Q&A CDI Week: CDI & Quality

As part of the seventh annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. ***Angie Curry, RN, BSN, CCDS****, the CDI director at Conifer Health in Frisco, Texas, a member of the ACDIS Advisor Board, and the 2017 CDI Week advisor, answered these questions on CDI and quality. Contact her at angie.curry@coniferhealth.com.*

Q Has reviewing for quality measures hindered CDI department's "traditional" CDI chart reviews or overall productivity?

A CDI programs involved in assisting with quality measures have seen a decrease in how many cases can be reviewed, according to traditional CDI staffing recommendations. Reviews have become much more than the original CDI goal of establishing a working DRG, and MCC/CC capture.

CDI programs are crucial in addressing potential quality issues while the patient is still being treated—whether as an outpatient or an inpatient.

Many programs have needed to decrease the expected number of reviews related to the increased time being spent looking for potential quality issues.

Q What were your initial focus items, and how have they grown or changed?

A Initially, CDI programs were minimally involved with quality initiatives other than establishing present on admission (POA) status. The industry soon realized if we could positively affect complications by establishing that conditions were actually present when patient entered the facility (and not caused by the facility) maybe CDI could assist with other aspects, such as core measures.

From there, we've seen interest in other quality measures such as severity of illness (SOI) and risk of mortality (ROM) scoring.

At this point, the evolution into quality has become part of the CDI review—including queries that may not move the DRG, but do provide an increase in SOI/ROM.

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

A Yes, absolutely!

Bundled payment initiatives, a CMS program, brought CDI to the table to discuss the accuracy of code assignment. These initiatives depend upon getting the primary diagnosis correct for the patient to show the true volume of inpatients that fall into either a voluntary or mandatory bundled payment. Thus making accurate DRG assignment more important than ever.

Pay-for-performance measures are another initiative where CDI has been very successful. Assisting providers in accurately capturing their patient's true SOI by capturing all comorbid conditions being monitored, evaluated, or treated in their documentation.

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

A The advent of quality measures is a great initiative to pull together an interdisciplinary team to look at the quality issues at your facility.

Many facilities have workgroups including quality, coding, and CDI teams to do second-level reviews to assist with physician education, providing guidance for quality teams, as well as education for CDI and coding teams.

Q How do you see quality in the greater healthcare industry evolving, and what can CDI do to prepare?

A Quality in the outpatient arena has become the next horizon for CDI programs throughout the United States.

Hierarchical Condition Category (HCC) capture is an integral part of outpatient care. CDI teams are learning how to review for HCCs as well as assisting not only providers but educating the hospital administration on how accuracy is integral in both inpatient as well as the outpatient medical record.

Accuracy in the outpatient record has the potential to increase the accuracy of the inpatient record, too. By getting things right in the outpatient record, those comorbid conditions can more easily be identified with an inpatient admission, and will once again assist in accurate reporting of SOI/ROM.

Facilities are experiencing decreased reimbursement for care provided. Therefore, medical record accuracy is more important than ever.

CDI programs have the potential to decrease denials, also decreasing the amount of time and staff used by facilities on the back end arguing for payment for services rendered.

I believe the future of CDI is accuracy, and at the end of the day we can all be proud of the work we do.

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Changes within the healthcare industry are driving the need for clinical documentation improvement (CDI) programs to become more actively involved in addressing quality of care metrics and outcomes reporting for their facilities. With government incentive programs, such as value-based purchasing and its various components, hospitals face financial penalties for underperforming on specific quality measures.

Furthermore, private reporting agencies pick up federal coded healthcare data and employ it on consumer advocacy sites and reports. Drive down any highway in America to visualize the effect of this reporting on the marketing of our community hospitals. Billboards lining the highways tout X Hospital as the number one provider of cardiac services in the region or Y Hospital as having earning accolades from U.S. News and World Reports for its care.

All this information is not only driven by the quality of the care provided but the quality of the documentation captured and the accuracy of the codes assigned related to that care. CDI programs may have originated to help with CC/MCC capture and drive MS-DRG assignments as a way to accurately capture reimbursement but now those efforts are also driving the narrative regarding the quality of care a facility provides.

Collaboration leads to quality improvement

The secret to success may not be a well-kept, nor very complicated, one. Simply, put CDI programs need to reach out and collaborate with their facilities' coding and quality teams. If these three departments are not on the same page, it could put the program and the facility at real risk. They need to align their medical record review efforts so that the picture of that patient's care can be as accurate as possible.

Quality departments can provide the team with the current baseline data and explain the various documentation and coding components to their focus areas. As a team, the three departments can examine their process workflows and identify areas of overlap and potentially mutually beneficial points of interest. Patient Safety Indicator 90 and hospital acquired condition documentation represent low-hanging fruit targets to start with. Programs should analyze their data to evaluate the current status of these items and lead the way to target improvement opportunities.

The CDI industry needs to move back to the original intent of the ICD coding system—as a method to capture data about healthcare trends—and really focus on capturing those chronic conditions that not only affect reimbursement but affect quality and risk adjustment as well. The healthcare industry seemingly moved away from that with the implementation of MS-DRGs but we need to go beyond those reviews now and capture everything that's going on with the patient during his or her treatments.

Systemic collaboration

As departments evaluate their workflows, they need to consider employing technology that holds all these initiatives in mind. Having everyone work within the same system allows the entire team to see beneath the covers, to understand when the physician was queried and why, to demonstrate the various ways each department staff member interacts with the medical documentation and effect on the final code assignment.

Oftentimes, quality, CDI, and coding employ different playbooks. Effective artificial intelligence (AI) in form of a system-wide solutions can bring these playbooks, these different documentation rules, seamlessly together. The technology should help you run all the rules of the game. AI at the point of care helps the healthcare team act rapidly when a quality of care concern may be suspected so the CDI team can ensure the most accurate documentation possible. It can be a real game changer in this ever-challenging healthcare game.