The Multitasking CDI Specialist in an Ever-Changing World: Work Smarter, Not Harder

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Learning Objectives

- At the completion of this education activity, the learner will be able to:
  - Enhance prioritization skills from review to reconciliation processes
  - Capture the most common diagnoses to positively impact mortality and length of stay (LOS) models
  - Query more effectively to reduce hospital-acquired conditions (HACs), impact risk adjustments for Patient Safety Indicators (PSIs), and audit-proof the medical record
  - Identify effective management tactics for program effectiveness and educational approaches for licensed independent practitioners (LIP)

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Why?

- Quality
- Productivity
- Communication
- Skills
- Education

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Clinical Documentation Improvement at Lifespan: Who We Are

CDI program: April 2009

- **Facilities**
  - Rhode Island Hospital: Acute care level I trauma teaching hospital—719 beds
  - Hasbro Children's: Acute care level I trauma teaching hospital—116 pedi beds
  - The Miriam Hospital: Acute care teaching hospital—235 beds
  - Newport Hospital: Community acute care hospital—129 beds
- **About us**
  - Reports to finance
  - Management: Director, manager, data coordinator, administrative assistant
  - CDI specialists: 13 full-time
  - Clinical ladder: 6 senior-level CDI specialists
  - Certification: 9 staff with CCDS status
  - Fully electronic medical record: EPIC and 3M 360
  - REMOTE program: 2 days/week

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Clinical Documentation Improvement at Lifespan: What We Juggle

- **Concurrent reviews**
  - PDX
  - MCC/CC
  - SOI/ROM impact
  - Mortality and LOS models analysis
  - HAC/PSI identification and risk adjustment
  - Audit-proofing
  - Review of all payer charts
  - Reviews continue until discharge
- **Retrospective reviews**
  - Post-discharge/pre-billing mortality reviews for all expired patients
  - Post-discharge/pre-billing HAC—PSI reviews
  - Reconciliation

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Efficient Review Process: 5 Levels

1. Fundamental review
2. Mortality/length of stay model concurrent review
3. HAC/PSI concurrent identification
4. Audit-proofing
5. Retrospective processes
   - Reconciliation
   - Post-discharge/pre-billing mortality review
   - Post-discharge/pre-billing HAC/PSI review

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Level 1: Fundamental Review

- DRG assignment: Medical/surgical
- MCCs/CCs
- Present on admission status
- SOI/ROM
- Query for further specification/clarification
- Follow-up reviews every two days until discharge

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Level 2: Mortality and LOS Model Concurrent Review

- Determine organizational focus
  - Hospital benchmarking
  - Collaborate with other key departments: HIM, case management
- Incorporate review into daily routine
- Consider combining top DRG mortality and LOS models
- Create most common diagnoses tip sheet
- Reassess upon each review any change in DRG
- Educate and collaborate: CDI/coding/LIPs

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MS-DRG Combination Sample

Explanatory Variables / Significant Predictors*	Mortality Group 903	LOS Group 294
Acute & Subacute Necrosis of Liver	X	X
Acute Kidney Failure	X	X
Acute Myeloid Leukemia, Active	X	X
Acute Respiratory Failure	X	
AMI		X
Arrhythmia	X	X
Aspiration Pneumonia/Pneumonitis		X
C. Difficile Enteritis		X
Cardiac Arrest	X	X
Cardiomyopathy		X
CC Chronic Blood Loss Anem		X
CC Chronic Pulm Disease		X
CC Coagulopthy	X	X
CC Deficiency Anemias		X
CC Fluid & Electr Disorders	X	
CC Lymphoma	X	X
CC Malnutrition	X	X
CC Metastatic Cancer		X
CC Other Neurolog Disorders		X
CC Paralysis		X

Vizient, Inc., AMC Hospital: Risk Modeling Summary for CDB 2016 Outcome = Mortality, AMC Hospital: Risk Modeling Summary for CDB 2016 Outcome = Length of Stay

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Common LOS/Mortality Diagnoses

Acidosis/alkalosis	Hypo/hyperkalemia
AMI (subsequent and acute)	Hypo/hypernatremia
Anemia (unspecified and/or deficiency)	Hypo/hypertension
Arrhythmia (AFib/AFlutter/bradycardia)	Hypothyroid
CHF (unspecified)	Malnutrition
Coagulopathy (thrombocytopenia)	Obesity/morbid obesity with BMI
Dehydration/hypovolemia	PVD
Depression	Renal failure (ARF/CKD/ESRD)
DM (with or without manifestations)	Underweight/cachexia/weight loss

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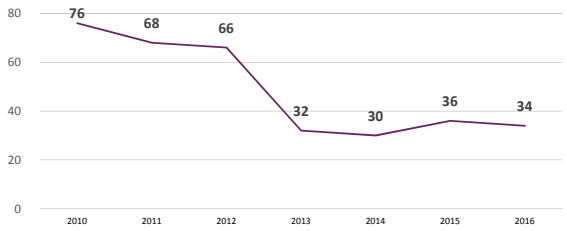
Risk-Adjusted Mortality: Historical Rank



2010 AMCs = 98, 2011 – 2013 AMCs = 101, 2014 AMCs = 104, 2015-2016 AMCs = 102

Vizient, Inc., AMC Quality and Accountability Performance Scorecard - Rhode Island Hospital, 2010-2016

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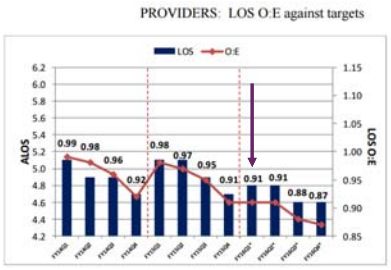
LOS O:E Against Targets—LOWER IS BETTER



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Level 3: HAC/PSI Concurrent Identification

- Determine organizational focus
  - Hospital benchmarking
  - Collaborate with other key departments: HIM, quality, infection control, chief medical officer
- Educate staff regarding impact on organization
- Concurrent review process with identification of a HAC or PSI
- Assess for exclusions or query opportunities
- Capture/query for PSI risk adjustment diagnoses
- Evaluate for documentation trends or risk
- Accurate concurrent evaluation will assist with and accelerate the retrospective review process

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Top Diagnoses to Impact PSI Risk Adjustment

- **Weight loss**
  - Malnutrition of all degrees
  - Underweight
- **Renal failure**
  - CKD
  - ESRD
  - Kidney transplant
- **Obese**
  - BMI > 30
  - Morbid obesity/obesity
  - Obesity hypoventilation syndrome
- **Neuro**
  - Parkinson's, multiple sclerosis, ALS, seizures, encephalopathy
  - Restless leg syndrome
- **CHF**
- **Alcohol**
  - Dependence/abuse/withdrawal/DTs
- **Chronic lung**
  - Emphysema
  - Bronchitis
- **Drugs**
  - Dependence/abuse/drug-seeking behavior
- **Paralysis**
  - Neurogenic bladder
  - Any type of "plegia"

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Case Study: Patient Safety Indicator 15 (PSI 15) Unrecognized Abdominopelvic Accidental Puncture or Laceration Rate

To qualify: Second abdominopelvic procedure one or more days after the index procedure

- 60-year-old male admitted for planned open left colectomy for colon cancer

  PMH includes: *Colon CA: rectosigmoid; s/p low anterior resection 12 years prior*, lung CA s/p left lower lobectomy, epilepsy and tobacco abuse.

  Open left colectomy with coloproctostomy and mobilization of splenic flexure on 12/13/16

  OP note: "A midline incision was carried out over the old scar using electrocautery and the peritoneum sharply incised and opened up with lysis of adhesions. **Tedious and careful lysis of adhesions** was carried out with sharp dissection bilaterally in the pelvis. The left tumor mass was identified and attached to the left pelvic and abdominal sidewall. **Again, tedious dissection allowed mobilization medially and then the small bowel had numerous adhesions between itself and the anterior abdominal wall as well as the colon and sharp lysis was carried out.** The sac was carefully examined and care was taken to avoid injury to this. It was quite deep in the retroperitoneum and away from the tumor mass." … "**The splenic flexure was quite stuck into the retroperitoneum and required tedious dissection to be mobilized.** The proximal portion of the descending colon about 10cm proximal to the tumor, was then divided using an automatic purse string device." … "The patient tolerated the procedure well and **there were no complications**."

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Case Study: PSI 15 (cont.)

- POD #2:
  - Hypotension, tachycardia, and bandemia
  - Return to OR for concern for intra-abdominal pathology
- 12/15 OP note:
  - Post-procedure Dx: Small bowel enterotomy
  - Procedure performed: Exploratory lap with repair of small bowel enterotomy

  "Upon entering the abdomen there was a large amount of enteric content in the peritoneal cavity. We cleaned and explored the abdomen. We immediately identified a small hole on the antimesenteric side of small bowel. We assessed the health of the bowel and it was without ischemia and the enterotomy was exactly anti-mesenteric." … "We interrogated the anastomosis at the level of the rectum which appeared healthy. There was no leak at this time and the bowel was without sign of ischemia even on pressors."
- CDI *concurrently* queried the physician to determine whether the pt. was experiencing:
  - Small bowel enterotomy that was Inherent to the dense adhesions as described in the 12/13 OP note
  - Small bowel enterotomy that was a complication of the 12/13 OP procedure
  - Unknown, unable to determine, or another dx that supports the above clinical criteria
- ***MD ADDENDED OP NOTE AS FOLLOWS:***

  "Small bowel enterotomy was felt to be inherent to the difficult nature of the pt.'s anatomy with dense, thick, adherent adhesions likely as a result of previous anterior resection as noted in pt.'s PMH."

PSIs 5/15/16–1/24/17

	Lifespan Totals		
PSI Code Reviewed	**Coded as HAC/PSI**	**Not Coded as HAC/PSI After Review**	**Total Reviewed**
PSI 03 Pressure Ulcer Rate	20	13	33
PSI 09 Perioperative Hemorrhage or Hematoma Rate	38	27	65
PSI 11 Postoperative Respiratory Failure Rate	20	20	40
PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate	36	4	40
PSI 15 Accidental Puncture or Laceration Rate	31	13	44
Grand Total	**145**	**77**	**222**

HACs 5/15/16–1/24/17

	Lifespan Totals		
HAC Code Reviewed	**Coded as HAC/PSI**	**Not Coded as HAC/PSI After Review**	**Total Reviewed**
HAC 05 Falls and Trauma	12	9	21
HAC 06 Catheter-associated Urinary Tract Infection (UTI)	21	3	24
HAC 07 Vascular Catheter-associated Infection	19	1	20
Grand Total	**52**	**13**	**65**

HAC/PSI Recap

- PSI v. 6.0 specifications
- POA status
- Correct code assignment
- Review surgical patients for accurate documentation
- Review all PSIs—not just those in PSI 90 for biggest impact potential
- Quick tips:
  - Respiratory failure: Assess intubation times
  - Complications: Inherent vs. complication, qualifying procedures
  - Hematoma/hemorrhage: Qualifying procedure, assess for coagulopathy on admission
  - Postop PE/DVT: Assess code accuracy, only certain sites qualify
  - Pressure ulcer: Check POA status, admission status, length of stay < 3 days

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Level 4: Audit-Proofing

- **Continued, concise documentation:**
  - Problem list challenges
  - Look for ambiguities in diagnoses (i.e., delirium/encephalopathy)
- **Show evolution and resolution of major diagnoses:**
  - Evolving on admission
  - Resolved
  - Now resolving
  - Ruled in/out
- **High-risk diagnoses:**
  - Sepsis
  - Pneumonia
  - Encephalopathy
  - Malnutrition
  - Respiratory failure
  - Present on admission status

Query when in doubt.

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Sample Query: Continued Documentation/Diagnosis Written Once

Pt admitted with CAP. PMH includes ESRD on dialysis, DM, bronchiectasis, HTN, and hyperlipidemia.

12/30/16 H+P: "RR=34 by my count while resting in bed, O2 88% on RA requiring supplemental O2, T max 101" … "80 y/o woman with h/o bronchiectasis presenting with fever, cough, and dyspnea found to have hypoxia, tachypnea, and fever all suspicious for pneumonia with **signs of sepsis on presentation."**
1/2/2017 daily PN: "CAP: continue azithromycin, ceftriaxone (day 3), cont supplemental O2."

ED nursing vitals reveal: 12/30/16 0810: Temp 100.9; HR 144; RR 32; Pox: 88% RA
Laboratory data reveal: 12/30/16 WBC: 12.1
Tx included 2L NS bolus in ED. Currently ordered for and receiving IV azithromycin.

Sepsis noted in H+P; medical record without further documentation of this medical diagnosis. Based on the above clinical information; and if clinically significant; please render a clinical opinion as to the status of the diagnosis of sepsis:

- Sepsis 2/2 community-acquired pneumonia present on admission now resolving/resolved
- Sepsis ruled out
- Unknown
- Unable to determine
- Or another diagnosis that supports the above clinical criteria

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Level 5: Retrospective Processes

- Reconciliation
  - Queries
  - Mismatched DRGs
- HAC/PSI retrospective reviews
  - Committee: CDI/coding/QI/infection control
  - Database
  - Retrospective queries done by CDI
- Mortality retrospective reviews
  - All expired patients
  - Retrospective queries done by CDI

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Licensed Independent Practitioner Education

- Onboarding
- Monthly resident rotation education by assigned CDI
- Physician pocket tools: 13 specialties
- LIP emails: Quick tips
- Tailored to MD directors
- Physician advisor
- 1:1 face time on nursing units
- Positive feedback to practitioners

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Example: Critical Documentation Information

Be sure to document HYPERTENSIVE CRISIS appropriately
ICD-10 has been updated to include:

Hypertensive urgency

- Severe HTN: **Systolic > 180 and/or diastolic > 120 mmHg**
- **No signs of end organ damage**
- Patient can have severe headache, shortness of breath, nosebleed, anxiety

Hypertensive emergency

- Severe HTN: **Systolic > 180 and/or diastolic > 120 mmHg**
  AND
- **Evidence of acute end-organ damage** (including but not limited to):
  - Stroke or encephalopathy
  - Retinal hemorrhage or other damage to eyes
  - MI or myocardial ischemia
  - AKI
  - Aortic dissection
  - Pulmonary edema

Examples of documentation:

- Pt with severe headache, B/Ps 190s/110. Pt treated with IV labetalol for **hypertensive urgency**.
- Pt admitted with acute encephalopathy and AKI, B/Ps 188/122, 190/120. Pt treated with IV labetalol for **hypertensive emergency.**

Johnson W, Nguyen ML, Patel R. Hypertension crisis in the emergency department. Cardiol Clin. 2012 Nov;30(4):533-43. Epub 2012 Oct 2

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Helping Staff Work Smarter, Not Harder

- Quality
- Productivity
- Communication
- Skills
- Education

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Management Strategies

- Shared drive
- Feedback
- Senior guidelines: Sample queries, policy and procedures
- CDI 2.0 education for junior staff
- Conference calls
- CDI/coding collaborative
- Time management tactics
- REMOTE program
- Flexibility
- Work-life balance

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Weekly Query Rates

Date	Facility	# Queries	Response Rate Goal > 95%	Agree Rate Goal > 90%
Week 1	NH	6	100%	100%
	TMH	20	95%	95%
	RIH	68	99%	97%
Week 2	NH	9	100%	92%
	TMH	26	99%	93%
	RIH	100	99%	93%

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CDI Staff Scorecard

	October 2016	November 2016	December 2016
Total initial cases	247	203	196
Total queries	57	52	58
Query rate	23%	26%	30%
Response rate	95%	98%	100%
Agree rate	98%	98%	97%

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CDI Staff Perspective: Minimize Frustration and Maximize Impact Potential

- **Do a complete review the first time around!**
- **Be time-efficient in your review**
  - Develop a routine to review charts. Formulate a template, if needed, to stay on track!
  - Don't wait to clarify ambiguities, POA status clarification.
  - After completing your initial DRG, evaluate mortality/LOS risk adjustments and be sure that all diagnoses are captured.
    - Don't forget the "little" diagnoses as they often have a big impact—i.e., hypotension, abnormal lab values, weight loss, adult FTT, obesity
- **Prioritize your follow-ups**
  - Follow-up reviews are often when you can concurrently assist in PSI/HAC identification and query if needed
  - Concurrent queries are often easier to get answered as the patient is current in the MD's recollection of events
  - Audit proofing/querying to "drag" diagnoses throughout record are often done on second and third chart review
- **Phone a friend**
  - Don't hesitate to ask for assistance from other staff, management, coding department if you feel that you are spending too much time on a difficult case
- **Don't get caught up in the "numbers" game**
  - Find a balance between quality and quantity with good time management
  - Focus on good, accurate, and complete reviews the first time around to ensure your follow-ups will be less time-consuming
  - Remember that all factors are taken into consideration while looking at productivity—i.e., queries, follow-ups, special projects, etc.
- **Open communication with management**
  - Management wants us all to succeed! They are our allies on the path to better and more accurate documentation.

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How to Work Smarter, Not Harder

Consider incorporating into your program:

- Five-level review process: Concurrent and retrospective
- Combine mortality/LOS risk adjustment models for your facility's top DRGs
- Identify the most common risk adjustment diagnoses
- Identify top diagnoses and documentation opportunities related to HAC/PSI for your facility
- Identify and monitor high-risk diagnoses
- Have designated time for accurate reconciliation of all cases
- Evaluate your retrospective processes
- Balance quality over quantity
- Evaluate your distribution of LIP education
- Flexibility

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Checklist

- Fundamental:
  - PDX
  - Identify all MCCs, CCs, SOI/ROM diagnoses
  - Query to clarify any ambiguities/POA status
- Identify all mortality and LOS risk adjustment diagnoses and query if necessary.
- Concurrently identify any potential HACs/PSIs and query if necessary to exclude or risk-adjust.
- Clarify all diagnoses only written once to audit-proof your record.
- Retrospectively reconcile your cases per facility guidelines. Be sure that all risk adjustment diagnoses are captured with correct POA status.

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If You Can Check Off All of the Above Tasks, Your Review Is Thorough and Complete. You Can Now …

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Thank you. Questions?

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