Q&A CDI metrics

CDI WEEK

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As part of the third annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. ***Donald Butler, RN, BSN,*** *CDI manager at Vidant Medical Center in Greenville, N.C., an 860-bed tertiary care center serving the eastern third of North Carolina, answered the following questions regarding CDI metrics. Contact Butler at* dbutler@vidanthealth.com.

Q ***What are the basic metrics that CDI programs should use to measure their success?***

A ***To measure this process, I believe there needs to be four fundamental metrics:***

1. Volume
2. Activity
3. Results
4. Compliance

Volume is simplest to measure—just look at the number of cases reviewed. There are a couple of broad benchmark sources; the most reasonable to me are in the range of 1,800 to 1,900 cases per CDI specialist per year, with appropriate consideration given to staffing, expertise, range of activity, and focus of the program, etc. Remember to define your target population, what cases does your CDI program focus on—i.e., Medicare, all DRG payers, all payers. Then report what percentage of that target the CDI program is actually able to review and set realistic goals.

The most common way to assess activity is to examine query rate/percentage. There are two manners this is reported. I prefer case query rate (how many cases had at least one query asked). Alternatively, you could divide the total number of queries by the number of cases reviewed.

I also find it helpful to report total query rate along with query rates for specific areas of focus. The generic term I use is "impact" query rate, where impact, or outcome, of the query is defined by the individual program. For example, did the query affect the financial, mortality profiling, core measures, etc.

One additional beneficial metric to include is the percentage of queries where a (substantive) response is obtained from a provider. Many folks will also include an "agreement" rate, which is probably best described where the provider›s response results in a desired or anticipated outcome. I caution against monitoring this metric too closely; it may subtly produce a bias in the way a question is posed and become counterproductive to obtaining a reasoned, considered, and honest opinion/response from the provider. However, it is helpful to look for outliers (very high or very low rates), which might help illuminate levels of collaboration, understanding, possible information sharing with medical staff, CDI specialists areas for education, etc.

When considering how to evaluate and report the results of your CDI efforts, focus on measuring the declared intent of the program. As we all know, there is a wide variety of CDI programs, and their focus varies too.

Every program can at least measure financial results for cases reimbursed on a DRG basis. To do this, examine the final coding

data set and determine if there is a diagnosis (or procedure) code present that is the direct result of query activity. Then determine what the DRG would be without that code, and then determine the difference in relative weight between the actual final DRG and the hypothetical DRG. Multiply that by your facility's reimbursement rate and you›ve measured financial outcome. Similar processes can be pursued for other types of outcomes depending on available tools (such as the APR DRG grouper). The ability to measure results may be limited by the available tools and data sources, but you should be able to conduct simple assessments.

Less precise methods of examining outcomes (than individual case examination) might be to trend the case-mix index (especially if intelligently focused to decrease variability that has nothing to do with CDI activity, such as pure medical CMI). You could also look to assess the CDI program's ability to capture secondary diagnoses, changes in your facility's PEPPER data, improvements on specific areas of clinical or DRG interest. Any data source that allows for following risk-adjusted profiling is a strong way to examine CDI success.

Finally, an active program of auditing to ensure that members of the CDI team are following appropriate processes and performing compliant queries is crucial.

Data and measures should both be examined at the program level as well as at the individual staff level. I support establishing metric expectations that are directly used for staff evaluations.

Q

Are there any metrics that you think could be misleading or are not recommended, and why?

As I mentioned in response to the previous question, the physician agreement rate can be problematic. You don't want your CDI staff to pose certain questions in certain ways to obtain a desired outcome, and you don't want your physicians answering just to get the CDI staff off their proverbial backs.

Another area of concern is our old friend the case-mix index. Monitoring trends is fine, but be aware of changes in physician or facility activity, such as the opening of a new service line or an annual meeting of the pediatric physician society of America.

Q

Do you have CDI review productivity standards, and if so, what are they and how did you develop this formula?

The CDI Roadmap available on the ACDIS website includes a white paper regarding variables affecting productivity and a sample document of how one CDI department determined its productivity expectations committee. The ACDIS team conducted extensive research in compiling the documents, so I would point people there for more information.

- "Variables affecting standardization of CDI staffing and productivity"
- "Productivity and staffing example"

That said, remember that what is "productive" for one program may not work for another. CDI efforts typically begin with CC/MCC capture as the priority. In such situations, CDI staff simply capture a secondary diagnosis or clarify a principal and move on the next record. Those more mature programs which review for severity of illness, risk of mortality, as well as principal and secondary conditions will take longer to review.

Q

What types of changes to metrics would you expect to see as a CDI program matures?

Program leaders should expect the complexity of data analysis to increase, as should their benchmarking efforts and awareness. Furthermore, programs should be shifting their focus areas as they mature to address the changing healthcare regulatory environment and coding needs.

While many in the industry suggest that the number of queries should decrease over time, in reality the gains made through query efforts and physician education (such as no longer documenting urosepsis) are often offset by changing focus to include quality measures, or hospital value-based purchasing measures, or changes in clinical indicators and definitions for diseases.

In what format and frequency do you present your CDI data to hospital administration?

The answer is, it depends. I run a weekly report (sort of a snapshot), but I also look at data monthly and quarterly. I typically use a table and numerical format and try to limit the number of graphs.

The best thing to do, however, is to ask the administration how they would like to view the information. While I prefer graphs for my own use, the senior administration prefers the tables. So I do both and only send on the tables to the administration.

Assessing program efforts for growth and compliance

Jonathan Elion, MD, *is the founder of ChartWise Medical Systems, Inc., in Providence, R.I. He is a practicing board-certified cardiologist and an associate professor of medicine at Brown University. He serves on the finance committee and board of trustees of one of the Brown-affiliated hospitals and is well versed in hospital finances. Here Elion describes how metrics can be used for auditing purposes.*

All programs should be auditing themselves and how they are performing. Program managers should audit queries for compliance, as well as for general characteristics of staff productivity and effectiveness. Essentially, there is no uniform target number that necessarily means your program is doing it right or wrong. It simply depends on what your overall expectations are.

There are any number of items that can be tracked and reviewed and any number of ways to do it, from simple Excel or other data sheets to more complex programs included in electronic query systems. The recent *2013 Physician Query Benchmarking Report* illustrates a number of focus areas, but let's talk about a few specifically.

Quantifying the number of charts an individual is able to review as well as the time it takes to review a single chart can help managers determine where an individual may need help. There are a number of housekeeping items that should be tracked and reviewed regularly as well, such as the topic or focus of the query. Managers need to be sure that a wide variety of topics are represented to ensure that the CDI program does not simply cherry-pick the most lucrative diagnoses. Keeping an eye on the range of query topics also helps managers discern whether CDI specialists engage in aggressive query tactics—always querying for sepsis, for example—and where additional physician education efforts are needed.

Programs should also be looking at how many queries are being answered and how many are being responded to in a positive manner (i.e., the physician agreed that additional information was required and added that information to the chart). But be careful about using any straight data without contemplating the information and trends that the data represents. For example, when reviewing the physician response rate, a particular physician may respond 100% of the time, yet the topic of the queries are the same as when the program started. If you still have to ask Dr. Elion to clarify whether a patient's congestive heart failure was acute, chronic, or acute-on-chronic after a year of query and education efforts, then additional or alternative methods may be needed.

Any analytics collected need to appropriately reflect the priorities of your organization, as well. The number of records reviewed by a CDI specialist who solely focuses on CC/MCC capture could be higher than those who additionally look for severity of illness (SOI)/risk of mortality (ROM) and other quality-related measures.

Managers also need to understand how current the data is and analytically be aware of any programmatic or facility changes within that time period. Opening a new service line or changes in staffing can dramatically affect the data, so review and analyze with all available information in context.

Assessing program efforts for growth and compliance *(cont.)*

Of course collecting and analyzing data should be done in the name of program improvement—but it also must be done with the aim of keeping administrators informed about that growth. As I am sure everyone knows well enough, the chief financial officer (CFO) wants to know financial impact of CDI efforts. However, increasing reimbursement should not be the focus of any CDI program, and tracking financial impact can be problematic.

For example, some facilities choose to track the difference between the admitting DRG and the discharge DRG. However, CDI professionals may not be responsible for that change, such as in a situation where a patient needs to be taken to surgery. If you want to get the CFO's attention, audit the records and determine where the facility may be losing revenue simply because the physician documentation isn't clear or because the physician did not answer the CDI program queries. At one 150-bed hospital, we found $250,000 in lost revenue simply because the physician didn't answer queries. Now if they had been responding, they may not have always agreed with the queries, but even if they agreed half the time, that is a good return on investment. If you want to get the CFO's attention, that will do it.

To obtain physician support for your CDI effort, look for data that illustrates SOI/ROM. Although this is "soft" data to the CFO, it can be a gold mine for physicians. With it, you can illustrate how your facility's physicians stack up against competing facilities and even internally against each other. If you can show a physician that his/her patients are staying longer than another physician's or at another hospital, the physician will always say that their patients are sicker. If you can show them how their documentation stacks up against others, it will change their behavior dramatically.

Finally, data isn't data for its own sake. It is the analysis of the data that matters. The CDI specialist needs to know what he/she is doing and how they compare to the program overall. You need to own your data and know what's in it. Understand every little bit of what goes into it.