

Q&A

Key performance indicators



As part of the 10th annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics.

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Q According to the 2020 CDI Week Industry Survey, respondents noted the number of chart reviews per day and query response rate as important KPIs in their facility. Nearly 34% said they do not monitor Hierarchical Condition Category (HCC) capture at all, and only just over a quarter said denial rates were important; 33% do not monitor denial rates at all. What does your facility monitor for KPIs? Does anything about the survey result surprise you?

A We use 3M software, and they have robust reporting capabilities. We are always expanding our use of every one of them. We use these reports in conjunction with numerous additional reports from a variety of vendors to amalgamate an automated daily dashboard with incredible “drill down” and customization features. A dashboard is available to every level of employee within IHC, customized to their need for real-time information. To date, we measure and track every KPI mentioned on CDI Week Industry Survey and any of the many CDI references.

We do still pay attention to the basic KPIs, like number of charts reviewed, number of new patients reviewed, percentage of charts queried, agree rate, response rate by individual physicians and by service lines, etc. For the past couple of years, though, we have turned our attention to quality measures including all Patient Safety Indicators (PSI), hospital-acquired conditions, PCCs, readmissions, mortality variables, and HCCs. All these measures absolutely have an enormous impact when it comes to the multitude of regulatory/reporting agencies, but they also (most importantly) impact our patient care. CDI specialists play a critical role on the front end of many, if not all, of these measures.

Not every CDI program is at the same level of maturity or readiness or even has the tools to address all the measures, though. Manual reporting and tracking is just not feasible. Even those programs that have automated reports available to them may not have the culture that is ready for them. It takes a great deal of education at all levels of the organization, starting with boards, key executives, decision-makers, and practice influencers, then infusing the understanding throughout

all providers with targeted education. Just try to get a large department of providers to sit down together, even with a gourmet meal, to receive education that is not focused on clinical pathology or offering CEUs! The providers must perceive the urgency, which is often difficult to communicate effectively.

Taking this to a macro level, the organization's perception of need must overcome the expense associated with obtaining the proper tools and personnel. If they don't see the need, then education is key.

Q Do you think it's important to track non-financial KPIs as well as financial KPIs? Is one more important than the other, or should they be looked at with equal importance?

A Yes; as I mentioned before, tracking HCCs, mortality variables, PSI mitigation, etc., is crucial to quantifying not only how CDI specialists' time is spent, but also what matters most: the impact on publicly reported data and quality of care measures. One challenge (and there are many) is that most publicly reported data lags three years behind, so one cannot rely on that data in the next annual budget meeting or soft/hard asset justification. The CDI department leader must have real-time, accurate, reliable data to prove worth and justify expansion into "soft" revenue streams.

So how do you get started? I believe this is where using an internal or external consultant can prove to be money well spent. They can gather enough focused data to justify the organization's investment in specialized software/hardware/additional staff members. In my opinion, only use consultants who have a firm grasp of the CDI world, otherwise you spend too much time trying to educate them. A good first step would be conducting a gap analysis to understand the current status of the organization's capabilities so the need can be readily evaluated.

To conduct a gap analysis, one identifies the ideal state: what you envision the CDI program to look like, what software, hardware, and personnel you determine will facilitate that vision. Don't think in a constrained manner when creating this vision—reach for the moon! Constraints will come later. This vision is the starting point for moving forward, whether you are a "do it

yourself" or you are able to bring in subject matter expert consultants. Start with a vision.

Some tips for creating a vision include reviewing industry publications and joining industry-focused professional organizations. ACDIS is the primary and complete industry organization. AHIMA is another good organization for resources and has dedicated part of its mission to include CDI topics. AHIMA addresses all aspects of the medical record, a much broader perspective, but allows the CDI leader to understand the work of one of the key stakeholders impacted profoundly by CDI work. The same can be said for quality organizations. The Agency for Healthcare Research and Quality membership is free, as is signing up for CMS notifications of current issues/changes that will impact CDI departments.

If a CDI leader is starting from scratch, network profusely to gather ideas on successful and unsuccessful strategies learned/practiced by other CDI leaders. There is no "cookie-cutter" methodology to start. One must consider several variables that can be convoluted and mired in cultural resistance. Remember, start small—small samples, single service lines, even just one physician. "Eat the elephant one bite at a time."

Q Who do you share KPI data with at your organization? It is all CDI specialists, just managers, the chief financial officer, or others? In your opinion, who needs to know the KPI data and why?

A I believe that a knowledgeable CDI leader should report KPIs on a regular basis at all service line meetings, weekly executive meetings, CDI staff meetings, or in the case of a real-time dashboard, be prepared to be called spontaneously about any aspect of the report. I get very happy when I am called or challenged about data that has been shared. It makes me happy since I know the person calling is paying attention and swings the door wide open for the opportunity to educate! There are always questions/comments about the data—happy and hostile—so this should be expected, and the CDI leader should be prepared to respond with passion but without defensiveness.

At IHC, we have weekly dashboards sent out to every CDI specialist in the department. The responsibility for pushing out this data is rotated among designated CDI

specialists. Individual CDI specialists' stats are blinded so we can retrieve our own specific report in a "safe" manner. We also have monthly virtual "all-CDI-staff meetings" where we discuss improvement strategies for the department, needs for focused reviews, future software enhancements, etc. KPIs are shared and discussed, and usually we discuss any corporatwide initiatives that are impacted by our work.

Sharing KPIs is paramount to educating all levels of employees about the work done by CDI. Data is king! This requires that recipients are prepared to understand the data, empowered to impact unfavorable or underperforming elements, and educated to know how to analyze and frame data productively/properly. I'm willing to bet that all CDI leaders have had a physician, on more than one occasion, argue until blue in the face about one insignificant number that was off by a miniscule factor. No provider likes a surprise, especially not one that might have negative implications or, in their words, "be used against them." Needless to say, never use these data in a punitive manner. Prepare, educate, prepare, educate, and then keep preparing and educating. It is never over!

Q What tools does your facility use to present KPIs to organizational leaders (spreadsheets, presentations, dashboards built into software services, etc.)? What do you think are the best ways to present this information?

A IHC has long been committed to be a highly automated organization in every aspect of the work we do. Our medical record is a highly customized Cerner product that had its genesis through a joint venture with Cerner to improve its existing multihospital, complex healthcare system. This was fully implemented about three years ago. Since that time, we switched CDI software to 3M 360, the same vendor used by our coders, which drastically improved our CDI effectiveness. Just recently we moved to 3M Engage One, a new platform that fires "nudges" to providers. [The nudges] are created through the system's recognition of key medical terms and combinations of terms [and] are designed to prompt the provider of possible diagnoses or specifications of diagnoses that may be queried by the CDI specialists if not documented.

Many CDI specialists' ears perked up when we learned about this new platform. While it was new and exciting, it felt a little like we could end up being replaced by software! But I can offer my personal reassurance that nothing can replace the clinical mind. Artificial intelligence (AI) can be a tad threatening, especially among insecure CDI specialists or departments in their infancy, but rest assured that clinical judgment, understanding the culture, and often having a solid relationship with an individual provider cannot be replaced by AI.

We are phasing in 3M Engage One throughout our entire organization. We are making the usual implementation tweaks along the way, but we're getting there. The tweaks are made considering comments and issues from all stakeholders that are prioritized collaboratively with the vendor. It can be a slow process once the big hurdles are addressed and the entire organization is live, but any issues that impact providers are automatically escalated to a higher priority, which keeps them engaged and an active participant in the process.

Q Most Industry Survey respondents who prepare KPI reports spend between one and five hours on these reports each month, but still nearly 10% said they spend 6–10 hours. Do you think it's better to spend more or less time on these presentations? For those spending 6–10 hours per month, what would you suggest they can do to cut down this time? What specific information is important to include in these reports?

A Less is best! Leadership, as well as CDI staff members, should spend little to no time preparing reports and focus their brainpower on reviewing and using reports productively. The caveat is the old saying: "GIGO: garbage in, garbage out." For this reason, continuously strive to standardize as many processes as possible, such as reconciling queries, defining minimum data set criteria for high-risk clinical diagnoses. CDI specialists also rely on these standard minimum data sets for clinical validation as well as querying for an undocumented diagnosis.

Standardization has proven to be key to ensuring high-quality data, especially as perceived by patients and families. They don't get different stories when the

hospitalist they started with rotates off and a new provider comes on. The new provider doesn't just rely on handoff, but can lean heavily on standard care, along with documentation. In a highly automated environment, it is crucial to be able to distinguish between CDI specialist-generated queries/data and program-generated prompts/data.

All this said, if a CDI program is not automated and/or the medical record is still manual or even a hybrid, manual collection may be necessary and is a resource-consuming process. Survival of a CDI program hinges on being able to prove a department's contribution to any organizational annual strategic plan. The greater the tie made to any of the initiatives and/or goals, the more likely the CDI department will be to survive through the years. Regardless of automation, data/statistics—and if possible associated revenue—should be captured. Leaders need to become familiar with industry standards and precisely how they are measured. Then work with the other stakeholders to define what and how measures will be collected and reported.

Q Has your facility adopted any CDI software solutions (such as electronic groupers, computer-assisted coding, or electronic querying tools)? Have these tools had any effect on program KPIs or how you collect and manage KPI data?

A The jury is still out on our recent upgrade to 3M Engage One. We've only gotten a small number of hospitalist groups up who are the early adopters. I anticipate as we roll out to additional hospitalist and other provider groups, that there will be greater strain on the system and may reveal different issues that will have to be addressed before having a reliable process in place.

If your organization is considering implementing new software, read up on how smooth (or bumpy) implementations usually go in general. Negotiate crucial events and deadlines with vendors after establishing them among a steering committee of stakeholders.

I've found the most informative method to learn about an implementation is to interview current users who can give it to you straight on how their implementation went and any lessons learned, no-repeat mistakes made. Select current users in various phases of use so that you get a variety of perspectives. Try to stick with similar organizations since their experiences will be a closer fit to yours.

Q How can leaders leverage KPIs to show CDI program success? How should CDI leaders decide which KPIs to monitor and place the most weight on?

A Leveraging KPIs is one of the most important roles of a CDI leader. Stay in front of the senior executive team or even boards. Attend departmental meetings and stay current with salient, priority issues of stakeholders. Figure out how your department can help mitigate their most urgent problems.

Ask to contribute a small paragraph to the organization's annual report after a full-disclosure discussion with your department staff, your direct line leadership, key stakeholder leadership, and the CEO. This is a huge opportunity! During this time, the CDI leader can put in plugs for new ideas and initiatives as it becomes more obvious by the data present that the CDI department has an enormous, far-reaching positive impact.

An overt presence in the annual report is not common, so barring that, get in front of every group of current and/or potential stakeholders at least quarterly. If appropriate and possible, bring a staff member with you. When it's handled well, their attendance goes a long way toward internal departmental relationships. All staff want to know they have the support of their stakeholders and their boss. On the flip side, the stakeholders in the meeting will observe an example of leadership, achievement, and staff appreciation. Once you get the stage, use it wisely and strategically.