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Association of Clinical Documentation Integrity Specialists

CDI QUALITY REVIEWS

Leadership research survey shows definitive shift to integrity-focused over financially driven CDI programs and increased attention to record reviews for overall quality measures

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With the advent of Value-Based Purchasing programs and other pay-for-quality measures, many CDI teams have shifted their focus to a holistic review process for accurate quality reporting.

"This is truly an evolution of the CDI department itself. We're moving away from just focusing on DRG-changing query outcomes and looking at a more holistic approach to the cases that we encounter. It also shows our true value and how our record review efforts bleed into other departments," says **Alison Bowlick, BSN, RN, CCDS, CRCR,** AVP of CDI at Ensemble Health Partners in Toledo, Ohio. "While we may not be as well versed in all of the quality parameters, really collaborating with other departments shows our worth as a CDI department as a whole."

In partnership with 3M, the Association of Clinical Documentation Integrity Specialists (ACDIS) CDI Leadership Council asked four of the Council's members to evaluate the results of a nationwide survey on CDI efforts related to quality measures and programs. Following is a review of the survey results and a summary of that discussion.

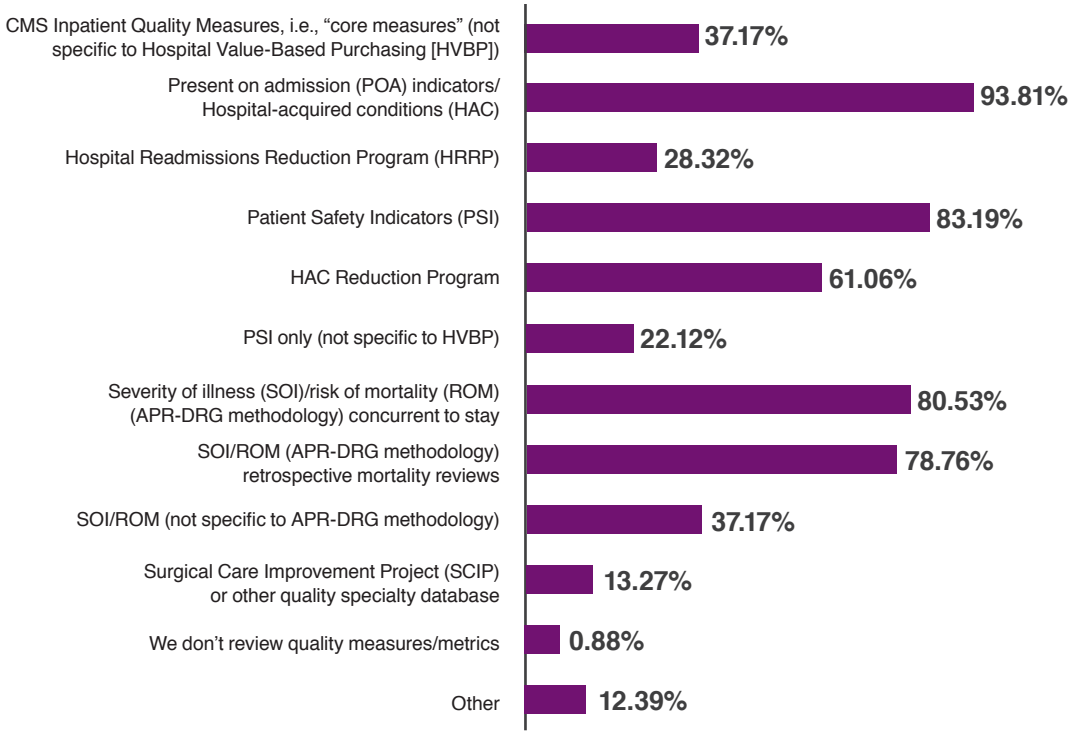
Quality review focus

As with any new review area, CDI departments have many avenues to choose from when it comes to reviewing for quality measures. Often the decision rests on the needs of the organization and the bandwidth of the CDI department. According to the CDI Leadership Council survey results, the most popularly reviewed quality metrics were present on admission (POA) indicators/hospital-acquired conditions (HAC) (93.81%), Patient Safety Indicators (PSI) (83.19%), and severity of illness (SOI)/risk of mortality (ROM) scores within the All Patient Refined Diagnosis Related Group (APR-DRG) methodology (80.53%), mirroring data from an *earlier Council survey related to key performance indicators*. (See Figure 1.)

While quality reviews may represent an expansion area for some organizations, others—particularly those paid under the APR-DRG system rather than the more common MS-DRG system—may have had quality built into their reviews from the beginning of the CDI department's existence.

"We use APR-DRG methodology, so for us, quality metrics are very important," says **Chinwe Anyika, PhD, RN-BC, CDIP, CCS, CCDS, CCDS-O,** manager of CDI and data operations, HIM, at Memorial Sloan Kettering Cancer Center in New York City. "Our program keeps track of everything that's going on. For example, we always get alerts for any HACs that come into the [EHR] system and then we review them to see if there are opportunities to improve documentation" as to whether that

Figure 1. Quality measures reviewed



condition was actually present on admission or truly something that was caused by the hospital stay.

If a CDI department is branching out into quality reviews for the first time, however, one of the biggest questions for leaders is determining how to handle the added workload. HonorHealth's team in Scottsdale, Arizona, formed workgroups in their department to focus on particular quality-related tasks.

The workgroups allow the staff on those teams to have a "more intense focus. We have a workgroup for quality and we have a workgroup for mortality," says **Lee Anne Landon, BSN, CCDS,** network manager of CDI at HonorHealth in Scottsdale, Arizona. "On the mortality cases, if the patient's SOI and ROM are not high enough, the CDI team conducts a pre-bill review within 24 hours. Our quality group also focuses on readmissions and PSIs, and we do a lot of work with HCCs and the risk adjustment."

In addition to focused workgroups, CDI leaders should reach out to other departments that align with the planned work to eliminate potential overlap and unnecessary rework.

"You may not need to be the one to report out on these particular metrics. Somebody else may be already tracking them, or contributing to them, so not operating in a CDI silo is important," says **Diana Ortiz, JD, RN, CCDS,** revenue cycle marketing manager at 3M Health Information Systems in Murray, Utah. "In addition to the quality department, a lot of these measures are ones to partner with your coding team on, especially HACs."

On top of avoiding repeat work, Bowlick says interdepartmental collaboration allows you to see different angles on quality review items. Each department and group brings their own perspective to the table that will enrich the whole quality review process.

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"You need a dual approach in collaborating with administration and the providers towards those efforts that you're going after," she says. "It's not just CDI, and it's not just quality alone, but you're coming at them twofold to really show how much impact that documentation has."

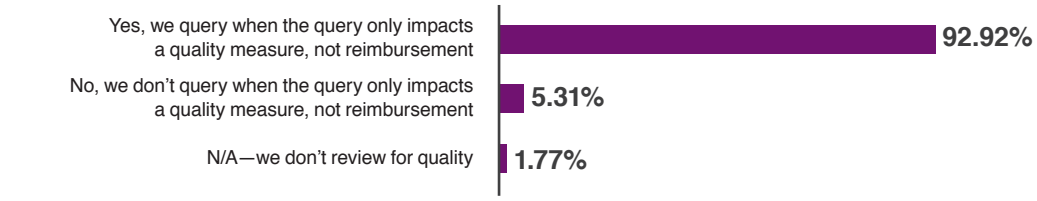
Quality-related query practices

In previous ACDIS surveys, respondents indicated that they would not send a query if it would ***only*** impact a quality measure (as opposed to carrying a financial impact). In fact, according to *the 2019 CDI Week Industry Survey*, 73% said they sent queries in these situations, which was actually up from years prior.

In this new survey, however, a strong majority of respondents (93%) said they do query when the outcome only affects a quality measure rather than reimbursement, showing a shift to overall documentation integrity over strict financial improvement. (See Figure 2.) Only one respondent indicated they did not review for quality measures at all.

"I think that the shift has happened not just within our department, but within our hospitals," says Landon. "They're becoming more aware of how documentation affects everything—the reputation, the O:E [observed to

Figure 2. Querying for non-financial impact



expected mortality] ratios, the penalty programs. I think there's an awareness across the board with administration at this point."

Part of that organizational shift, according to Ortiz, may stem from the advent of *publicly reported quality scores*, such as those available from Hospital Compare, Leapfrog Group, and U.S. News & World Report. The scores reported on these sites are based on documentation and coding, and they put the organization's performance on display for potential patients. If a patient is choosing between two organizations for an elective procedure, for example, it would be natural for that patient to choose the organization down the street with a five-star rating rather than the one with a two-star rating.

"There's a lot of transparency around quality data, and there are a lot of challenges around making sure we get that reported accurately," Ortiz says. "I don't think it comes as a surprise that organizations turn to their CDI team to help with that. There has been a demonstrated success through the ease of reporting DRG changes, so it's not surprising."

Opting to only send financially focused queries may leave the organization open to missed opportunities and potential denials downstream. The best approach, according to Bowlick, is a comprehensive and holistic one.

"It's really looking at the integrity of the chart as a whole and making sure that that's showcased," she says. "Make sure that you're sending queries that are both [financially] impacting as well as non-impacting because they are also important to that overall record."

In addition to reimbursement, publicly reported data, and denial prevention, complete and accurate documentation also lends itself to better patient care and continuity of information—a point that may improve physician buy-in to the CDI process.

"I've heard directly from physicians that when the documentation is right it gives them more time to take better care of their patients," Ortiz says. "They know what's really going on right from the start. They have better

continuity when they're consulted about a case or when there are hand-offs. It really does come back to patient care."

Quality reviews and staffing

While CDI professionals often find themselves tasked to tackle new reviews or service lines with limited resources, nearly 40% of respondents said their department increased its full-time employees (FTE) to optimize its quality reviews/capture rates. This statistic may indicate an organizational focus on documentation integrity at a higher level than just the CDI department since organizational leadership would have to approve FTE increases. (See Figure 3.)

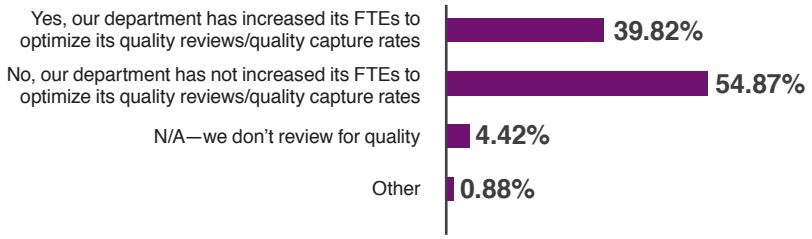
Often, however, CDI professionals are asked to prove a return on investment (ROI) before they have a chance to receive additional staffing. Even with a proven ROI, there's no guarantee that new staff will be approved, especially in light of the COVID-19 pandemic and many organizations furloughing staff to cut costs.

When you have fewer staff members, you may have to readjust your productivity metrics to account for the additional depth and time required for quality reviews, according to Anyika. At her organization, which has a core focus on quality, they prioritize these reviews over standard chart review productivity metrics.

"Because of the quality we are concerned about, we concentrate on follow-up reviews a lot, because that's when things really happen to the patient," she says. "Compared to what other hospitals do, our workload is much lower, but more in-depth at the same time."

If adjusting productivity expectations isn't in the cards, there are a few ways CDI leaders can tackle the added task of quality reviews without bogging down all their staff members. For Landon, the solution was to form workgroups.

Figure 3. Quality reviews and staffing



In those groups, "everybody learns, but a subset becomes more an expert in the area," she says. "I don't have to have everybody be an expert, but everybody needs to have a knowledge base. Everybody's getting a little benefit, and only a subset has to do the research."

CDI leaders should also lean on their existing technological solutions and dig into the various features at their disposal to help their CDI staff be as efficient as possible when adding new review areas, Ortiz adds.

"Make sure you're capturing every opportunity to use the concurrent tools available to you," she says. "CDI is meant to be a concurrent role, so try

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to leverage tools that allow you to prioritize your work, look for those patients ahead of time in order, and make sure that you're getting to review patients that align with organization goals.

Using technology, leaders may also be able to leverage the data yielded to build a case for future staffing increases. Remember, to focus efforts, create an action plan, then collect data to present before approaching organizational leadership with requests for additional staffing or technology.

"You can't boil the ocean with quality," Ortiz says. "While there's a lot your team *could* do with the resources you have, you have to consider what you actually can get done. As far as the business case to increase FTEs, it's probably good to focus on a couple particular measures and demonstrate success."

Physician education

Generally, CDI professionals find that sharing quality data with providers offers a great entry point for physician engagement and education.

"I think sharing quality data with the physicians is really essential. It's kind of where they live," Landon says. "We bring the quality data right down to the granular level. Anytime we're doing education and we provide a case summary, we always include the SOI/ROM changes of the documentation

we're querying for, so they can see the big picture and they can also bring it down to the small picture of their particular patient."

Echoing the centrality of physician education, the majority of survey respondents (62%) said they share high-level information about quality reporting with physicians, followed by just under 45% who said they share their organization's quality data with the medical staff.

Though it's often touted as a great way to increase physician buy-in, only 16% said they educate physicians using publicly reported data, and an additional 20% said they don't educate physicians on quality measures or data at all. (See Figure 4.) Part of this disparity may be because the CDI team members themselves lack the information necessary to pass along to the physicians, Ortiz suggests.

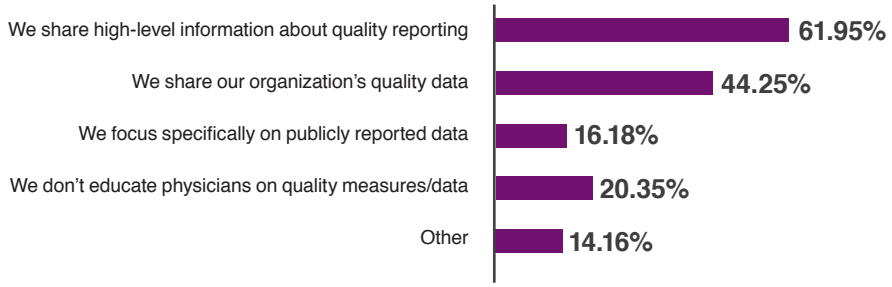
"There's still a lot of ambiguity around some of the quality measures, so there's a challenge on the CDI side to make sure we understand it the best that we can before we feel comfortable relaying it to a physician," says Ortiz.

If CDI professionals want to leverage quality information and data but feel at a bit of a loss on the details, it may be the perfect opportunity to collaborate with the organization's quality department.

"Many of us aren't well versed in this arena and we have room to grow. But then it comes to a point when maybe we're blurring the lines with our quality department and we should be collaborating with them more and using them to co-educate," Bowlick says, suggesting that CDI teams work to align their education with the education provided by the quality department and co-present with them for the physicians.

Leaning on the data gleaned from quality reviews can be an easy entry point as well, Anyika adds, and that data can serve as a springboard for future educational efforts.

Figure 4. Sharing quality information with physicians



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"Physicians love the data. They want to know how they're performing when compared to their peers and then when compared to other services," says Anyika. "The chiefs always have me submit data to them about everybody, all the providers in the department, so they can see who needs help and who doesn't. And then, in that case, I can provide one-on-one education for those physicians."

Depending on who you're educating and in what setting (one-on-one versus group sessions, for example), you can tailor the data presented to get straight to the heart of the matter. For example, Anyika says, if you're educating a full group, do a deep dive on just a couple case examples and leave time for questions; if you're educating an individual physician, bring more examples, but only use that physician's own personal cases.

Of course, it's always good to use your own judgment and personal experience as well when approaching physicians with education. It's not a one-size-fits-all situation.

"You know your docs better than anyone else," says Bowlick. "Can you create some friendly competition between groups and show the data that way, or will that lead to any disengagement with the department?"

Tracking review impact

Like any new review focus or expansion opportunity, proving an ROI and tracking the CDI team's progress is one of the central parts of a CDI leader's role. Quality impact, however, can be a bit difficult for a leader to get his or her hands around because quality metrics don't have an immediate financial ROI when the case is billed.

"It's a very retrospective process," says Bowlick. "It can be so hard for us. Many of us are clinicians ourselves and we'd like to fix and stabilize and move on right away."

Likely because of the difficulty of tracking quality outcomes, and even though nearly all respondents reported *querying* for quality concerns, still 23% of survey respondents said they don't track quality-related query outcomes at all. (See Figure 5.)

"I think tracking quality is more difficult—it really is," adds Anyika. "But it is possible. It can be done and it is being done. CDI programs' financial effects are easier to communicate because you can see it straight off. It's an easy calculation to do."

As the saying goes, the best way to eat an elephant is one bite at a time, so breaking the problem into manageable steps helps simplify the tracking process.

The first step for CDI leaders is deciding what tools to use to track and analyze their data. According to the survey, slightly more than half of respondents (54%) said they track quality-related query outcomes using their CDI software, and 17% said they use a home-grown spreadsheet. (See Figure 5.)

If a CDI program doesn't have the budget for a new or upgraded tracking system and opts to use the home-grown spreadsheet approach, CDI leaders should factor that consideration into the department's workloads and staffing requirements, Landon suggests. Additionally, if your department is understaffed or has had to furlough team members as a result of the pandemic, the added responsibilities related to manual data entry should be eliminated whenever possible.

"If you're using a manual spreadsheet, it means your staff has to enter that data," she says. "In this time, when we're talking about taking on more responsibilities, having less staff, furloughs, and so forth, you don't want any more manual tracking that takes your staff away from their primary purpose of reviewing."

"Our approach has been to help the CDI team do their best work by using technology to automate quality reporting and to alert them to quality data they may not see," Ortiz adds. "You want to guarantee the accuracy of the data as well as the efficiency of it. Obviously, you don't want your team spending so much time on tracking that they can't get the work done."

Figure 5. Tracking quality-related query impact