Risk Adjustment

As part of the fourteenth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. Patty King-Musser, DNP, BSN, RN, CCDS, senior director of CDI at Geisinger Health System in Pennsylvania, answered these questions. King-Musser is a member of the ACDIS Furthering Education Committee and the ACDIS Pennsylvania local chapter. For questions about the committee or the Q&A, contact ACDIS Editor Jess Fluegel (*jess.fluegel@hcpro.com*).

Q: According to CDI Week industry survey data, 46.97% of respondents reported that their CDI team reviews for risk adjustment during their chart reviews in the inpatient setting, while 11.82% do so in both the inpatient and outpatient settings. In what cases does your CDI team review for risk adjustment, and what has been your experience thus far? What challenges and/or successes have you had?

A: We are currently an inpatient-focused program. We work to maintain a comprehensive review focus in the setting of ever-increasing and changing expectations made on the CDI program. Risk adjustment capture and optimization is one of the components the frontline CDI specialists are cognizant of when performing reviews. It began with mortality reviews, with the focus on optimizing to move the severity of illness (SOI) and risk of mortality (ROM) to a 4:4 (or as close as possible). It has grown exponentially to include all case reviews. For every review, when interpreting the documentation, the CDI specialist is aware and monitoring the risk assignment and utilizing their knowledge of common risk adjusters across multiple DRGs. Monitoring the "success" is a challenging aspect. As most are aware, a direct correlation is difficult to make with much of the work CDI accomplishes, but one way we are measuring improvement is by connecting the increased capture with an improvement in our quality rankings within certain measures. We work with a consulting group that is in the same organization as Vizient, which is generating more meaningful connection in the traditional CDI metrics and quality capture reporting.

Q: When asked which risk adjustment methodologies their organization uses, the most popular choice of respondents was CMS-HCCs (48.74%), with the Elixhauser Comorbidity Index and Vizient's Risk Adjusted Index tied for second place (44.16%). What methodologies does your organization use, and how was that decision made? What advice do you have for a CDI professional wanting to get educated on them?

A: Our organization transitioned to Vizient about one and a half years ago. We changed to Vizient as it aligned better with the comparison groups and had a higher number of organizations utilizing its methodology. It was felt Vizient supported a closer alignment with organizational quality metric capture and the CMS Five-Star Quality Rating System. As with many data repositories, one can easily find themselves navigated into a deep hole—it is important to understand/outline the objective prior to researching the data. Establish a clear question and identify parameters—for example, "For 30-day CHF readmissions, what are the

top five variables with the most opportunity for capture?" This will help to maintain the focus. The information gleaned can be used to educate the CDI staff and provider groups. CDI should be provided with the basic knowledge of quality measures and the impact they have on improving capture in their reviews. I caution to not get too specific with identification of different metrics depending on the measure (or patient population), as this risks productivity and the potential for CDI to overlook capture of other things. The strategy we use is: Provide the foundational knowledge and make them aware of important risk adjusters that impact multiple metrics. Emphasize to be aware of these, but it is not to be the only focus. Maintain the perspective of a comprehensive and accurate clinical review, and everything else will fall into place. There are great resources on the internet, peer organization contacts, along with Vizient advisors. Our organization created internal Vizient data experts who help pull reports and present information.

Q: A little less than half of respondents reported that their team tracks their mortality observed-to-expected (O:E) ratio and/or SOI/ROM impact (49.37%), and the next largest proportion said that they don't track their risk adjustment impact (25.55%). Does your CDI team track its risk adjustment impact, and if so, how? Do you have any advice for CDI professionals wanting to start tracking their impact?

A: Our team does track O:E mortality and risk adjustment, SOI and ROM. The frontline CDI specialists are attuned to monitoring the SOI/ROM in their review to ensure it is aligned with the perspective of the patient acuity they are feeling when examining the documentation. Second-level mortality reviews are another attempt to ensure the capture is correct prior to final coding. From the leadership perspective, monthly tracking of the trends in SOI/ROM and O:E are closely monitored and included in the executive report-out.

We can break this information out by facility, unit, or service line to identify where to focus efforts if malalignment is suspected. I caution not to take these data points at face value. If there is a decrease for a particular month, investigate further to see if there is an identifiable or special cause. Many times, the difference is a result of normal variation. If the decrease in results is sustained, a detailed investigation is executed.

Q: When asked if their CDI program reviews mortalities for risk adjustment and SOI/ROM capture, as well as who on their team was responsible, there was a wide range of answers from all CDI staff to CDI second-level reviewers to team leads/managers. How does your organization handle this, if at all? If so, what challenges and/or successes has your program seen in helping with these reviews?

A: All CDI specialists are loosely monitoring SOI and ROM in their cases. All mortalities with an SOI/ROM less than a 4:4 are sent for second-level review by the leads or a manager. We have recently posted positions for dedicated second-level review CDI staff to look at mortalities and other identified cases that are likely to benefit from this process. One challenge is time. These are done when there is "free time" and not the priority. A concern is when the number of cases in the queue gets high, the sense of urgency can create anxiety and cause distraction and missed capture of less obvious opportunities. We have realized benefit with additional capture, particularly on cases without a CDI review and high clinical complexity that can have multiple causes. This demonstrates the importance of the clinical and coding perspectives on each review to optimize the capture.

Q: Most respondents reported that their CDI team is not involved with Risk Adjustment Data Validation (RADV) audits (62.62%). Is your team involved, either as a part of the core team addressing these audits or only as needed? If so, how? Do you think CDI teams will become more involved in future years?

A: We are not currently involved in a formal manner in this type of audit. It is ad-hoc at most. I do see this as another opportunity to ensure accurate capture. The organization has entertained the idea of outside companies to do this type of audit but has not confirmed this is the best direction.

The key is always to get the cases right the first time, so re-reviews and audits are not a standard need. Until that time, using the opportunity information to educate, train, or optimize software programs to support capture is the approach.

Q: There are multiple risk adjustment methodologies, including the Elixhauser Comorbidity Index, HHS-HCCs, and Healthcare Effectiveness Data and Information Set (HEDIS) measures. Which does your organization use, and how was that decision made? Can you explain how they differ?

A: Our consulting partner uses a blended methodology to calculate and measure the CDI impact to our risk adjustment. As it is proprietary, I cannot identify a specific method, but understand it is heavily influenced by the CMS risk adjustment model. I do not feel any are ideal, but Elixhauser makes a good attempt to capture individual patient complexity using a summation of points attributed to known patient complexity and complication factors, more so than the other models.

Q: How has your productivity calculation changed when your CDI programs expanded to encompass risk adjustment variables (length of stay and mortality) and other quality-related metrics, in addition to traditional focused reviews?

A: The productivity calculation as far as number of reviews per day actually increased. It was felt that improvements in software and EMR support provided enhancement to allow CDI more time for reviews and less time satisfying the software. We also adjusted some of the shared processes between coding and CDI in effort to streamline workflows. What was not appreciated was steps that needed to be added to compensate and to decrease missteps. It was recommended by the consulting group based on industry calculations and supported by the executive team. I hesitate and argue that there is more time needed per review to ensure the comprehensive and inclusive capture of clinical, quality, compliance, coding, and denials mitigation support. Our leadership also added an additional software program that added redundancy with little benefit—but I digress. There is value in standard process metrics, but they must be realistically calculated to ensure we are not setting the stage for failure. Stretch goals are important to encourage growth, but if too lofty, they can destroy motivation. Consideration for unit-specific patient populations is important as an ICU case requires different attention than an elective surgical case.

The query metric is another factor that increased in expectation. I do support the adjustment in this metric, as the list of things that CDI evaluates and monitors for in reviews has grown. This naturally coincides with an increased query rate. To ensure the capture of queries and their impact, particularly when reaching out for things other than the traditional CC or MCC, adjustment was important on the reporting side. The risk adjusters, quality metrics inclusion/exclusion criteria, denial mitigation support, etc., are ever increasing. The significance and impact of a highly functioning CDI program will continue to grow. Constant evaluation of appropriate and accurate monitoring of the program is important not only to demonstrate value, but to understand the next area of focus. ■