Q&A CDI WEEK

CDI expansion

As part of the sixth annual Clinical Documentation Improvement Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. ***Jeff Morris, RN, BSN, CCDS,*** *supervisor of clinical documentation improvement for the University of South Alabama Health System, answered these questions about CDI expansion. Contact him at jwmorris@health.southalabama.edu.*

Q When did you first get involved in CDI, and what was your CDI program's focus?

A I began in CDI four and a half years ago when my organization was looking for someone to educate providers on coding and documentation, specifically ICD-10. The sole focus of our program was to be a clinical resource for the coding staff, serve as a liaison between providers and coders, and educate our providers on the increased specificity that would be required for ICD-10-CM/PCS coding.

Q How has the focus of your CDI program changed over the years?

A Until last fall, there was one CDI at our children's and women's hospital and one at our main medical center. After ICD-10 implementation, we began adding staff members and now have a total of six CDI professionals, including myself. Our job duties shifted from being an educational resource to a more traditional CDI role, performing concurrent reviews, querying providers, and providing education.

Q How has your CDI program kept up with changes in the larger industry?

A We've tried to stay abreast of all the changes affecting healthcare quality and reimbursement, which can be challenging at times. I try to research these initiatives to stay current and disseminate the information to members of the team. The ever-expanding initiatives can be overwhelming to the staff-level CDI specialists, who are trying to balance their job duties with professional education.

Q What do you think is the most important thing for a CDI specialist/manager to do to stay informed about industry trends?

A I think the most important thing is for individual CDI specialists and managers to set aside some dedicated education time each week, and read all of the industry news and trends. There are so many great resources out there ranging from articles, webinars, podcasts, and discussion forums. The best thing about these resources is that the majority of them

are free. I encourage everyone to become active in ACDIS at the local and national level—the most valuable resource is the networking, whether it occurs in person or virtually. It's great to be able to talk to others that may be thousands of miles away, but are experiencing the exact same issues that you are experiencing, and you know you are not alone.

Q What do you think CDI programs/staff should track in terms of data to show program effectiveness and opportunities for expansion?

A From a management perspective, I think it's important to look at query rates, both for individual CDI specialists and the program as a whole. Also look at provider response rates for those queries issued. Our program has no set query quota or expected rate, but I feel these statistics are valuable to assess individual CDI and overall program growth.

We are a teaching hospital, so our query rates vary by experience of the provider. Obviously, we see a spike in queries in July and the months following the new interns' arrivals, and then they tend to level off some after they have attended our specialty-specific documentation education sessions. The provider response rate allows me to assess engagement and take a deeper dive into those queries that are marked as no response. It may be that the provider is not engaged, doesn't understand the query process, or possibly the question wasn't asked in a clear and concise manner. Whenever the cause for a poor response rate is discovered, education can be tailored to assist either the provider or the CDI specialist. Fortunately, we have recently maintained at least a 95% query response rate.

Q Where do you think the greatest opportunities for CDI program growth lay in 2016?

A I think outpatient CDI and risk adjustment are great opportunities for the industry as a whole, with many established programs beginning to expand into these arenas. Since our programs are still in the infancy stage, as compared to other well-established programs, we are not currently seeking expansion outside of "traditional CDI."

Since we do have a freestanding children's and women's hospital in our health system, we review obstetrics and pediatric charts. I have heard so many colleagues state that they do not review these areas, but I recommend the management do an analysis of these areas to determine if there is opportunity for expansion at their organizations.

Q When CDI programs identify target areas, what are some of the typical obstacles they face in obtaining administrative support for program expansion?

A Even though our senior leadership understands the benefit of CDI initiatives and how they relate to quality measures and outcomes, I feel that we still must show our worth as it relates to these initiatives. Just as we have to show the providers what's in it for them, we must also show senior leadership the same thing.

Mel Tully, MSN, CCDS, CDIP, **is the vice president of clinical services and education for healthcare solutions CDI at Nuance Communications. In the following article, she discusses how documentation improvement is expanding beyond the traditional setting and how it can improve quality and reimbursement across the healthcare continuum. Contact her at *Mel.Tully@jathomas.com.***

Value-based payment models reward providers for delivering quality care at the lowest possible cost. To optimize clinical and financial performance in this system, providers must prove they are meeting or exceeding these quality standards, achieving better clinical outcomes, and controlling costs.

Documentation that does not accurately reflect the care provided places reimbursement and quality ratings at risk. With clinical quality and financial outcomes linked more closely than ever, the increasing—and frequently changing—burden of clinical documentation required across the continuum of care will only increase.

Complete and precise documentation of a patient's medical condition is important not only to ensure quality of care and patient outcomes, but also to accurately assess patient populations, the services they require, and their health risk. This is central to population health management. The shift in care from acute hospitals to outpatient clinics and ambulatory centers has hospitals working to figure out the most appropriate treatment setting for their patients, while trying to improve quality outcomes and maximize financial reimbursement.

In the meantime, the Department of Health and Human Services is watching closely; this year 85% of all Medicare fee-for-service payments will be tied to quality and value, and by 2018 the agency will tie 90% of payment to this these metrics. In addition, up to 6% of a hospital's Medicare revenue is at risk from mandatory pay-for-performance programs, including the Value-Based Purchasing Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition Reduction Program.

Simply reporting billing data is not enough with these measures in place. Providers must capture the entire patient story in order to establish a reliable baseline, pinpoint areas for improvement, and meet the requirements of value-based care. And they must do so across the continuum of care to ensure continuity of patient care and financial integrity.

Outpatient care delivery and reimbursement are critical to an organization's overall clinical and financial performance and must not be overlooked. Healthcare leaders see ambulatory CDI as a gateway of untapped opportunity to improve revenue, compliance, quality care, and patient satisfaction.

Earlier this year, Nuance conducted a survey with hospital executives and senior leaders to understand more about initiatives to expand CDI beyond the traditional inpatient setting. More than half of the respondents indicated they place nearly equal priority on a need to develop outpatient care delivery revenues (62%), with pressure to transition to value-based payments (60%) and better population health management (58%). These initiatives are closely linked.

Despite this, there are high rates of documentation error in the outpatient setting that go unrecognized. Physicians have been taught to ensure documentation supports the reason for the patient encounter. Instead, they should be detailing all conditions that require ongoing observation or further intervention. My colleague, Angela Carmichael, calls this "thinking in ink." If it's crossed the physician's mind during the patient examination, she recommends it be put in the patient's record. This is especially critical for health plans with risk-adjusted payment methods where complete and consistent documentation and accurate reporting of a population's disease burden drives per member, per month payments.

Capturing quality documentation should not compromise quality care—it should augment it. Real,

real-time clinician workflow solutions in concurrent, retrospective, and prospective clinical documentation efforts can improve the accuracy and completeness of clinical notes.

Enabling technology such as computer-assisted physician documentation automatically provides feedback to physicians while they are documenting patient encounters. Clinicians create more complete and accurate documentation in real time, and everyone on the care team has access to the same clinical insights, which improves care coordination and patient outcomes. Our clients tell us that these technologies, when integrated with a hospital or health system EHR, offer the additional benefit of optimizing CDI specialist expertise and workflow, reducing the number of queries posed to physicians, and allowing CDI specialists to use their clinical expertise and patient care experience to review more complex cases and additional payers.

CDI is a vital and strategic part of hospital and healthcare organizations' quality and financial objectives. And it is one of the most strategic programs that can be implemented to ensure quality, patient safety, and revenue integrity initiatives operate at the highest levels in outpatient and physician practice settings—where accountable care organizations, bundled payments, and risk-adjusted payment methodologies are prolific.

At Nuance, our Advanced Practice CDI™ methodology incorporates clinical strategies with easy-to-use technologies and continuing education and support to integrate workflow processes that increase collaboration, drive clinician acceptance of clinically supported clarifications, and ensure the availability of timely, accurate information.

The unfolding policies linking payment to performance and quality data signal that value-based purchasing is here to stay. With clinical and financial outcomes inextricably linked, complete and accurate clinical documentation across the continuum of care is critical for hospitals and health systems to prove they are meeting or exceeding quality standards, achieving better clinical outcomes, and improving patient care.