Aligning CDI with organizational mission: What matters?

POSITION PAPER

Summary: This paper is the second in a series on risk-based clinical documentation integrity (CDI). As the use of risk adjustment in healthcare expands, so too does the reach of CDI professionals in capturing the patient's story, including level of risk related to demographic factors, comorbidities, and health history. This series will highlight the major risk models, explore the ways in which CDI professionals can impact risk-adjusted methodologies, and describe how these methodologies are transforming the nature of the CDI profession and the day-to-day work of CDI professionals.

FEATURES

The core of any organization is its mission—a clear expression of why the organization exists. A healthcare organization's mission is like the top of a pyramid, and the departments below (including CDI) are the building blocks that support and foster the mission.

Mission statements typically address aspirational goals that get to the heart of medicine, such as serving the community, providing excellent care, stressing inclusion and diversity, and following best practices grounded in a code of ethics. A sample mission statement may read: "Optimizing health through meeting the 'triple aim' of improving the experience of care, improving the health of populations, and reducing per capita costs of healthcare."

Using this example, a CDI department tasked with capturing more clinically valid diagnoses that result in a more complete clinical picture will achieve two things. Not only will the department improve risk-adjusted, externally reported quality metrics, but its work will allow health services researchers who use CDI-derived claims data to better analyze population health and implement solutions that improve patient health. In turn, this reduces overall healthcare expenditures through improved care delivery.

In their work to achieve the department's mission, CDI professionals may encounter several challenges, both internal and external:

➤ **Internal factors** can include low staffing allocation (insufficient FTEs to support mission), insufficient analytic support/tools, or suboptimal reporting structure. Regarding the latter, for example, is CDI a stand-alone department, able to make decisions without interference or competing attention from other departments? If CDI reports to quality, case management, the clinical care team, HIM, or revenue cycle, these departments may have goals that appear to be odds with CDI. This indicates a "siloed" healthcare organization in which departments do not talk to each other or participate in the organization's broader mission, but rather focus on their own narrow goals and day-to-day concerns.

> ➤ **External factors** include CMS payment rules and compliance and reporting regulations, industry expectations, and competition among healthcare systems. These should not be viewed as insurmountable obstacles, merely a framework of rules within which CDI must work to improve the documentation and subsequent coding of the health record.

When something goes awry with the organization's quality rating, reimbursement, or lengths of stay, the CDI team may inherit the responsibility to correct the problem. Subsequently, the team may feel like it is saddled with "making the documentation right." However, instead of viewing this scenario as an unfair task, CDI professionals should instead view it as an opportunity. While CDI leaders acknowledge the above-listed obstacles, none of them should ultimately inhibit the department from furthering the organizational mission. CDI leadership must be able to strongly and positively communicate to organizational leadership that CDI is part of the same team and is working toward the same mission.
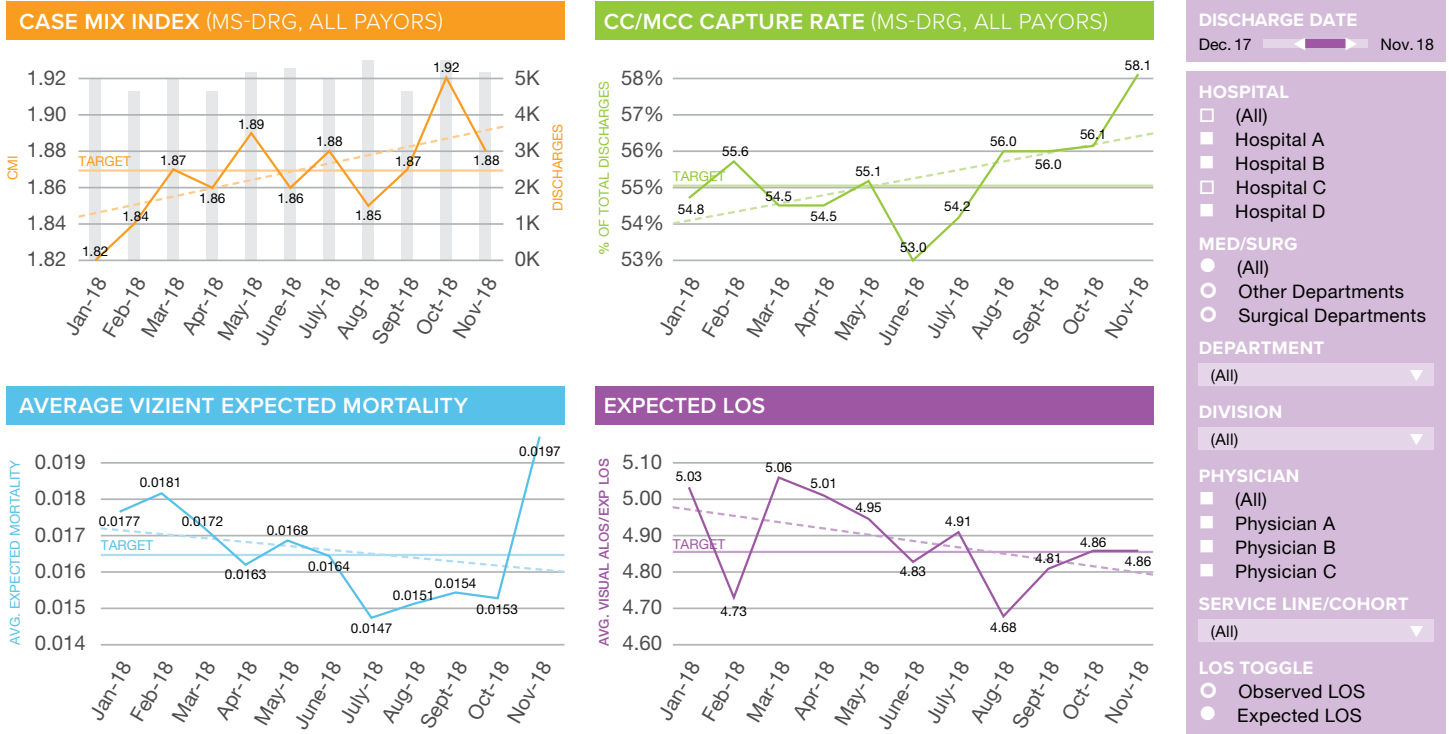
Because CDI efforts impact multiple facets of organizational success, CDI professionals can help break down silos. Regardless of whom CDI reports to, collaboration presents a tremendous opportunity to elevate CDI's position in the organization. The CDI team should work to foster an atmosphere of collaboration with other departments, including quality, case management/utilization review, medical staff, revenue cycle, and especially coding (as final code assignments are the data supporting an organization's success). A collaborative reconciliation process that enables CDI and coding professionals to achieve accurate, reliable claims data provides an organization with the data it needs to achieve its mission.

A focus on risk-based methodologies can direct the CDI program back to mission support. CDI should serve as subject matter experts in mortality reviews, improving observed vs. expected (O:E) ratios and demonstrating positive outcomes for the population served. For example, an outpatient CDI specialist can reduce per capita cost through identification of diabetes, providing proactive disease management that lessens the burden of complications and morbidity.

According to an Association of Clinical Documentation Integrity Specialists (ACDIS) position paper, "Data is the only way an organization can support the quality of care it provides to patients, and this data is based on complete and accurate documentation and coding" (ACDIS, 2017). The CDI team should leverage data to showcase the impact of their work. CDI can create dashboards that demonstrate the team's impact not only through traditional metrics—such as case-mix index and capture of complications and comorbidities (CC)/major CCs (MCC)—but also through better quality metrics that align with risk. Showing the complexity of patients and positive outcomes is a powerful incentive as it impacts an organization's ability to leverage contracts and influence patient choice (ACDIS, 2017).

> **"CDI leadership must be able to strongly and positively communicate to organizational leadership that CDI is part of the same team and is working toward the same mission.**

Below is an example dashboard with a comprehensive picture of traditional CDI revenue metrics as well as risk.

CASE MIX INDEX (MS-DRG, ALL PAYORS)

CC/MCC CAPTURE RATE (MS-DRG, ALL PAYORS)

AVERAGE VIZIENT EXPECTED MORTALITY

EXPECTED LOS

DISCHARGE DATE
Dec. 17 — Nov. 18

HOSPITAL
☐ (All)
◼ Hospital A
◼ Hospital B
☐ Hospital C
◼ Hospital D

MED/SURG
⬤ (All)
◯ Other Departments
◯ Surgical Departments

DEPARTMENT
(All) ▼

DIVISION
(All) ▼

PHYSICIAN
◼ (All)
◼ Physician A
◼ Physician B
◼ Physician C

SERVICE LINE/COHORT
(All) ▼

LOS TOGGLE
◯ Observed LOS
⬤ Expected LOS

Physician engagement and alignment

Healthcare organizations need excellent physician engagement to achieve their mission and vision (ACDIS, 2019). The same holds true for CDI programs: CDI's ability to meet program outcomes significantly diminishes without physician buy in.

Many physicians claim to be "engaged" in the CDI process. When translated, this typically means that they understand the value of accurate, complete documentation and willingly work with the CDI department to achieve that goal. But although many CDI leaders claim success by pointing to high query response rates, the CDI team may be exhausting itself with the amount of energy and resources needed to obtain these responses. Additionally, query response does not always equate to meaningful documentation that supports accurate and specific code assignment. The result, even in programs with a superficially high level of engagement, is documentation integrity loss and poor program outcomes.

To engage physicians in the documentation integrity process, CDI must ensure that physicians have a basic understanding of the value and impact of complete and accurate documentation. Doing so ensures that physicians become active

participants in the process. Merely supporting provider documentation behaviors through the deployment of technology, for example, may not be enough to achieve tangible results. Another recommended method for obtaining buy-in is creating alignment between organizational and physician goals. This includes tying physician outcomes and mandates to CDI efforts, providing mutual success measures.

To keep physicians aligned with the processes and outcomes that lead to good organizational risk capture, provide regular updates with specific metrics and trends that impact their work. Don't underestimate the power of data when it comes to promoting buy-in. Whether through CMS star ratings, readmission ratings, U.S. News and World Report rankings, or other quality-related programs (discussed in the first paper of this series), the goal is to translate outcomes into specific provider opportunities. If CDI professionals empower providers with both knowledge and assurance that what they document matters, that will win the first battle.

> **Consistency in messaging is vital. CDI professionals must always seek to convey, "Why is it important to us (you and me), and what can we do to make a difference?"**

After achieving initial buy-in, CDI can encourage ongoing behavioral change through repetition and helping providers develop new habits. This translates into regular education touchpoints with the providers (face-to-face meetings, tip cards, monthly newsletters, etc.). Consistency in messaging is vital. CDI professionals must always seek to convey, "Why is it important to us (you and me), and what can we do to make a difference?"

Specific examples that translate data into meaningful messaging for physicians include:

➤ Risk adjustment capture supporting accurate organizational comparisons to peer groups or to other states, nations, and service lines. To translate this message, CDI can ask providers, "Are we adequately representing how sick our patient population is to demonstrate the quality of care we provide?"

➤ Viewing each patient encounter as an opportunity to capture patient complexity by ensuring capture of all appropriate secondary diagnoses. Documentation should support the presence of both chronic and acute conditions that support quality scoring (such as Elixhauser and Vizient) and thereby contribute to risk adjustment methodologies.

➤ Using a provider's own documentation to demonstrate how attention to documentation integrity allows for capture of increased acuity, as measured through severity of illness (SOI) and risk of mortality (ROM).

Sharing these examples helps providers better understand the value of their documentation and encourages them to embrace documentation accuracy. These actions should reduce the frequency of queries, minimizing query fatigue.

Supporting deep provider engagement requires ongoing education, reinforcement, and effort from CDI professionals. Some time-tested strategies include

establishing regular contact points during meetings and providing tip sheets or newsletters. Because busy physicians may only be able to keep two or three key risk drivers in mind, be sure to tailor the message by specialty and focus on high-yield commonalities across risk models. Examples include:

➤ Common acute conditions such as encephalopathy or electrolyte imbalances

➤ Common chronic conditions such as chronic kidney disease or congestive heart failure

Once these first lessons have been absorbed, include additional diagnosis suggestions at future touch points. Review each provider's queried diagnoses and offer continued tailored education.

Note that physician engagement, while important, does not guarantee the achievement of CDI program and organizational outcomes. Sometimes, success requires different tactics, including better alignment of physician and CDI outcomes. This alignment may require involvement from key organizational executives, but it can pay off. Examples include:

➤ Including response rates in the contract language of employed physicians:

• As a necessary component for continued employment

• As part of a bonus structure

➤ Mandating that queries must be answered as part of physicians' documentation requirements to maintain admitting privileges

> **According to ACDIS (2020), a culture of collaboration, one that supports CDI as a partner in providers' success, is preferable to rigid accountability.**

Remember, though, that hard measures require a soft touch. A CDI program should begin by speaking with various physician groups to identify their most important issues and outcomes, then determine how to tie the identified elements into CDI processes. According to ACDIS (2020), a culture of collaboration, one that supports CDI as a partner in providers' success, is preferable to rigid accountability.

Remember that priorities can change, so ongoing physician dialogue (including review of current practices and metrics) is vital to long-term alignment and success. To keep engagement high, provide regular updates with specific examples and metrics that depict physician participation trends and successes.

Auditing, benchmarking for success

A CDI department aligned with an organizational mission of improving risk capture and scoring, together with an engaged physician staff, will lay the foundation for success in risk-based CDI. But auditing and benchmarking are the final, critical pieces of the puzzle.

Before starting any new initiative, including risk capture, the CDI program should perform an internal or external audit. The results can establish a clear starting

point from which to assess opportunities and direct focused improvements. Audits often reveal unrecognized areas of opportunity.

CDI can perform audits alone or in phases. Regardless of approach, start with a random account selection (50–100 accounts will provide a sufficient sample size) and focus the review on missed opportunities to capture risk-driving diagnoses. Review for the following:

➤ Diagnosis patterns, such as unspecified codes, that could impact risk with added specificity

➤ Provider specialties that frequently miss risk-based diagnoses

➤ Diagnoses with limited or missing clinical support, thereby at risk if audited

> **Measuring impact can be challenging without relevant data. Selecting the appropriate benchmarking solution to measure the organization's CDI efforts is an important first step.**

Establish the top 10 missed or at-risk diagnoses from this audit. Then, either take these results and formulate improvement techniques or start the second phase of a more focused review process. Run claims data for the audited codes, drill down to specific providers whose documentation isn't truly reflecting the severity of their patients, and focus on areas where education based on clinical criteria can impact risk adjustment factor (RAF) scoring. Yearly audits will help track education and documentation improvement effects, as well as correlate the impact of CDI's efforts.

Measuring impact can be challenging without relevant data. Selecting the appropriate benchmarking solution to measure the organization's CDI efforts is an important first step. One potential solution is the Program for Evaluating Payment Patterns Electronic Report (PEPPER). PEPPER data is published quarterly for short-term acute care hospitals and "provides provider-specific Medicare data statistics for discharges/services vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying where it is an outlier for these risk areas. This data can help identify both potential overpayments as well as potential underpayments" (RELI Group, n.d.-b).

The PEPPER User's Guide states that hospitals and auditors can use the PEPPER to identify potential trends for frequently coded diagnoses such as "significant changes in billing practices, possible over- or under-coding, [or] changes in lengths of stay." It also notes that "PEPPER draws attention to any findings that are at or above the upper control limit (high outlier) or at or below the lower control limit (low outliers for coding-focused areas only)" (RELI Group, n.d.-a). Because PEPPER data lags behind by six months, many organizations will supplement PEPPER with private data/analytic repositories to provide more timely analysis, or gather this data through internal work with their decision support and analytic teams.

In addition to PEPPER, other key performance indicators (KPI) to consider benchmarking include the following:

➤ O:E ratio (i.e., Vizient or other model)

➤ CMS star ratings

➤ Cohort averages (occurrence of particular diagnosis-related groups, CC/MCC capture rates, etc. of hospitals with similar service lines, bed count, and geographic location)

➤ Hospital-acquired conditions/Patient Safety Indicators

➤ Readmission rates (not necessarily a CDI responsibility, but can be impacted by CDI work)

➤ RAF score averages

After establishing a baseline, what next? Though it can be tempting to try and address every finding, this will dilute CDI's efforts. Instead, consider these strategies:

➤ Focus on three KPIs with the greatest area of opportunity.

➤ Use tracking mechanisms already on hand rather than trying to reinvent the wheel. Assess the capabilities for reporting risk-adjusted focal points in the CDI platform or electronic medical record.

➤ Define tracking standards to ensure data collection compares apples to apples.

➤ Refine the time frames in which CDI will report findings (such as weekly, monthly, quarterly, or yearly).

➤ Determine whether the program needs additional sources of information to help define trends. These may include new service lines, providers, or other facility initiatives.

➤ Involve other departments to obtain data and drive change. Consider involving case management, utilization review, and quality.

➤ Consider a quarterly review, as monthly data can be highly variable. Data lag is a real concern that organizations may not take into account. Be patient and understand that CDI efforts are a long-term investment. Auditors, including Recovery Auditors and Medicare Administrative Contractors, can go back and review claims as old as five years, which means any recent CDI efforts would not impact these audit results or change the documentation in the older claims. CMS quality reporting and U.S. News and World Report use data from the prior two to five years to apply scores and benchmarking.

> **CDI programs must be proactive in anticipating future audit targets, such as social determinants of health (SDOH).**

CDI programs must be proactive in anticipating future audit targets, such as social determinants of health (SDOH). For example, if SDOH become a future exclusion or consideration for a risk adjustment model, quality measure, or focus area, an organization that isn't capturing SDOH may suffer lower public reporting scores, avoidable penalties, recouped overpayments, or lost financial incentives when auditors review their current-day claims a few years down the road. CMS is already utilizing the following SDOH in risk-adjusted payment models for Medicare (Medicare Advantage), commercial insurers (HHS Affordable Care Act), and Medicaid (AAPC, 2021):

- ➤ Age
- ➤ Sex
- ➤ Socioeconomic status

- ➤ Disability status
- ➤ Medicaid eligibility
- ➤ Institutional status

(In addition, the FY 2022 Inpatient Prospective Payment System final rule notes that there are plans to incorporate SDOH in quality reporting efforts and risk adjustment applications.)

Benchmarking data can be extremely useful but must be reviewed carefully to determine its validity for the organization. Cohort data selection is key to accurately representing data (note, though, that a program will likely have to purchase this information). National averages can point a program in an initial direction, but CDI should perform comparisons across facilities with similar bed count, service line offerings, and geographical location.

> **Set realistic, obtainable expectations and goals. If the organization is currently in the 20th percentile, getting to the 80th percentile in six months is probably not realistic—but getting to the 50th may be.**

Creating a starting point for benchmarking and defining goals will help show ROI and track the need for additional interventions. Start with the initial audit data, determine the areas of focus, and then compare to the appropriate cohort group if possible. Set realistic, obtainable expectations and goals. If the organization is currently in the 20th percentile, getting to the 80th percentile in six months is probably not realistic—but getting to the 50th may be. Rome wasn't built in a day. It's important to remember that even small percentages of change will impact the facility and its patients. Provide feedback to those involved in risk capture to help solidify the importance of the work being performed and the improvements coming from it.

Benchmarking components will change as healthcare becomes more holistic in its review of the care continuum. Data points currently taken for granted could well be benchmarked items in the future. CDI programs must be cognizant of the ever-changing environment and documentation needs. Today SDOH are reportable, but many external quality reports have not yet emphasized the importance of collecting these data points. Soon SDOH will play a much larger role in driving SOI/ROM, predictive analytics, and care models. Simple diagnoses that cannot be properly addressed due to SDOH can become much larger issues (hypertension, lung disease, etc.) down the line. Coding SDOH now will build stronger risk-based associations later, and will allow for innovative, tailored healthcare delivery systems that improve the health of all patients.

What is an ACDIS Position Paper?

An ACDIS Position Paper sets a recommended standard for the CDI industry to follow. It advocates on behalf of a certain position or offers concrete solutions for a particular problem. All current members of the ACDIS Advisory Board must review/approve a Position Paper and are encouraged to materially contribute to its creation.

References

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