



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. **Katy Good, RN, BSN, CCDS, CCS**, is the clinical documentation program coordinator for Flagstaff (Arizona) Medical Center, where she has effectively teamed up with quality, coding, and care coordination to expand her CDI program's focus. She answered these questions about the role of CDI in quality measures and record reviews. Contact her at Kathryn.Good@nahealth.com.

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

A We have been consistent with most CDI initiatives. The backbone of our program is concurrent record review. Our CDI team reviews all inpatient admissions concurrently and follows them through discharge. CDI specialists also reconcile DRG mismatches with coding. Ancillary duties involve physician education, Patient Safety Indicators (PSI) and hospital-acquired conditions (HAC), denials, mortality reviews, and supporting our facility in whatever way we are able. As coordinator of our program, I am responsible for program development and education. I perform retrospective reviews of all mortalities, PSI-90 and HAC fallouts, Program for Evaluating Payment Patterns Electronic Report (PEPPER) audits, and auditing of our internal processes.

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

A In 2011, our hospital became increasingly involved in monitoring and sharing of quality data. CDI was in a separate department at that time, but when the quality team quickly realized that quality data is aggregated from coded data, they immediately recognized that CDI needed to be involved in the conversation.

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

A Initially, we were primarily involved in severity of illness/risk of mortality (SOI/ROM) education with our physicians. When their observed/expected rates for mortalities or complications were high, we would review for opportunities and share them with physicians directly. Now, we are also involved in review of PSI/HACs and mortalities, and have expanded our program to review all payers.

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

A The takeaway message for all of these initiatives is that accurate capture of all relevant conditions and treatment is becoming increasingly important. This has moved CDI out of the realm of finance and into the quality arena. I will not deny the connection between quality and finance, but the focus has changed. We have shifted our efforts from basic MS-DRG maximization to comprehensive all-payer review with an emphasis on SOI/ROM.

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

A It really depends on the resources of the facility or department, as well as the current state of the CDI program. If resources allow, programs should work towards all-payer review. They should move away from simply MS-DRG-focused reviews to an SOI/ROM-based process. With limited resources, it can be as simple as educating CDI specialists to ensure that current reviews are maximized. CDI leadership needs to make sure they are familiar with their facility's quality data. Even if they do not have great access to their quality team, most of this information is publically reported. Get to know the data, see where the problems lie, and consider the impact of CDI. Then propose collaboration.

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

A Though this is not where I ever expected to land in my career, it has been an incredibly empowering experience. I came into this position without any CDI experience and was tasked to take on a program that had completely fallen apart. I have had the benefit of having amazing leadership support throughout the years who have trusted and encouraged me to continue to push forward.

It's pretty amazing to look back at where I and the program started and see everything we have accomplished. Along the way, we've had a lot of growing pains. We moved into the quality department in 2013 and rapidly expanded from two FTEs reviewing Medicare to eight FTEs reviewing all payers. Our program is 100% homegrown. Training CDI specialists and ensuring consistent processes has been a challenge.

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

A There is a real push for more transparency in the industry. Data is increasingly available to hospitals, patients, and insurers. I see our role as ensuring accuracy through this process. It also means an expanded knowledge base is required across the industry. CDI leadership needs to stay informed of trends not just in coding, but also in quality metrics, medical necessity, and care coordination.

Ultimately, we need to be flexible. I have no doubt that there will continue to be an increasingly important role for CDI in this industry. But what this looks like has changed drastically in the last five to 10 years, and I only see that progress continuing at lightning speed. Instead of fighting against that in favor of traditional CDI roles, we should aim to stay in the forefront, adapting to provide what is most beneficial to our facilities, our patients, and the healthcare industry as a whole.

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. Contact him at jelion@chartwisemed.com.

At the end of a recent talk I gave on the subject of CDI and its impact on quality and value, I was offered the following observation from an audience member: “The only thing that our chief financial officer (CFO) measures now is case-mix index. All of our CDI metrics are no longer looked at or tracked.” After considering this question carefully, I replied, “I think your CFO is about to have a rude awakening!”

CFOs today need to be focusing on quality and value, as more than 60% of healthcare payments will be based on quality outcomes by the year 2018. This requires attention by hospitals now, not in 2018, as the 2016 performance results for certain quality measures will shape payments for 2018.

There is an increasing focus on quality in the delivery of medical care, along with an associated alignment of Medicare reimbursement based on quality measures. One of the pillars of this new reimbursement model is value-based purchasing (VBP). By way of introduction, VBP is set out as a requirement by the Affordable Care Act, and focuses on reducing healthcare costs while improving quality. This initiative is sometimes referred to as pay-for-performance.

There are a number of Patient Safety Indicators (PSI) that are being used to measure a facility’s quality scores. One of the major measures being used for VBP is known as the PSI 90 composite, published by the Agency for Healthcare Research and Quality (AHRQ). It is a weighted average of the adjusted observed-to-expected ratios for the following conditions:

- Pressure ulcer
- Iatrogenic pneumothorax
- Central venous catheter-related bloodstream infection
- Postoperative hip fracture
- Perioperative pulmonary embolism or DVT
- Postoperative sepsis
- Postoperative wound dehiscence
- Accidental puncture or laceration

One of the major things coders and CDI programs can do to help a hospital properly document their performance against these PSIs is to help document and code conditions that may prevent a patient from being included in the calculations. For example, when evaluating a patient with an “iatrogenic

pneumothorax” (air in the chest cavity caused by something a doctor did), the patient would be excluded from reporting if there is also a pleural effusion (fluid in the chest cavity).

While hospital executives are getting up to speed on the potential impact of VBP on their finances, coders and CDI programs need to become familiar with the components of AHRQ PSI 90, and improve the documentation and coding of patients who need to be included and excluded from reporting.

The measurement of many quality measures is directly affected by CDI. Most quality measures (complications, mortality) are reported using observed-to-expected rates (O/E ratio). An O/E ratio greater than 1.0 means that the observed events are occurring more often than expected. Failure to document comorbidities results in a higher ratio and implies a lower quality measurement. By fully documenting the comorbidities, the quality scores will be more accurate.

In addition to improving the quality of the clinical documentation, attention needs to be paid to coding. Coders must create a complete and accurate set of codes that correspond to all of the conditions documented, keeping in mind that quality coding affects apparent CDI program performance and quality measures. Providers should spend time auditing and reviewing their coding practices and performance. If it’s not coded, it cannot be reimbursed or measured. But if it’s not documented, it can’t be coded.

The “expected” part of quality calculations should properly reflect the condition of the patient. When CDI programs only pursue reimbursement, this important function can be overlooked. Many diagnoses will affect the risk of mortality without changing the DRG or reimbursement. Failure to pursue complete documentation will adversely affect quality measures.

I don’t believe that it has ever been acceptable to simply look at case-mix index alone as a measure of the success of a CDI program. Given the current activities surrounding VBP, an even greater imperative exists for both a robust, well-rounded CDI program and comprehensive statistics to guide it. Indeed, it sounds like someone needs to provide some education to the hospital executives on quality and value-based purchasing.