Nontraditional settings

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. Rebecca Lewis, MSN, RN, CPN, NPC-BC, CPC, CCDS, ACDIS-approved CDI educator, and Viji Anchan, MSN, RN, CPN, CRC, CDI specialist, at Nemours Children's Hospital in Florida, answered these questions. Lewis is a member of the ACDIS Furthering Education Committee and the ACDIS Pediatric Networking Group. For questions about the committee or the Q&A, contact ACDIS Editor Jess Fluegel (*jess.fluegel@hcpro.com*).

Q: According to the 2024 CDI Week Industry Survey results, 27.06% of respondents either have a dedicated outpatient program or have inpatient CDI also reviewing some outpatient records, which is practically the same as 2023's results (26.82%). Additionally, 16.75% of respondents noted that while they do not currently have an outpatient CDI program, they plan to expand into outpatient. How is your outpatient program staffed? Do the same CDI specialists review both inpatient and outpatient records, and if not, how often do inpatient and outpatient teams interact? What advice do you have for those looking to expand into outpatient CDI?

A: Seven years ago, our organization launched an outpatient CDI program that covers both inpatient and outpatient services. Each team member is assigned to one or two inpatient teams and three to four outpatient sites. Here is some advice for those interested in expanding to outpatient services:

- Understand your goals for the expansion
- Be aware of the differences between inpatient and outpatient documentation requirements and coding rules
- Provide specific training to the staff on outpatient procedures
- Leverage technology to handle the large volume of patients seen in outpatient sites
- Engage the providers, as their collaboration is essential for the success of the outpatient program; and educate them
- Foster collaboration between the CDI staff and the providers

Q: Among those who currently review outpatient records, the most popular focus area was HCC capture (48.11%), followed by 19.46% who said risk adjustment generally and 15.68% who said evaluation and management (E/M) coding. Why do you think these focuses work well for outpatient programs? Which services does your outpatient program review or not review? How did your program decide which outpatient services to review, and what advice do you have for CDI programs needing to choose their focus?

A: We primarily focus on Health and Human Services Hierarchical Condition Categories (HHS-HCC) due to the nature of our organization, which is pediatric. When we initially started the outpatient program, our CDI team concentrated on cleaning up the problem list. This approach allowed us to build rapport with the providers as we offered our assistance in cleaning up and maintaining an updated problem list. We

prioritized building a relationship and engagement with providers before shifting our focus to HHS-HCC recapture and risk.

In addition to HHS-HCCs, our outpatient CDI program also reviews the Healthcare Effectiveness Data and Information Set (HEDIS) measures, specifically the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) triple weight measure.

When selecting the outpatient service at the start, we picked primary care sites, recognizing them as the key custodians of patient charts. We are now expanding our efforts to include specialty clinics such as cardiac and GI clinics, which have a significant number of complex patients with chronic diagnoses.

Q: The most common time CDI specialists perform outpatient chart reviews is prospectively (32.43%), though 23.24% of respondents say retrospectively. When does your program perform outpatient chart reviews? If prospectively, do you have any tips for those who are new to this type of review?

A: Currently, our CDI team only conducts prospective reviews, focusing mainly on primary care offices. We send reminders and queries to providers to notify them about the need to capture chronic diagnoses during upcoming patient visits. These reviews are conducted one or two days before the visit. We do not do retrospective reviews, but we generate reports to track the rate of chronic diagnosis capture and to identify which HEDIS measures have been met or not. We produce reports by site and provider and utilize them to provide additional education based on our findings.

Q: When asked if their organization has a set policy governing outpatient query practice, 19.46% said they have a policy based on the ACDIS position paper "Queries in outpatient CDI: Developing a compliant, effective process" and 16.76% said they created one based on the ACDIS/AHIMA Guidelines for Achieving a Compliant Query Practice brief. What does the query process look like for your outpatient CDI reviews? Do you have a separate policy for these queries or is it combined with the inpatient query policy? Can you tell us a bit about your program's outpatient query process? Is there a set policy governing those queries? What guidance/resources did you use to build that policy or procedure?

A: We do not have a separate policy that governs outpatient query practice. Instead, it is merged with the inpatient guidelines. We follow the *ACDIS/AHIMA Guidelines for Achieving a Compliant Query Practice*.

Q: Most respondents said that their outpatient CDI program track impact manually using a spreadsheet (22.70%), while the next top answer was that they currently don't have a way to track their impact (14.59%). Does your outpatient program track its impact, and if so, how? Do you have any advice for those who want to start?

A: For outpatient, we track impact by conducting retrospective reports on risk diagnosis recapture rate and HEDIS measures met by the providers.

Q: The most common pediatric setting/service line reviewed by CDI teams was general pediatric inpatient admissions (42.25%), followed by neonatal ICU (NICU) chosen by 41.76% of respondents, and pediatric ICU (PICU) chosen by 38.50% of respondents. What service lines does your CDI program look at for pediatric cases, and how was that decision made? Does your program have any plans to expand into other pediatric settings or service lines? How do these reviews usually differ from reviewing cases for the adult population?

A: Coming from a stand-alone children's hospital, my insight into pediatric CDI differs compared to most CDI specialists. Our CDI program is less than three years old, so we have not had the opportunity to expand into every service line, but there are intentions to do so within the next few years. At the program's initiation, we started with general pediatrics, followed by our comprehensive cardiac care unit, neonatal ICU, and most recently pediatric ICU. Taking this approach allowed our CDI team to gradually introduce themselves to pediatric diagnoses and procedures. As the complexity increased with each ICU setting, we focused our efforts on comprehensive provider education and ensured lines of communication were always open.

Q: While ICD-10 coding accuracy was the top focus for pediatric reviews (40.78%), APR-DRG accuracy was also a common focus (38.34%). What has been your experience learning to review with the APR-DRG system, and how does it differ from the MS-DRG? Do you have any tips and/or resource recommendations for those who want to understand it better?

A: I learned to review whilst utilizing the APR-DRG system and later learned the MS-DRG system. With APR-DRG, the focus is not CCs or MCCs, but rather the severity of illness associated with a diagnosis and the cumulative effect that diagnoses have on the final DRG. In my opinion, the APR-DRG system better represents the complexity and acuity of a patient. In general, when the accurate level of specificity is documented, the acuity better reflects the patients and is overall higher compared to when diagnoses are unspecified.

Q: When asked how they track their pediatric CDI impact, 24.96% of respondents said they don't currently have a way to track their impact. Does your program track its impact, and if so, how? Do you have any advice for those looking to start? Why do you think this might be a struggle for CDI departments?

A: Tracking CDI impact can be daunting. Currently, our program does this manually by reviewing the final code set against the queries asked and determining how the outcome of the queries influenced the final code set and DRG. As we utilize the APR-DRG for our case-mix index reporting, we assess the impact on the APR-DRG for all our patients, in addition to the impact on the patient's billing DRG if it happens to differ. Electronic health record and data reporting systems are continuously improving, but tracking CDI impact has shown itself to be inconsistent, often requiring additional validation. If a CDI specialist is not clear with the intent and outcome of their query, it can be incredibly difficult to assess the impact of a query on the documentation.

Q: Besides outpatient and pediatric settings, respondents were asked about other settings they currently review or plan to in the future. Almost 65% said they currently review inpatient short-term acute care cases, 83.55% review inpatient surgery cases, and 75.25% review trauma cases. Among those making plans for the future, a much smaller 4.75% said they plan to review inpatient psychiatry cases, and about 3% plan to review inpatient rehabilitation cases. What settings outside of traditional inpatient care does your CDI program review, and which, if any, are you looking into for the future? Have you noted trends of any settings growing more or less popular in recent years? What holdups do you think there are, if any, to such expansion?

A: Other than traditional inpatient care, our CDI program also reviews inpatient rehabilitation cases and, in the future, plans to review trauma cases. I think that areas such as inpatient psychiatry, inpatient rehabilitation, and outpatient will continue to become more popular as value-based care trends shift the focus of CDI programs. From a CDI perspective, I think there is a holdup to expanding into these areas because the opportunities for documentation improvement are not as evident as they are in traditional inpatient settings. Appropriate inclusion of comorbidities and the supporting clinical indicators is going to require ongoing provider education and follow-up that CDI programs don't always account for when planning program expansion. ■