which is meant to be punitive.

I can tell you, nobody's going to beat themselves up more than that CDI will, there's nothing you can say or do that isn't going to make them make that correction. People want to do a good job, period, is what I have found. If you're reasonable, and you use, even a negative as a positive to just demonstrate this is what we can do better next time, and that's it. That's the end of it. None of this works without education to the CDIs, education to the providers, education to the administration, buy in from the providers, which is not always easy, and support from administration.

I will tell you from the day I came to this hospital, I've had nothing but support from the top dogs, from the CFO, the Chief Director of Rev Integrity has been amazing with me, incredibly supportive and really anything that I've needed, they have made sure I had it. Again, it is fostering that environment and making it all work together that was very important. Next slide, please.

These are our metrics, and this is something that 3M generates. The 11a, I really do like this. But again, none of these metrics are meant to stand alone. I do know programs that say, well, we require a 25% query rate, in relation to what? In relation to case mix, in relation to SOI, ROM increase, relation to finance, what is it that you're asking for? Because I can have a 25% query rate, and it could be garbage, unnecessary queries, they're just trying to hit a number.

Again, these all play into one another. This was me for one week. I just used myself as an example. I really do like this report because it does tell you how many initial reviews are done, how many re-reviews were done, how many queries were sent out, what that percentage is to how many reviews that you did. Again, it breaks it down even further of how many disagreed, how many alternates, how many agreed, how many responded?

This, I will tell you, has been instrumental, the response rate percentages alone are beautiful. This is just me as a single person, but if I put every single one of my CDIs in here at the bottom, where you see the grand total, it will show you the averages of your response rates, it'll show you total of initial and continued review days, your queries, how many, and average percentage of queries overall.

Kim
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Again, how one plays into the other. The 20d is my favorite report in the whole world, because it tells you everything. It gives you every query that was sent out. I can go into that 20d, click on a name and say I just wanted to see what the query looks like. I want to make sure that this was compliant, because we write our own queries.

Again, we have to make sure that we're being compliant. It tells us financial impact. It tells us which physicians are answering, not answering. How many queries we've may have had to withdraw for one reason or another. Again, this is a great report to get into because it really does give us the next slide, which is a report card.

Next slide, please. These are our provider report cards. We give them out every month. During COVID. We chose not to do this because again, we didn't shut our program down, we queried for impact only, so we weren't overburdening providers. But again, this is what they see. This is actually our ICU, we break it down into surgery, medicine and ICU. This is our ICU. We are able to show them how many queries they've actually gotten a month because a lot of them love to squawk and say, "There's so many." And they've gotten two.

To show them that, to show them if they didn't answer, if they didn't respond to us, what that missed revenue looked like, their response rates, their agree rates, their disagree rates, their no responses. We have educated to a point where these physicians do understand what CCs MCCs, primary diagnoses is the very illness and risk of mortality scores, the other's usually a clarification, but they understand what their queries are all about.

Prior to COVID hitting, this was a remarkable report card. We got a lot of support from the director of the ICU making sure that these things were at least responded to. You can see at the bottom, our total, and we had a 98% response rate from all ICU providers, that is unheard of. It was just excellent, and we really are able to keep on track.

Giving them this feedback, telling them that big brother is still watching. Again, they understand this is a level of accountability if they don't answer. This takes a little extra time, because if you're having to calculate missed revenue, but again, you get all of this from that 20d report, and it's instrumental in making sure they get their feedback that they see how they're doing. Physicians are incredibly competitive, they want to make sure they're the best.

We use that, and this is how we use that. To be able to say this is where you're at. We don't sit here and say, "Well, Dr. Smith is doing better than Dr. Jones." They can see that, and they will work hard to improve. If they're not understanding something, we have found, they really will reach out to us and say, "I'm not understanding why I got to do this." We have a 15 minute sit down. Again, Dr. Dolan, our physician advisor has been instrumental in this as well, and is knowledgeable as we all can be as nurses. A doctor talking to a doctor has a different impact. That's what we have worked very hard to do this year. Next slide, please.

Enter prioritization in all of this process. Again, what are our programs priorities? What do you want to be seeing? How you set up your prioritization is going to be very different on how I set my prioritization depending on my program goals, depending on what I think is the most important that we absolutely, positively cannot go a day without seeing, that's going to be at the top of the list.

Prioritization works two ways. It pulls in information, so, pulls in documents for CAC, which CAC is the computer assisted coding, making those suggestions. The more you refine what you're pulling in, the more accurate CAC is. CAC is also artificial intelligence. If you're doing the thumbs up and the thumbs down, if you're consistently hitting a thumbs down on something, eventually, it's going to catch on and say, they're telling us that this isn't right, and it will kick it out of the system.

I do strongly suggest that you use the audit suggested codes if they are correct, and that you give them a thumbs down if it's not accurate. Then you can go back to your IT team and say, "I don't understand why this keeps getting pulled in." One of the problems we were having, every single patient I saw was a smoker, and I'm Like, "I don't understand this." What CAC was pulling in was we had a template, and the template showed us, it stated smoking history.

Kim
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CAC kept pulling that in. We had to just make a small adjustments, we no longer see that. Then the numbers that you assigned to the outline priority. When we start what Julie has presented, exact those numbers and how that added up to make a score, you're assigning a number, however high or low that you want to assign, and then that's going to add into your score and then prioritize it. Again, what are your program goals? That will dictate the number of values you assign to any prioritization factor.

Next, slide please. Specific targets that we use for prioritization, sepsis and pneumonia, we created swim lanes for them, we created high priority numbers for these particular DRGs and diagnoses, because we knew we had a validity problem, we wanted to have better documentation to support sepsis, and we obviously wanted to reduce denials.

This, in particular was high up on the list when I first came. We worked very hard with the providers, with quality, because again, we're all aware that we have a core measure to deal with as well and sometimes documentation on core measure and treatment of this condition doesn't always match up. We wanted to make sure that we had some solid documentation to back up a sepsis diagnosis, as well as pneumonia. We targeted this one. Again, we were seeing a very high percentage of simple pneumonias without MCCs. We started these targeted reviews starting October 2019. We did very much improve our MCC capture for simple pneumonia, and we did increase our capture of complex pneumonia as well, and I will show you those in just a second.

Next slide, please. This is what our swim lanes look like. This is how we have them set up right now. Some have been removed, some have been added. But in these worklists themselves, if I assign cases to myself, obviously it's going to show up in my worklist. We created the bundles swim lanes based on code, not DRG. If CAC and 360 was suggesting that somebody had a pneumonia diagnosis, regardless of the diagnosis, if it was a simple or complex, it went into that swim lane by code.

We also created one just as an auto suggest DRG because we wanted to make sure that we were capturing not only, yes, this patient has pneumonia, but are they treating this patient for a complex pneumonia, an aspiration pneumonia? Again, that allowed us to do targeted reviews for DRG. Our C-DIFF swim lanes, and our bundles program swim lanes are based on code, not DRG.

Anybody that has the code for C-DIFF, whether its present on admission or not, whether it's a principal diagnosis or a secondary diagnosis, it will go in that swim lane. We created that swim lane so we could see them in real time, CDI sees them in real time. We can notify quality through notifications and say, this looks like it's not present on admission, do you want to take a look at it? Again, while the patient is still here, and then that's another pair of eyes on a record and they say wait a minute, we see that the patient was on antibiotics for two weeks, but less than a week ago, can we ask If this was likely present on admission based on the clinical indicators?

It is what it is, we're not going to be HAC free, no hospital will be. But again, it gives us the opportunity to really drill down on these things. Next slide, please. This is... I love this report too. This is our focus DRG pairs, in summary, and really this is how we're able to quickly abstract information and give that feedback to the providers. They knew this was a special area of interest. They knew we were really going to start drilling down on this. At any point in time, I can run this focus DRG report and it tells me how many complex pneumonias I have versus how many simple pneumonias? It also breaks it down by payer. Your Medicare, your Blue Cross, other commercial payers, it really does break this all down for you.

You can run this two different ways, and that's why I have that big red circle down there because I can run it and say, I just want to see all reviewed visits. Meaning, I only want to see CDI reviews, I don't want to see the whole thing. Or I can change that and say, I want to see all of them. I thought this was actually a very interesting metric to even compare and see how we were doing as opposed to how they were doing on their own.

Next slide, please. This is what we looked like pre-COVID. I really didn't want to throw in the COVID numbers on this slide because obviously, that's going to be very skewed. Where we started in May of 2019, you can definitely see we had more simple versus complex. As we educated to this and continued

Kim
continued

to provide feedback to the providers, we started to see that change. Again, we provided this metric, which was all, and then we provided a graph that was all reviewed visits, all CDI visits. You could also see the change in what they were doing versus what we were doing.

We had a huge lopsided metric when it came to CDI reviews versus we left them alone. That significantly changed as we continued to provide this feedback. Really, it's the press of a button and putting in the dates that you want to look at, to be able to provide this feedback. Again, every month when we did our lunch and learn, they got their data. When we hit January, and this was a little pre COVID, we know that's cold and flu season and we know the flu with respiratory symptoms is going to put us in a DRG of 193, and 194, or 195. I actually just instead of saying, well, this is lopsided because of the flu, I wanted to show them really from one year prior to this year, how well they did with capturing complex pneumonias versus simple pneumonias, or influenza.

As you can see on the left, this is way skewed, and then on the right, we did a lot better. CDI reviews versus all reviews. They did a pretty decent job. Now, I can't take the flu out of the 193 DRGs. That's going to be there. We're going to get hit with those cases, and we're going to see that lopsidedness. But they did a lot better this year opposed to last year, so that it was just a great thing to show them. With all of this being said, and with my voice getting a little more, I really do want to just go to the next slide, which is our results, where we were and where we are.

This is my proud mama moment. This is where I get to say, this is where my team shines. When I got there in March, our average revenue for CDI and I had seven of them, with less than $300,000. They saw a 98% of Medicare cases only with the seven CDIs. There was no follow up discharge. They were just assigning working DRGs, and going on to the next case, and rarely were able to get back to cases that they had seen already. Their initial reviews were through the roof. Not a lot of re-reviews.

Our monthly query percentage at that point in time was 17%. Our monthly case mix was abysmal, it was 1.39, medicine, 1.15, surgery 1.51. Again, we see... We're a level two trauma center and we see some pretty heavy duty traumas. That just to me was way off. Our sepsis denials per month were 30. We were getting about 60 to 75 clinical validity denials a month, and 30 of those were sepsis denials. Top 10 DRGs, Medicare DRGs, we had 392, 312, 690 and 194. That was my top 10. There was no HAC or PSI reduction program at that point in time.

Now comes February 2020. A year later, our revenue on average is $900,000 a month. My guys just had two huge breakout months, where they were well over a million dollars. Again, that was huge. We see about 60% of the inpatients, we do DRGs and APRs with 5.5 CDIs. At that time, I do have somebody who works 20 hours a week, but that was... She started in March, so that half is me, because I still do the cases, I still want to keep my hand in all of that.

We do use EPIC a little bit when we want to catch our patients prior to discharge. We're still working on that process. Our monthly query percentage went up to 35%. As a ratio, if you're looking and saying, well, that increased and so did our revenue and so did our SOI, and so did our case mix, that's what I mean by metrics really working together, and not standing alone. Our case mix, 1.55, our medicine case mix, 1.3. I look at that and say that was our entire hospital case mix last year. This is a huge win. Surgery, 2.98, excellent. A couple of months ago they were over three.

Again, everybody working together and doing a really good job. Our sepsis dials, we only see about five to seven a month, and our top 10 DRGs are all with MCC, except for one. We initiated a HAC and PSI reduction program, and we did do an identification of bundle DRGs by code in real time. Again, this is how we were able to really expand and prioritize, and the prioritization really was instrumental here, in making sure that we were targeting what we needed to target right out of the gate, and then moving it along.

We're always asked to do more with less. We continue to be asked to do more with less and that is every department in every hospital, especially since COVID. Again, having these tools to assist us to be as efficient and productive as possible was instrumental. Next slide, please.

Kim
continued

Communication, education and feedback, these are essential elements to our success. We've continued education with CDIs and providers. Keeping up to date, letting people know what's coming down the pike, this is huge. We even know now, the IPS rules for our fiscal year 2021, we're going to have to break down CKD3 to A and B. We need to let the providers know, but we also need to let CDI know that that's what's coming down the pike and when they're going to need to make adjustments.

We want to make sure CDI stays current and sees what's coming down for the future. What are future trends? Again, when we look at denials, we can say okay, this is what they're saying today, and things have shifted, now, we need to shift a little bit and make sure that the providers are not only stating X, but they have to say Y and Z now. We need to educate to that, we need to explain to them why. That is one of the key elements I will tell anybody is to make sure you are explaining why. Don't just say do it, because I said so, it's not going to get done. Explain why.

It's frustrating for physicians, they're spending less and less time at the bedside, more and more time in their jobs, and having to go back to those records. Again, to be able to prepare them and get them ready and say this is what's coming, at least they see it coming and it's not so much of a hit, or a pushback. Feedback on performance for CDI and providers is vital. Again, I want to strongly say, your feedback to your CDIs should not be punitive.

If you're seeing somebody struggling in an area, we should be able to say okay, well, you're struggling, let's see what we can do to help you and help you master that skill. Use examples of strong performance, and believe me, we've got plenty of those. Then use missteps positively as a teaching tool. That's really all it is, is to say, okay, you didn't do it this time, but next time, this is how you do it. Really, I look at it every day and say, did to kill anybody? No, great. Move it along. It's okay, we're going to make mistakes. Not any one of us is perfect. Providers by nature competitive, showing them their stats, I'm telling you, it is instrumental to continue to move your program forward. Because not only do they want to do well, they want to continue to do well and they want to continue to improve, they want to be the best. Trying to knock off the top dog, it becomes a little bit of a competition. It really is important to do that.

Last slide, please. Monitoring for success. We choose the metrics that are in line with our program goals. Again, your prioritization is going to be very dependent on what your program goals are. It will change as your program goals change. So, don't forget about that. We have a tremendous supportive IT department, we meet with them twice a month. We have standing meetings just to make sure everything's going smoothly. If we need to make changes, they are there to walk through things with us and see how things work. Then if we have to tweak it along the line, they do. Again, I do have to compliment South Shore Hospital in general, but our IT department is fantastic.

Managers are really instrumental in educating the hows and whys to their staff, to their providers, to administrators. We're the go between every aspect of this, make your expectations clear. Again, metrics will ebb and flow. I can't sit here and say I want you to do 15 a day, five days a week, and that's 300 a month. Well, how many working days did you have? Did somebody have a day off? Were they on vacation. Again, these are never hard and fast numbers, they're a guide. But they also help guide your program. They also help you see what's your strengths, and where you need to work on a weekly basis, on a monthly basis, however you run your metrics.

Listen to your CDIs. When we initiated prioritization, there were just some things that weren't working or weren't making sense. They weren't coming to me saying, I don't want to use this, I don't like it, they really were coming and saying, this isn't working, and I don't know why this isn't a priority. Again, it's a computer system, it's not going to be 100% perfect either. It doesn't override your common sense or your experience. But again, if something isn't working or something isn't right, listen to what your CDIs are talking about, and then see if you can make the adjustments.

Show reports to demonstrate positive team progress and positive progress with your providers for the institution. It's really important that administration sees that too, that everybody's working hard to get there. Again, when we talk to our CDIs and we can use examples where prioritization, or other indicators

Kim continued

would have helped with the review process. Like okay, we dropped the ball on this. Next time, this is why we do what we do, or maybe we should assign another number to this, make it more of a priority, who knows.

But again, it's always a tweaking process. When COVID hit, Massachusetts got hit pretty hard. I know I'm talking to a national audience and I know some states are feeling that right now, and really prioritization for us was essential.

We lost the ability to do any elective surgical cases. We knew the surgical cases that we had, we really needed to drill down and make sure we maximize what we could. It also was instrumental with the COVID-19 patients, making sure the documentation was accurate. So, we should capture these accurately. Again, those two elements, we had to make the changes in 3M for a while for our prioritization, but that's exactly... It was a huge help, and we saw a really significant change and even surgery documentation on their patients.

That's it. That's all I really have to say, and I really appreciate you guys taking the time to listen to our Cinderella story. I will once again, compliment my team who works with me every day to get there and they pushed. So, thank you.

Karen

All right. Thanks so much, Kim. This is your host, Karen, again, I know we're at about time, but we have some really great questions come in and we just want to close with... You'll see a poll on your screen, this is just if you'd like more information on different topics. I'm going to leave it up there for a little bit. But please feel free to still submit some questions. We will address them afterwards if we send a follow up email to you. Don't worry if we are not able to answer them as we are at about time.

But to bring up a couple of questions that might apply to questions I had as well. One asked about really the patient setting that this tool or application covers. Does 360 Encompass cover ambulatory practices as well? I think I can answer that one pretty quickly, and that from a CDI standpoint, it wouldn't apply to ambulatory. But we do have that the coding tools within 360 Encompass that would apply to that, and we also have another solution for HCC management. Julie, I don't know if you have any other quick comments on that one, but I thought I would just bring that up real quick.

Julie Imburgia

No, only that CDI prioritization right now is only available for inpatient.

Karen

Got you. Okay. Thank you. I hope that gives you a quick answer to that. I think one that was interesting, and maybe, Kim, I think that she talked about it recently, too, we had an audience member ask if you actually provide the actual provider specific names, whereas this report card presented, how frequently. Anything you want to share further on that working with a physician?

Kim Conner

Every department has their own way of doing it. The ICU did not want to put people's names down. They just wanted to put numbers. A person was assigned to a number. Medicine and surgery have no problem having the providers names put there. We provide this report every month. Once we do our financials, and usually we wait a couple of weeks to make sure everything's in and final coded. We run the report, and then we take it from there, and we're able to really provide that information pretty quickly. Our medicine department meets once a month. They get these report cards at that time.

Karen

Awesome. Thank you. All right. I'll ask one more and then we'll wrap up here. Can either one of the presenters talk about DRG reconciliation process, the working to final? Any comments there?

Julie Imburgia

This is Julie, with 3M. I can say that we do have the ability to prioritize, I'm not sure, specifically what the reconciliation question's about, but priority worklists do you provide for the ability to prioritize by those cases. If a case has been coded by a CDI, and once it's final coded, you can create a separate swim lane for those reconciliations or you can have them prioritize in a priority worklist as you choose.

Karen

Got you. We did have a question, just as a follow up that relates to that, I think it was earlier in the presentation. Hopefully we gave that audience member a little more context. But they asked about

Julie continued

explaining the context of swim lanes. Any further comments, Julie or Kim, just on that? I think you gave a good overview, but just any closing comments on those and how you use them?

Kim Conner

For us at South Shore, when you're assigned to a floor and I'll just use the ICU as an example, you would go into the main swim lane, check out your new patients, assign them to yourself, and then it goes into your swim lane. Again, you might have patients that you have already seen that have a higher priority than your brand new patient. Again, that's how we utilize that, and that's why we assign the patients and put them in those swim lanes. Just again, you'll see the prioritization.

Julie Imburgia

Then if I could just add, swim lanes are really synonymous with the worklist. Just gives you flexibility in creating different types of worklists, using different parameters for specific needs like Kim had shared.

Karen

Awesome. Good clarification. Thank you guys. Apologies we didn't have time for extensive Q&A, but really appreciate the questions. We can see them in the system and follow up with you afterwards via email. I'm going to go ahead and close this poll, and just we have a couple of last reminders on the handouts and things like that, Julie, if you could go to the next slide.

We wanted to remind you that you can.... Yeah, thank you. You can download the document that you see listed on the slide in the handout section. We'll also be emailing out a link to the recording so you can see that. We do, if you go to the next slide here, if you just click through please. We also want you to know how you can register for another webinar in this particular series on improving clinicians documentation through technology, as well as one other one we think you might be interested on the next slide for physicians. Julie, if you could go to the next one real quick, thanks. Technology's Role in COVID-19 World.

We do have a lot of webinars at 3M. These were a couple we wanted to make sure that you're aware of. There is a handout that has the registration link, since we're not sending out the slides to this particular presentation. But again, you'll get an email follow up next week with the link to the recording. Please, take a look at that.

Julie and Kim, thanks for an excellent presentation, and all of you joining us today, we really appreciate that. If you don't mind, once I close this, there will be a very brief survey that will display when I close the window, and it'll be fantastic if you just took one minute to let us know how we did, we really appreciate that. With that, this concludes 3M's Health Information Systems webinar. Hope you have a great rest of the day. Thanks, everyone.