Q&A CDI and quality

Clinical Documentation Improvement Week

As part of the fourth annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. **Mary McGrady, RN, MSN, CCDS,** *associate director of CDI, and* **Irina Zusman, RHIA, CCS, CCDS, AHIMA-Approved ICD-10 trainer,** *director of coding and CDI at 1069-bed NYU Langone Medical Center in New York City, answered the following questions regarding CDI and quality. Contact McGrady and Zusman at* Irina.Zusman@nyumc.org *and* Mary.Mcgrady@nyumc.org.

Q ***Please describe the relationship of CDI to quality initiatives, and how CDI can make a difference.***

At NYU Langone Medical Center, the CDI program is viewed as a vehicle for providing education to providers in addition to a team that impacts documentation improvement in terms of severity of illness, risk of mortality, and reimbursement. The CDI program and coding team work closely together to preserve the integrity of the medical record. That said, we have aligned with our department of Clinical Quality and Effectiveness (CQE) on several initiatives. Our chief quality officer has worked with UHC (University Health Consortium) on many quality initiatives and recognizes that CDI and coding are integral to the success of these initiatives.

A few years ago we started working on HACs (Hospital Acquired Conditions). We created hard stops for coders on HAC cases, meaning that if a condition triggers a HAC, the case is flagged and the coder cannot release the bill. Instead, this case is referred to a coding manager for a second review. If additional clarification is needed, CDI is engaged. If CDI determines that the case is a HAC, it is then sent to the CQE department. If CQE does not agree, additional discussion and follow-up is required (note: see flowchart on following page). By working on this project together, we have developed a relationship that facilitates open communication and allows us sometimes to agree to disagree.

Q ***Which quality measures and/or quality related items (Patient Safety Indicators, etc.) does your CDI program review on a concurrent basis?***

The Clinical Documentation Specialists (CDS's) recognize conditions that may trigger a HAC during concurrent review. In these situations they may query for a POA (Present on Admission Indicator) or to clarify any ambiguity in documentation. We began a similar process for PSIs (Patient Safety Indicators). The complexity of inclusion and exclusion criteria for PSIs makes it a bit more challenging for concurrent review. It is a learning process and if CDS's don't catch PSIs on concurrent review the coders send the case back to CDI to be queried retrospectively.

Our leadership has recognized that in order to produce accurate clinical data we need a collaborative approach. We created a CDI-coding liaison position, an actual CDI professional, who evolved into a role of a go-between coding and CDI. One of our team members, a foreign trained physician and CCS, now reviews all HAC and PSI cases and works closely with CQE. He is able to validate coding and educates coders and CDSs on the subject of PSIs. He also queries as needed or if the case was previously reviewed by CDS, discusses the case and requests a query by the original reviewer.

Has reviewing for quality measures hindered your department's "traditional" (i.e., principal and secondary diagnosis) CDI chart reviews or overall productivity?

The amount of work diminishes with time, because people come to understand it. Coders look at these cases differently; CDI now recognizes something developing when the patient is in-house and are more in tune to documentation that may indicate PSIs, or documentation that may need clarification to close the loop on the condition that has been initially suspected and later ruled out. It has been a learning process for the quality team too, because they were not familiar with the coding rules prior to collaborating with us. As we all gain experience, the effect on productivity decreases. The creation of the full-time CDI-Coding Liaison position has off-set any potential productivity loss.

All queries go through CDSs. Coders do not query—not even retrospectively. If a case requires clarification they refer it to the CDI team.

Also, we have noticed as we do our presentations, and as CDIs do 1:1 education on the floor, our work gets easier. The physicians in our facility are very data oriented. We have found that once we expain to the physician how one word can affect coding (for example "surgical complication" vs "a complication inherent to the procedure" means vastly different things in coding) it catches their attention. From these discussions, surgical departments are eager to learn from us; instead of avoiding CDI they want our input. In reaction to certain data reporting, the general surgery department even engaged a surgeon to act as a physician liaison between CDI /coding and their department. We consult this physician when there is a complex case and interpretation is required to make sure we are capturing everything correctly. He also helps with wording on difficult queries and we can rely on him to help with delicate doc-to-doc discussions if necessary.

Other departments learned about this role and appointed physician CDI/coding liaisons. We added physician CDI/coding liaisons for vascular surgery, neurosurgery and cardiology. Now most physicians see our services as a value-add rather than an obstacle.

Our CDI team is responsible for additional initiatives as well, including targeted reviews and all Medicare cases without a CC or MCC. But we are fortunate that our organization recognizes the value of CDI. In October 2012, NYU Langone's Emergency Department (ED) was closed for repairs and renovation following damages sustained from Hurricane Sandy. When it reopened in 2014, a new CDI process in the ED was started with two CDI/coding liaisons dedicated to the ED. Now we have a total staff of 19 covering over 1,000 beds. This includes two people in our Hospital of Joint Diseases (affiliated with NYU Langone) and two emergency liaisons.

Can you describe your relationship with your quality department? For example, do you regularly collaborate via meetings, etc. with your quality and/or patient safety hospital committee, or do you have a referral relation with wound care nurses and/or your infection prevention department?

We have formal quarterly meetings with our CDI physician champions. A lot of informal communication also occurs—CQEs can call us, or they can just walk over and have a conversation because we're in the same building. We also frequently correspond over e-mails. Many ad-hoc meetings also occur. In fact, just the other day we held one with the wound care team who asked us to create templates and tools in our EMR to make their documentation processes more efficient.

Does your CDI department query a physician and/or other provider when the query only impacts a quality measure, not reimbursement?

We do. Part of our metrics focus on severity of illness and risk of mortality scores which do not always influence payment. We have many other metrics as well. We are in the process of determining how to measure length of stay pre- and post-query.

We're also looking at how to quantify HACs and denial avoidance. It's hard to report on, but if we can show that there were 20 queries one month directly related to a HAC, we can extrapolate an estimated number to demonstrate to leadership that our queries helped to avoid negative outcomes.

WORKFLOW PROCESS FOR PSI REVIEWS