

Q&A

CDI WEEK

CDI and Quality

sponsored by



As part of the first Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. **Nancy Rae Ignatowicz, RN, MBA, CCDS**, system manager of clinical documentation for Provena Health in Frankfort, IL, answered the following questions from ACDIS regarding CDI and quality.

Q *In what ways can a CDI program impact quality scores, and why are these scores important?*

A *A CDI program can impact not only hospital but physician quality scores by getting appropriate words written in the chart which reflect the most complete patient complexity that can be transferred into codes.*

These codes are then used to create report cards for hospitals and providers, which are publically available for review. Some examples can be found at www.healthgrades.com and the CMS website (www.hospitalcompare.hhs.gov). You can look at whatever hospital you want, including your competitors' scores. If you don't use the right words, it looks like you're keeping patients in the hospital longer than you should, or it looks like you're operating inefficiently by spending more money and resources than would be expected.

When you are a hospital and you are working with a third-party payer, your quality scores are evaluated by the payer to determine how much they're going to pay you to take care of their patients going forward. Insurance companies are looking at it and saying, "Your outcomes don't look good, so we're not going to pay for our insureds to go see your facility for this care." We've also seen patients have a higher copay when they go to see one physician rather than a partner physician who is part of the same group practice, because of the data that the insurance company is evaluating on individual physicians. Third-party payers have told

physicians that they're no longer allowed to be a provider in their plan when they look at this data.

We are becoming the physician's best friend because it's become very apparent to them that what they document reflects the entire picture of what's going on with their patients, and that others are scrutinizing their documentation.

Q *How do you balance traditional CDI chart review duties with reviewing for core measures and other quality indicators? Does one suffer, or productivity decrease?*

Our primary focus is CDI, and when you do both CDI and quality the results are suboptimal. It decreases your productivity from the CDI perspective unless staffing is adjusted.

So it depends on where you want your program to focus. I've done it before where I was disease-specific—you looked at things like pneumonias and you did it all, including patient teaching. It can work; it just depends on how you develop your program and how you staff it.

We find it most beneficial when we're primarily CDI, but when we discover things we take a collaborative approach where we notify the quality department. We provide them with all the information we know about the case, but we're not necessarily looking at

CDI and quality: Two sides of the same coin

Jon Elion, MD, FACC, president and CEO of ChartWise Medical Systems, Inc., in Wakefield, RI, says that a good CDI program shares much in common with—and can help impact—quality scores and initiatives. His comments follow.

How does CDI impact quality scores? “Get credit for the work you do.” A patient that comes in with a heart attack is supposed to be sent home on aspirin and a beta-blocker—that’s one of the core measures you’ll be evaluated on. If you don’t send someone home on a beta-blocker, are you a bad doctor? Or am I so clever that I recognized that the patient has sick sinus syndrome and that beta-blockers are contraindicated? “Get credit for the work you do” means you have to document why you’re not giving the beta-blocker. That’s an example of careful and complete documentation helping a physician’s quality scores.

There are three things that are interrelated: CDI, case management, and quality/core measures. When a case manager asks a question about whether a patient should be observation or inpatient, she’s querying the physician. She doesn’t call it that, but that’s what it is. A CDS might say, “Doctor, I noticed that the patient was admitted for an angioplasty through the ED. Which of the following diagnoses pertains?” The magic words she asked for was “admitted through the ED with chest pain.” Those magic words meet InterQual criteria for inpatient level of care. That’s a case management function; that’s a query.

We have gone through a history in CDI where we did retro queries: After the patient was discharged, somebody looked at the chart and asked the doctor questions. We have moved to a concurrent review model where we’re getting the information while the patient and the doctor are still involved. It’s the same thing with core measures. We’re starting to move to a concurrent review model.

everything they would look at. We’re giving them a heads-up concurrently of what’s going on. Obviously, if we see any of the core measures diagnoses, we’ll let them know. We have alerted the utilization review department when we see the chart before the care manager does and the patient needs clarification for admission status. Any time there’s something in the chart about healthcare-acquired conditions and there are discrepancies, we’ll address our part and also notify quality.



What are some of the quality vs. coding conflicts you’ve seen, and how do you resolve these issues?

You want to eliminate the word “postop,” which sometimes reflects cause and effect, and other times it’s just a timing factor. You want the physi-

cians to document whether a complication was due to surgery or due to some underlying condition. For example, when chronic respiratory patients have problems postop, it may not be related to the surgery but to their underlying medical condition. That can help eliminate it from being a complication code.

Some quality directors were concerned because they thought when we queried the physician for a link between a catheter and a UTI, or a central line and a bloodstream infection, that we were actually initiating more documentation of healthcare-acquired conditions. So we collaborated to develop our screening criteria as to when we ask for the linkage. We took the infection control criteria of what qualifies for an infection with a Foley or a central line and use that to initiate a query for the linkage. If the physician makes the link without a query, we’ll alert the infection control department and address the CDI issues appropriately.

Ignatowicz has more than 30 years of healthcare experience, including data presentation. In her current role, she has operational responsibility for Provena Health’s six CDI programs in each of their acute care hospitals across Illinois. She directs a team of 15 CDI specialists. Contact her at Nancy.Ignatowicz@provena.org.