Q&A CDI WEEK

CDI and quality

ChartWise 2.0
Better data. Better outcomes.

As part of the fifth annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. ***Melinda Matthews, RN, BSN, CCDS,*** *supervisor of inpatient CDI at Wake Forest University Baptist Medical Center including Brenner Children's Hospital Winston-Salem, North Carolina, answered the following questions regarding CDI specialist's role in ensuring accurate quality metric reporting. Matthews graduated from Forsyth Technical Community College and the University of North Carolina Greensboro and began working in CDI in 2011. A multiple time speaker at ACDIS National conferences, she also co-presented at several other related programs. Contact her at mgmatthe@wakehealth.edu.*

Q Can you describe your facility's CDI efforts and your involvement?

A Our team of 20 inpatient and six outpatient documentation improvement nurses has worked hard to immerse ourselves in several key quality areas. We see the future of documentation improvement and we want to solidify our positions as supporters across several different initiatives. Our administration is already testing software (natural language processing engines) that will assist with improved provider documentation without CDI intervention.

Given the size of our program, we elected to immerse ourselves in support of quality initiatives to ensure our positions for years to come. I encourage other programs to stay active, expand your program beyond where you currently are to establish a firm foundation for the future.

Our team reviews documentation concurrently to identify any potential or confirmed hospital acquired condition (HAC) or patient safety indicator (PSI). Our process is a joint effort and includes our associate chief medical officers, key physician leaders, medical coding, and quality/analytics department. Modifications to our CDI software provided a tracking mechanism to facilitate communication between the various team members. This has enhanced our throughput and time-to-resolution, with a goal of accurate capture and decrease delays related to final billing. At this time, we have a standing meeting each Monday to discuss any problematic cases.

Q When did CDI start getting involved in looking at quality-related documentation concerns and what was the impetus for the evolution?

A Pressure ulcers. Back in 2011/2012 the nursing leadership requested our assistance to identify present on admission status of any pressure ulcers. This quickly expanded to include other HACs and now PSIs.

Q What were the initial focus items and how have they evolved?

A Initially, we found that pressure ulcers were being documenting at the time of arrival by our nursing staff, but the physicians were not including this documentation in their assessment. After working with several physicians, we identified a major barrier within our EMR. The physicians did not know how or were unable to view the nursing flow sheets. So we completed aggressive education across our medical center to promote knowledge, understanding, and importance of correct documentation. Things have improved tremendously with our pressure ulcer documentation today, and with modern technology we have the ability to capture/identify potential areas of concern electronically.

Q Has ongoing changes in CMS and other payer reimbursement models pushed CDI program involvement with quality forward?

A Our efforts with our quality initiatives are solid and growing daily. We have a dedicated clinical documentation compliance coordinator who has our process in place. We have multiple individuals within our team with advanced knowledge of HACs, PSIs, Meaningful Use (MU), and Value Based Purchasing (VBP). It is our goal to consistently have a resource available to provide education for both staff and physicians/providers if needed.

Q What first steps do you think CDI program managers and/or staff members can do to expand into quality?

A Start small and then gradually expand. Network, meet, and establish relationships with your quality department. Ask that they educate you regarding what is needed. Question your quality department on what key areas they feel you should focus your efforts. Identify the reasonable areas where your documentation team can begin and demonstrate a return on investment.

Q What was the most rewarding aspect of your team's efforts?

A The interdepartmental friendships we have made. There are really great folks trying to achieve monumental tasks associated with quality measures. Knowing that you can help achieve a positive outcome to improve the nationally reported data for our medical center is certainly rewarding. It has also been enlightening to know how extensively we can assist concurrently.

By identifying these issues when the documentation first appears in the chart, we can implement measures to address, correct, or even remove the documentation if needed. Once something is copied and pasted forward in the record over several days, it is very difficult to have the documentation corrected or removed by the care team.

Q What was your team's greatest challenge?

A The data, details, and technical requirements surrounding HACs and PSIs were overwhelming. Our quality/analytics team, although extremely nice, was very verbose and enjoy sharing the finer details surrounding quality measures and requirements.

Initially I would sit in our meetings and envision someone "HAC-ing" my computer and the mathematical equation for "PSI." The terminology has been so challenging. Breaking the information down into manageable pieces as they applied to our team was daunting. This is when I realized that starting small was key.

Our team, who have been extremely stoic through it all, have becoming blazingly honest in their feedback. Keeping it simple has never been so challenging. When we are asked to expand our efforts into additional areas of quality my goal is to break the information down into easy to understand, easy to remember, and need-to-know basics so that the volume of complex information shared with our CDI team is limited. However, be aware: while our CDI staff has been successful by knowing the basics, leadership is not so lucky. Trust me when I say, if leadership cannot understand HACs and PSIs, your team will not either.

Jonathan Elion, MD, is the founder of ChartWise Medical Systems, Inc., in Providence, Rhode Island. He is a practicing board-certified cardiologist and an associate professor of medicine at Brown University. He has served on the finance committee and board of trustees of several Brown-affiliated hospitals and is well versed in hospital finances. Here Elion discusses the role of CDI in quality measures.

To support a growing focus on quality measures in healthcare, there is a need for improving the precision and completeness of the data used in the analyses. Complete and accurately coded data is essential, and clinical documentation is the cornerstone of accurate coding. All aspects of the patients' conditions, treatments and outcomes have to be fully documented, and accurately and completely coded.

The easiest place to see the importance of clinical documentation in quality measures is when looking at "Observed-to-Expected" rates, sometimes referred to as an "O/E" ratio. These are commonly calculated and reported for complications and for mortality. A ratio greater than 1.0 means that the observed events are occurring more often than expected. Failure to completely and accurately document comorbidities will result in a higher ratio implying a lower quality outcome than what may truly be happening. By fully documenting the comorbidities, the quality scores will be more accurate.

The coding department is tasked with ensuring that high-quality data drives the calculations of quality measures. This means creating a complete and accurate set of codes that correspond to the information in the clinical documentation. True, this is generally outside the purview of CDI programs, but CDI managers need to be aware of the impact of the quality of coding on apparent CDI program performance and on quality measures. In addition to looking at the documentation side, healthcare providers should also spend time auditing and reviewing their coding practices and performance. If it's not documented, it can't be coded. But if it's not coded, it cannot be reimbursed or measured.

So, the most obvious role of a CDI program is to fully document all comorbidities, thereby assuring that the "Expected" part of quality calculations properly reflects the condition of the patient. When CDI programs emphasize the pursuit of increased reimbursement, this important function can be overlooked or missed. There are many diagnoses that will impact the Risk of Mortality (ROM) without changing the DRG or reimbursement; failure to pursue the full documentation of these will have an adverse impact on quality measures that rely on O/E ratios.

With this in mind, it is disquieting to see that only 75% of 248 respondents to the ACDIS survey report that they query even if the answer would only impacts a quality measure, and not reimbursement. This should be 100%. It would be interesting in future surveys to find out the reasons underlying this result, as this may reflect an opportunity to education hospital executives on the importance of full and complete documentation and a comprehensive CDI program.

It is also interesting (albeit unsettling) that nearly 38% of 237 respondents report that reviewing for quality measures hinders their traditional CDI chart review productivity. This too suggests some opportunities for further clarifications in future surveys. How is productivity being measured, as there are many potential metrics that have been suggested (such as the number of reviews, number of queries, improved reimbursements, increase in Severity of Illness, etc.)? This figure also suggests that many programs do not consider that working on behalf of solidifying quality measures is not part of the traditional CDI chart review, when in fact it should be.

The following list summarizes some of the activities related to providing the best environment and data for quality measures, including:

- Educating hospital executive on the need to consider all aspects of documentation, not just those that directly impact reimbursement;
- Carefully documenting conditions that are Present on Admission (POA), as failure to do so may have a significant negative impact on quality measures;
- Designing and running a CDI program that emphasizes a full and complete chart, not just information needed for reimbursement. Remember that many conditions may impact ROM (the "expected" part of the O/E ratio) without directly impacting reimbursement;
- Fully documenting all conditions and comorbidities,
- Implementing periodic code reviews and audits to ensure accurate and complete coding of the information on the chart; and
- Making sure that there is adequate documentation (not just orders) regarding do-not-resuscitate ("DNR") and palliative care status. These are not yet fully incorporated into all quality measures, but are being studies and will start to show up soon, so we might as well get in the habit of doing it now. There are specific codes for DNR (V49.86 for ICD-9 and Z66 for ICD-10) and for palliative ("comfort") care (V66.7 for ICD-9 and Z51.5 for ICD-10).

The CDI field has seen a gradual change from reviews and queries done only after discharge to where they are now done concurrently during the hospital stay. Quality measures are also poised to make a similar transition, as we strive to know not only how we were doing six months ago, but how we were doing six minutes ago. This will in turn allow a hospital to focus on improving the quality of care while the patient is still in the hospital, resulting in better outcomes.

All of this is driven by a high-quality CDI program that is concerned about more than reimbursements, and is motivated to develop a complete medical record. And at the end of the day, isn't better quality and better patient outcomes the goal?