Individual physician performance has a direct impact on a health system’s financial, patient safety, and care quality initiatives. It is also a key performance indicator, integral to helping hospitals deliver better care at lower costs. As the healthcare industry implements ICD-10 and continues the shift towards reimbursement tied to value, efficiency, and clinical quality of care, the need to enlist physicians to help drive clinical practice changes and improve documentation is urgent. Forward-thinking hospitals are looking for strategies and tools to help manage the change and to align physicians with organizational goals; they are finding that implementing a physician scorecard is a must.

The overarching objective of a physician scorecard is to drive improvements in clinical, financial, and operational performance. At a more granular level, scorecards can help management to keep a finger on the pulse of physician activity within the hospital, foster shared accountability among team members, and ensure the organization is on track to meet key targets and objectives related to value-based purchasing (VBP), hospital acquired conditions (HAC), the Hospital Readmissions Reduction Program (HRRP), and more traditional core metrics related to case mix index (CMI), charge capture, accurate and compliant code assignment, reimbursement, and regulatory compliance.

At the heart of it all is physician documentation. For example, under ICD-10, the new code sets will improve a healthcare organization’s ability to document patient quality of care, paint a more accurate clinical picture, and receive reimbursement reflective of severity of illness and utilization of resources. But in order to realize those benefits, physicians will need to change the way they document care in order to ensure the record reflects the right information related to laterality, specificity, severity of illness (SOI), and risk of mortality (ROM). Similarly, in order to “get credit” and realize potential bonuses under VBP or avoid penalties under HRRP, physician documentation must include the right information and metrics regarding clinical process of care (e.g., delivery and timing of medications and procedures); patient experience of care (e.g., communication with doctors, pain management, communication about medications, and discharge information); outcomes (i.e., safety, infections, mortality); efficiency (i.e., spending and utilization), and present on admission (POA) indicators.

For administrators, leaders, and physician champions considering a scorecard solution, a myriad of questions may spring to mind, such as: How can a scorecard help? Which metrics should we track (and how many)? What data sources should we use (and how do we get the data)? Are there compliance considerations? How do we build the scorecard? And how do we present it to the physicians? While the answers to these questions may depend partly on each organization, the process for designing and implementing a physician scorecard will consistently involve assembling a team, defining strategic goals, identifying and designing metrics, collecting and analyzing the data, building in benchmarks, considering compliance, deploying the scorecards, and following up to drive change:

**ASSEMBLE A SCORECARD TEAM**

Development of a physician scorecard ideally includes coordination between a team of organizational leaders, administrators, physicians, and representatives from health information management (HIM), coding, clinical documentation improvement (CDI), quality, IT, data, finance, and compliance departments. Critically important is the recruitment of a physician leader (e.g., chief medical officer) to sponsor the initiative, provide input into the development of the metrics, and to communicate the results to other physicians. Ultimately, if the scorecard is to carry legitimacy and impact physician behavior, it is helpful for the results to be communicated by a fellow physician.

**IDENTIFY STRATEGIC GOALS**

While there are many potential benefits of implementing a physician scorecard, to be truly effective the scorecard must be linked to strategic, organizational, or departmental goals. Additionally, a good scorecard will deliver actionable intelligence to physician leadership; assist in identifying, quantifying,
Health Solutions: Physician Scorecards

tracking, and prioritizing areas for improvement; and foster shared accountability among physicians, management, and other involved team members. Otherwise, the scorecards will become “just another report,” lost in the stream of data and information that confronts physicians and administrators daily. In other words, the scorecards have to be useful, they have to impact behavior, and they have to provide actionable information that will help management and physicians achieve organizational goals. For example, an organizational goal might be to better understand overall case mix, as compared to benchmarks of peer organizations (or the case mix and utilization patterns of specific physicians, as compared to peer physicians within the same organization). Another objective might be to improve clinical quality and care processes in order to provide exceptional care and to realize bonus reimbursement under VBP. Yet another goal might be to reduce the possibility of a government audit, investigation, or demand for repayment by ensuring complete, accurate, and compliant documentation. Having specific objectives and goals in mind will drive the selection of the metrics to track and present on the scorecard.

SELECT THE METRICS

There is an almost unlimited number of metrics, statistics, facts, figures, and data points that might be interesting to report on a scorecard. So much so, that it would be easy to get excited and try to present them all (or at least too many metrics to be truly meaningful). When designing a scorecard, the best approach is to “keep it simple” and to focus on the metrics that matter the most. Start by choosing a few core metrics (three to five is ideal, but no more than ten) that are of critical importance to achieving the stated strategic goal, then refine and add new ones over time; the process should be iterative. In the context of physician performance, some core metrics might include ones that measure case volume, case type and severity, and resource utilization:

- **Total number of cases**
- **Case mix index (CMI)**
- **Average length of stay (ALOS)**

Additionally, CDI leadership should make sure the scorecards draw attention to the accuracy, completeness, and quality of physician documentation. Focusing on physician documentation is important because the documentation drives the coding and the coding drives the reimbursement. If the documentation is not sufficiently robust, the organization may not be capturing CC, MCC, SOI, and ROM, and other key items, which ultimately drive DRG selection and relative weight (and thus reimbursement).

When thinking about how to measure a given activity, it sometimes helps to think in the abstract. For example, CDI program managers who want to measure whether physician documentation is accurate and robust will be hard pressed to find a data point like “accurate/complete” or “not accurate/incomplete” (outside of performing a chart audit for each and every case for each and every physician). But the number and type of physician queries are good proxies for that same information (i.e., if a given physician consistently receives a higher than average number of queries, it may be an indicator that the documentation is not sufficiently robust). Additionally, CDI managers and organizational leaders may want to understand whether physicians are engaged with the CDI program, are providing information to improve existing documentation, and making the relevant improvements in their documentation practices over time. In this respect, another good metric to include on a scorecard is physician query response rate. Overall, some query-related metrics to consider are:

- **Total number of queries**
- **Top query types**
- **Query response rates**

Finally, with so much emphasis being placed on clinical quality and process of care and reimbursement increasingly tied to value, it is important to consider including at least a few metrics that will help the organization track performance and accuracy of documentation in these areas. While not all of the VBP and HRRP metrics will be applicable across physician specialties and case types, and while different programs have different goals related to quality and utilization, there are some straightforward (and illuminating) items that healthcare organizations should consider tracking and monitoring. For example:

- **Hospital acquired conditions (HAC)**
- **HRRP related readmissions**

Higher than average HAC rates associated with a physician may not necessarily indicate a quality of care issue. Instead, it may signal a need to improve the physician’s POA documentation.

Taken together, these case, query, quality, and efficiency metrics can fit easily onto a single page scorecard and provide a baseline picture of physician performance.

COLLECT AND ANALYZE THE DATA

One of the most challenging steps in building a physician scorecard is identifying the right data sources and collecting clean, accurate, and complete sets of data. Most healthcare organizations face similar data challenges: numerous, unconnected reporting systems; clinical, financial, and operational data in silos; a variety of existing reports with varied purposes and intended for different audiences; and therefore multiple “versions of the truth.”

Given that one goal of the physician scorecard is to improve transparency and a second goal is to accurately measure and impact physician performance, it is mission critical that the data be authoritative, complete, and accurate. The solution lies in developing a standardized and consistent process that lays out how to identify, extract, cleanse, crosswalk, merge, load, analyze, and report on the data. Build in checkpoints and discussions among team members to validate the data. Best practice is to document the process and data sources in a standard operating
In most instances, these data sets will only provide results at the American Hospital Directory (AHD), or Definitive Healthcare. But Hospital Compare, or subscription data sets such as Comparion, publicly available state or federal data sets such as MedPAR or performance and identify areas for improvement.

Comparison and add the necessary context to evaluate physician HAC/POA, Readmit Date). Query Count, Query Dates, Query Reason, Query Response Date, Physician Specialty, Account Number, Discharge Date, DRG, (e.g., Facility, Physician Provider Number, Physician Name, as well as the necessary data points to develop the scorecards that can be used to link and compare each data set to the next. Ensure each data set includes common and standardized fields or VBP/HAC/HRRP tracking data) for all inpatient discharges.

For a given quarter: claims and reimbursement data for all inpatient discharges, CDI and physician query data for all CDI following for a given quarter: claims and reimbursement data for all inpatient discharges, CDI and physician query data for all CDI-reviewed inpatient discharges, and QualityNet (or similar quality or VBP/HAC/HRRP tracking data) for all inpatient discharges. Ensure each data set includes common and standardized fields that can be used to link and compare each data set to the next as well as the necessary data points to develop the scorecards (e.g., Facility, Physician Provider Number, Physician Name, Physician Specialty, Account Number, Discharge Date, DRG, Query Count, Query Dates, Query Reason, Query Response Date, HAC/POA, Readmit Date).

**INCORPORATE BENCHMARKS**

So now you have defined the strategic goals, identified the metrics, pulled the data, crunched the numbers, and developed the scorecard. What comes next? And how do you evaluate the results? You have statistics on physician case load, CMI, query activity, utilization, and quality. Let us look at a hypothetical example: last quarter, Dr. Smith’s CMI was 1.4811; he saw 166 patients; 22% of his cases required queries; his query response rate was 74%; his top three query types were (1) Encephalopathy Specificity; (2) Underlying Cause of Symptom; and (3) Pressure Ulcer Specificity; his ALOS was 4.3 days; 1.2% of his cases resulted in HACs and 6% of his cases resulted in readmission. But are those results good or bad? Are they above or below average? Without proper context, it is difficult to draw conclusions. Benchmarks will provide useful points of comparison and add the necessary context to evaluate physician performance and identify areas for improvement.

In some instances, it might be possible to use benchmarks from publicly available state or federal data sets such as MedPAR or Hospital Compare, or subscription data sets such as Comparion, American Hospital Directory (AHD), or Definitive Healthcare. But in most instances, these data sets will only provide results at the facility or health system level (not necessarily at the individual physician level). Following the “keep it simple” approach, the best place to look for physician-level benchmarks is using the organization’s own internal data sets. Through the scorecard development process, you will have already calculated metrics for each physician. So it is no large stretch to include a benchmark—which reflects the average among peer physicians of the same specialty—for each metric. Another source of data to consider is publications and surveys from industry groups such as HFMA, HCCA, AHIMA, and ACDIS. For example, in a recent survey conducted by ACDIS, the majority of respondents suggested 85 to 91 percent as an acceptable physician query response rate. Without that information, a hospital would not know whether an average query response rate of 80% among its physicians was good or bad. Returning to our hypothetical example, it is not until we see the peer benchmarks presented in the example scorecard in Appendix 1 that we understand Dr. Smith is underperforming as compared to his peers with respect to CMI, query volume, query response rate, and HAC, whereas he is outperforming his peers with respect to readmissions and LOS.

**COMPLIANCE**

It is always important to keep compliance top of mind. The scorecard must be designed in such a way that it does not incentivize or promote inappropriate physician behavior. For example, organizations have fallen under scrutiny for utilizing scorecards to attempt to pressure doctors into increasing admissions regardless of whether a patient needed hospital care, or to attempt to increase revenues by documenting care that did not occur or severity that did not exist. The purpose of the physician scorecard should always be to improve accuracy of documentation, to maintain focus on clinical process of care, and to identify areas for potential improvement in a manner that is compliant with industry standards, regulatory requirements, and law. Consider partnering with your organization’s compliance department to obtain input on whether the presentation of a certain set of metrics could actually be driving (or even creating the appearance of driving) inappropriate incentives or messaging.

**THE SCORECARD: PULLING IT ALL TOGETHER**

The final step in the process is to create the scorecard. It should be simple, easy to interpret, and make use of visualizations to “paint the picture” or “tell the story”. The example in Appendix 1 presents one possibility for organizing a physician scorecard.

Utilize the results of the physician scorecards to identify areas for improvement, organize discussions and communications strategies, update policies and procedures, tighten internal controls, and develop and implement training and education. Dive deeper into the results through chart audits, supplemental data analysis, and reviews to identify root causes. Sit down with physicians who are consistently not in compliance with the organization’s query response policy. Hold discussions to remediate and educate on the importance of complete, accurate, and compliant documentation. And finally, reap the rewards of the hard work, team efforts, and focus.
Appendix 1: Example Physician Scorecard

**Physician Scorecard**

ABC Hospital System CDI Program
January, 2015 - March, 2015

**Physician Data**

<table>
<thead>
<tr>
<th>Attending Physician:</th>
<th>DR. SMITH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of Cases*:</td>
<td>166</td>
</tr>
</tbody>
</table>

* Number of Cases reviewed by the CDI team

**Query Volume**

<table>
<thead>
<tr>
<th>Total # of Cases with Queries:</th>
<th>36</th>
</tr>
</thead>
<tbody>
<tr>
<td>% with Queries:</td>
<td>22%</td>
</tr>
</tbody>
</table>

**Query Response Data:**

<table>
<thead>
<tr>
<th>Total # of Queries:</th>
<th>31</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of Responses:</td>
<td>23</td>
</tr>
<tr>
<td>Total # of No Response:</td>
<td>8</td>
</tr>
<tr>
<td>% Responded:</td>
<td>74%</td>
</tr>
<tr>
<td>% No Response:</td>
<td>35%</td>
</tr>
</tbody>
</table>

1) ABC Health System's target physician query response rate is 95%.
2) The average query response rate for your peers during this period is 90%.

**Top 3 Query Types:**

<table>
<thead>
<tr>
<th># of Queries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encephalopathy Specificity</td>
</tr>
<tr>
<td>Underlying Cause of Symptom</td>
</tr>
<tr>
<td>Pressure Ulcer Specificity</td>
</tr>
</tbody>
</table>

**Quality & Efficiency**

<table>
<thead>
<tr>
<th>Dr. Smith</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of Cases with HAC:</td>
</tr>
<tr>
<td>% with HAC:</td>
</tr>
<tr>
<td>Total # of HRRP Readmissions**:</td>
</tr>
<tr>
<td>% with HRRP Readmissions:</td>
</tr>
</tbody>
</table>

| Average Length of Stay (ALOS) | 4.3 |

**Peer Group Avg**:

| 0.5% | 12% |

**Stoplight**

- Red
- Green

*Peer Group: Internal Medicine

**Readmissions related to disease states tracked under CMS HRRP (AMI, Heart Failure, COPD, Pneumonia, Elective Hips/Joints)
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ABOUT THE FTI CONSULTING CDCI PRACTICE

The CDCI practice at FTI Consulting focuses on understanding how data can be used to educate, assist, and transform Clinical Documentation Improvement (CDI) programs within the healthcare environment.

Our Physician Scorecard solution provides analysis of hospital claims data, CDI program data, and VBP and HRRP related quality and efficiency indicators. We pair the scorecard results with analysis and recommendations from FTI’s physicians, clinicians, and HIM/CDI specialists. We assist clients with communicating the results to their internal physician staff to ensure acceptance and engagement, and provide training to drive improvements in physician documentation.

Our ProTrend™ outcome metrics reporting package provides analysis of APR and MS DRG data and helps organizations to monitor Case Mix Index (CMI), CC/MCC Capture Rates, and overall volume as compared to nationwide benchmarks for similar institutions.

Our Value Based Purchasing analytics monitor all of the metrics within each VBP domain in real time. We pair this monitoring with the real-time education to help provider organizations realize improvements to the quality metrics that will be reported to CMS, thus ensuring compliance and maximizing future reimbursements. Additionally, we utilize analytics to validate the CMS-published VBP data and scores against the data the hospital reported to CMS and help to facilitate appeals process triggered by identified discrepancies.

We also support hospitals by assessing their performance post ICD-10 Implementation through analytics that target ICD-10 codes and their corresponding APR and MS DRG methodologies. Our experts regularly assess the current state of Clinical Documentation Programs and help organizations identify gaps, correct any issues, and enhance the success of their CDI Program.

REFERENCES

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