Q&A Program monitoring

CDI WEEK

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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. **Karen Chase, RNC, BSN,** *Assistant Director of Clinical Documentation Improvement at Stony Brook University Hospital in Long Island, New York, a 603-bed academic medical center, answered the following questions regarding program monitoring. Contact Chase at* Karen.Chase@stonybrookmedicine.edu.

Q ***To whom does your CDI department report, and why?***

Our CDI program has been around for about eight years and I have been leading it for about two and a half years. The first five years it resided in care management, and reported to nursing. The program really did not thrive there and it was almost to the point of being dismantled. I was a quality management practitioner looking at and working with our statistics every day. A lot of our statistics were off because the documentation and the coding were not accurate. So they decided they were going to give me a chance to take a stab at it [running the department] and put a quality spin on it, and learn the documentation piece of it.

We had three nurses [CDI reviewers] when we were under care management. Now we've expanded to 10 nurses and changed our reporting structure to finance. I don't report to quality, but I pull quality into everything we do. I am concentrating on quality and the revenue is going up. That's my spin. The success of my program is that docs don't want to hear about the money. Most of our physicians aren't paid through the hospital; none are hospital employees. We have some hospitalists, but the surgeons and intensivists are not employed.

Under care management, it was about CCs/MCCs and money. I'm focused on quality statistics—mortality, severity of illness statistics. That is how I preach it to the physicians. They all know me from the quality arena and they have bought into it what I am trying to achieve. I do have a medical director; she reports to me, and to the CMO, who also reports to quality. That is how quality gets in there. I report to the director of revenue cycle, who reports to the CFO.

Q ***Does your CDI department audit for query accuracy and compliance? If yes, can you describe your process?***

Yes, but what I do is a manual process at this point. Unfortunately the only program we have is a basic Navigant program, with no computer assisted coding or query program—we only use it to track our queries. Everything is sent through e-mail and they CC me on all emails. I pick 10 queries per month for each CDI reviewer, pull the chart, and see if they are leading, are they appropriate, or was there anything that was missed. I also look

to see if the chart was reviewed an appropriate number of times. Was the working DRG appropriate? What was the CC/MCC capture rates for that CDI for that week?

It's not the best way, but I'm not automated yet. Any new software purchases need to be approved through the state of New York. We moved to an electronic health record two years ago, about six months after I started, and we are hoping to get a 3M program approved in the near future

What quality metric does your hospital administration find most helpful/compelling when evaluating the success of your CDI department?

In the beginning we used CMI and we had tremendous increases. But then we became stagnant and had to find other ways to measure our progress. Now we use mortality index, also CC/MCC capture rates by service line. We also take DRGs with triplets and compare quarter to quarter how many have CCs, MCCs, or no CC/MCC, such as DRGs 245-247, 280-282, etc. I have a dashboard with those metrics I show administration.

One of our improvements this winter was pneumonia (DRGs 193-195), and through documentation improvement we brought our MCC capture rate from 19% last year to 27% this year. We also share success with Patient Safety Indicators (PSI).

We also look at quality metrics—core measures metrics like aspirin on arrival—and try to help out our quality department in any way we can. We alert quality when there is a quality issue. For example, if something flags as a PSI, they give it to me, our [CDI] people review it, and if it's a documentation issue we can fix and query. If not, I toss it over to quality. Even though quality and CDI are separate, because I come from that department we work well together. We also do mortality reviews. If a patient dies, I get that chart, we get it coded, and we have an ICU nurse who reviews them for documentation improvement. If she sees something that is a quality of care issue, it goes to the quality department. Quality does more retrospective reviews and we do more real-time reviews and we can pick things up faster with our concurrent reviews.

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

I have an expectation but no formula I've formally figured out. It became very different when we went electronic—we used to do more, but electronic reviews kind of killed us. We use templated queries but they are cut and pasted into an email—it's a manual process that affects productivity.

Now we average two to 2.5 charts per hour. I expect 2.5 charts an hour on average. We also work on projects that affect productivity; for example we just worked with nutrition on getting a nutrition note developed, and worked with IT to get it automated/sent directly into the docs' inbox. They [CDI] fill out how many hours they work on these projects a week and I take this in to consideration when I look at productivity. I count educational sessions in productivity also. I always say that an hour of education might be worth 100 queries!

I keep a statistic of the number of daily case reviews, how many new reviews, how many follow-ups, and how many verbal and written queries. I also look for physician agreement rates. That's how I monitor productivity.

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

Everything they like to see is on a dashboard. They want to see trends. We typically present to administration by service line. Interdisciplinary teams meet with each service line, and either I go to that meeting, or the CDIS who covers that service will go, and we go over the metrics each month. That works. Every once in a while from a question we receive the metrics might change. For example, a service line will ask us to look at craniotomies and why the reimbursement was down. I use a program called SMART that I can run data from, and it shows that they did less craniotomies in the last three months, or it might show we had less CCs or MCCs on those cases. When you bring their dashboards, they're more engaged. You can pull the cases and how their craniotomies had less CCs and MCC, and they'll say, "But most of those patients had cerebral edema!" So it's beneficial—it helps the physicians and it

helps us. I also have a decision support team that I can pull data from, and all billing data goes to UHC, so I can pull that data as well.

Data gets physicians involved. Once you start to throw mortality data at them—especially surgeons—they'll call me and ask "Was there a word I missed on that chart?" Their observed to expected mortality rate should be 1. When we started the program some of our surgeons were over 4, which is horrible. But it's all based on the number of CCs and MCCs on chart. You only need 1 MCC to get the money, but we go above and beyond and get 4-5 on the chart, and their outcomes are fabulous, which is what they want to see. Every once in a while a physician will ask about CMI, but not about money.

When monitoring your CDI program, take a comprehensive approach

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 best practices for monitoring CDI programs, both departmentwide and on an individual level.*

In general, you should be able to monitor performance of three key areas: Your overall program, each CDS, and your physicians. For example, a CDS sends queries and they can be responded to or not; and some will come back as "unable to determine." If a CDS has a high percentage in this last category, they might have a problem with the clarity or appropriateness of their queries. Some hospitals let all their CDS know how all the other CDS' are doing; it's a friendly competition to see how they stack up. Some only want to show individuals their own performance; the metrics should be flexible enough to accommodate either strategy.

Regarding monitoring your doctors; you might hear "We love that doctor, because he always answers our queries!" But what if he always needs to be queried on CHF? This is not revealed simply by looking at physician response rate. If you always query the same physician about the same topic, he may need targeted education on how to document that disorder better. Monitoring your response rate to queries is not enough, you need to monitor by topic.

CDI managers are comfortable using the common metrics for monitoring their CDI program, for example the calculated financial impact. That's a starting point. But you also want to monitor impact on severity of illness/risk of mortality (SOI/ROM), beyond just the pure financial metrics. At the same time, you have to be very careful with the calculated financial impact. For example, the change in reimbursement reflected by the change from the admitting diagnosis to the discharge diagnosis cannot always be claimed as a financial difference directly attributable to CDI intervention. The admitting diagnosis can change on its own as testing is done; a surgeon may operate and that changes the profile without input from a CDS. For example, a surgeon removes a gallbladder, and a CDS queries for renal failure, but in the meantime a cardiologist documents acute systolic heart failure. That means a CDS can't take credit for any increased reimbursement due to the documentation of renal failure—the increased reimbursement is due solely to the documenting skills of the consulting cardiologist. What you really want is the true baseline state; what would have been documented had the CDS not intervened? It requires an honest approach from the CDS. You want to be able to measure: What would have happened without CDI influence?

One other thing to monitor is the productivity of each CDS. How long was a patient there before they reviewed the chart? What percentage of eligible charts are reviewed? What percentage get a second, subsequent review? How many chart reviews are being done each day? Those are some important metrics to look at regarding productivity.

Another metric you should monitor as a lost opportunity is a variation of the hospital's discharge not final billed (DNFB) report. As soon

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as a patient is discharged the clock starts ticking. Many hospitals strive to send the bill out in as little as six days. But what if the patient has queries pending? That's why you want to measure your DNFB with pending queries, which I call DNFB-PQ or "DNFQ" ("discharged not final queried)." These cases are hugely important, these are docs you need to go after to get their queries answered.

As far as frequency of monitoring, it's certainly nice to see some dashboard reporting on a daily basis, so you can see when the "check engine" light is blinking. It's not always helpful to detect a problem that occurred three months ago. A real time basis can be helpful in making timely corrections. But at minimum, a monthly sit down by the CDI manager to monitor the department is necessary. CFOs will want to see a report every month.

Regarding query forms, I am personally strongly in favor of multiple choice queries—and thereby helping to promote best practices. All queries should be vetted by a coder, a physician, and a CDI specialist. It is easy for well-intentioned folks to created queries that probably would not pass review from the trio outlined above. For example, "Doctor, why did you order this test?" That's curiosity, not a valid reason for a query. Or, "Doctor, the chart says the patient has COPD; could they also have cor pulmonale?" That's way too leading. Overuse of blank or "general" queries put too much reliance on the CDS to be creative. Standardizing your queries can reduce variability in query quality, assure best practices, avoid leading or non-conformant queries, and make review and internal auditing easier and more standardized.

For the upcoming change to ICD-10, we should be promoting the best and most complete documentation we can, whether it's the inpatient or outpatient setting, or whether we're coding under ICD-9 or ICD-10. For example, in ICD-9 something may not require the specificity of laterality, but under ICD-10 it will. The answer should be: Let's do it right, now! Don't say "we're going to wait to ICD-10." Work as if we're already working under the auspices of ICD-10. Get that complete description of the fracture; maybe you don't need it under ICD-9, but why wait? Or in an outpatient chart; you can't code a "probable" diagnosis, but you can code "probable pneumonia" on an inpatient. Don't let the doc worry about that. Let the doc write most complete chart he can, and the coder will take care of the rest.

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