acdis 2022 IMAGINE
May 2–5, 2022 | Kissimmee, FL

Make the Business Case for Your CDI Program With Redefined Performance Metrics

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Presented By

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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Explain the importance of Identifying CDI program goals/leadership roles
  - Describe the importance of aligning metrics with program goals
  - Understand the importance of leveraging technology to achieve goals/metrics
  - Discuss how to capture impact for validation/denials, and risk adjustment/HCCs

Future Steps for CDI Programs

- More patients are being treated as outpatients/observation
- Higher demand for outpatient CDI programs
- Inpatient CDI is more important
  - Maximize severity of conditions to support inpatient level of care
  - Focus on admission documentation
  - Detailed daily documentation to define acuity/risk
  - Ensure quality metrics are well defined

"Anyone can steer the ship, but it takes a leader to chart the course."

– John C. Maxwell

- CDI program goals start with leadership
- Leadership and management are two different entities
- How you chart the course as a leader will determine outcomes
- What is your leadership style?
  - Autocratic
  - Democratic
  - Laisser-faire
  - Paternalistic

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Background of the CDI Program

- Arrived mid March 2019 to a 400 Bed Hospital
- 7 CDIs (5 nurses 2 coders) Experienced but misdirected
- New physician advisor/(new to CDI/coding world)
- Poor communication between CDI and providers
- Poor communication between CDI and Coding

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Background of the CDI Program

- No denials/denial prevention program
- No HAC/PSI reduction program
- No clinical validation process for highly denied diagnoses
- Program goals not well established/No clear metrics
- Low CMI/Low revenue impact
- Medical/surgical staff not well educated on the how's and why's of CDI

How Does It Look Now?

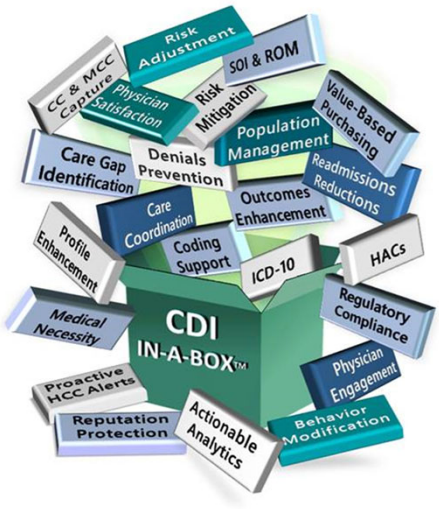
- Currently 8 CDIs and 1 CDI validator
  - CDI director & clinical validation denials
  - Team leader – PSI 03 project lead/quality spokes person
  - CDI ICU educator
  - CDI HCC project leader
  - CDI oncology educator
  - CDI medical necessity denial specialist (CM background)
  - CDI validator (coder fills this position)
  - Physician advisor

Restructuring Achievable Goals/Metrics

- No metric stands alone
- Goals and metrics need to be clearly defined
- Identify goals of the organization
- Expectations need to be clear
- Every goal/metric needs to be measurable
  - If you can't measure it, how can you improve it?
- Identify potential obstacles
  - Overlapping departments (coding, quality, case management)
  - Physician engagement
- With expansion of CDI in the retrospective space and outpatient space, measurables are more challenging

How and What Do You Choose?

- Identify team strengths
  - Critical thinkers
  - Innovators (new projects)
  - Educators (one on one training and group training)
  - Collaborators (work with other overlapping departments to achieve common goals)
- Identify what has been mastered and what has not
  - Look to the past to navigate the future



How and What Do You Choose?

- Identify organization goals
- Identify trends in your facility. This can give you a focus
  - "Slang" documentation
  - Denial diagnoses/denial volume
  - Admission orders/supportive documentation for inpatient admissions
- Evaluate provider's understanding of what is needed
  - This will drive education

Using Technology to Abstract Data

- Financial impact of queries (better documentation= lower $ impact of queries)
  - CC/MCC capture (EHR reports)
  - Increase SOI/ROM APR cases (EHR reports)
  - HCC capture (use Epic reporting and manual calculation)
- Second level reviews (communication between CDI and coding)
  - Written query process (allows for better capture and tracking)
- Overall, SOI/ROM increase (all cases)
- Monthly CMI with and without COVID cases (breakdown surgery and medicine)

Using Technology to Abstract Data (continued)

- Denials (electronic tracking/manual process)
  - How many per month/what is the denied diagnosis
  - Did CDI send a query
  - Implemented pre-bill validation process (measure reduction percentage)
- Record reviews (EHR reports)
  - Target 17/day (10-12 new/5-7 rereviews) looked at monthly
- Provider query response rates (ICU, medicine, surgery, ED)
  - Overall percentages
  - Individual performance
  - New technology to incorporate queries as part of the medical record

Physician Metrics and Report Cards

Provider	# of Queries	Financial Impact	Missed revenue	Response rate	Agreed rate	Alt Response	Disagree	No Response	MCC	CC	Primary Diagnosis	APR (SOI/ROM)	Clinical Validity	HCC	Other	HAC/PSI save
Dr. A	18	$22,278	$0	100%	83%	11%	6%	0%	6	2	4	4	2	0	0	0
Dr. B	6	$5,484	$0	100%	67%	16%	16%	0%	1	0	0	1	1	0	3	0
Dr. C	8	$6,261	$3,297	88%	25%	25%	38%	12%	5	2	1	0	0	0	0	0
TOTAL	32	$34,023	$3,297	96%	58%	17%	20%	4%	12	4	5	5	3	0	3	0

- Overall department view and individual performance
- Alternate responses count as a response and don't negatively impact
- Missed revenue is if the query sent was not responded to and there was potential financial impact
- Overall department goals as part of incentives (response rates, agree rates)

Reconciliation Second-Level Reviews

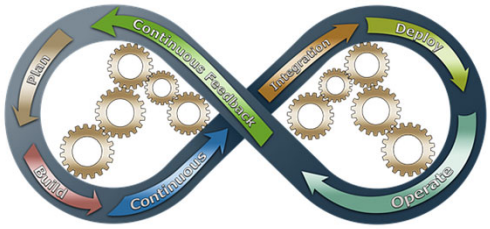
- Important part of our process
- CDI reconciles every case we touch
- Presents as co-operation between coding and CDI
- Additional revenue within the rules
- Captured as a monthly total also as an individual metric
- Use to capture manually on a spread sheet
  - Reliant on CDIs to report
- Now use CDI/coding query to electronically capture
  - Removes manual process
  - Better compliance with the process
  - More accurate capture of impact

CDI Clinical Validation

- **Problem: (The CDI and Coding riddle.)**
  - Documented diagnoses are reportable under Coding Guidelines.
  - Payers can deny diagnoses based on clinical definitions even though the diagnoses meet the definition of a principal or secondary diagnosis.
- **Further complication:** *Coding Clinic* 4th Q 2016 pgs. 147-149 which addresses that payers may require a clinical definition/criterion to establish a diagnosis.
- Volume of denials for clinical validity continues to rise.
  - The average clinical validity denial rate increased 23% from 2016 to 2020.

CDI Clinical Validation

- **Clinical validation is difficult to measure.**
  - Get involved with your denial management team.
  - What are your facility's trends (monthly/annually)?
- **Denials team seeing any new trends?**
  - What is causing it?
  - Is there an educational opportunity?
  - Is CDI or denials team in communication with payers?
  - Bad faith denials (we have all seen them!)
- **Are you included in payer contracts?**



Measuring Validation

- Developed a process for highly audited and denied diagnoses through EHR
- Goal to send these accounts out clean and well supported
  - Pre-bill clinical validation
  - Pre-bill DRG validation
- **Tracking and measuring is still somewhat manual process**

Measuring Validation

- **Started with the #1 clinically denied diagnosis (sepsis)**
  - Retrospective review of denials for the past FY.
  - What percentage of clinical validity denials were sepsis?
  - What payers have the highest rates of sepsis denials and why?
  - How much per denial did we stand to lose (average)?
  - From this data, what percentage of Sepsis denials decreased?
    - Based on previous year average, did we prevent financial loss?
    - Comparatively, what was our overturn rate?
    - Did we reduce manpower hours on appeals? (if using outside contractor)

Social Determinants of Health

- Health Inequities are preventable differences in health outcomes closely linked to social, economic and environmental conditions
- Identifying social determinants improves patient outcomes and carriers a higher complexity for medical decision making
- Documentation of the identified social determinants AND intervention/plan must be documented
- Social determinants of health potentially impact level of care (E/M)
- New coding guidelines for FY 2022
  - Allow capture of SDOH from other clinicians who are not the patient's provider (nursing, CM, Social services)
  - *Patient self-reported documentation may be used for code assignment*

Not An Uncommon Scenario

- 80 year-old woman is returning after 3 months for a BP check and weight check. Weight loss was noted during her last visit and Ensure was suggested twice a day.
- She is weighed again and has continued to lose weight. Since she was last seen, she reports her husband of 45 years passed away.
- **CDI questions:**
  - Does the patient have a degree of malnutrition (RAF 0.455)?
  - Does she have a degree of depression (RAF 0.309)?

https://www.aapc.com/resources/riskadjustment/

https://www.medicareinformatics.com/Account/Login?ReturnUrl=%2FValueBasedReimburse%2FRiskScoreCalculator

SDOH Questions

- **Z59.41 Food insecurity**
  - Is she having difficulty accessing food?
  - Does she have meals on wheels?
  - If so, does she enjoy the meals? Is she giving the meals to someone else?
- **Z59.6 Low income**
  - Is Ensure cost prohibitive?
  - Does she have meals on wheels?
  - If so, does she enjoy the meals? Is she giving the meals to someone else?
- **Z60.0 Problems of adjustment to life-cycle transitions**
  - Providing grief counseling?
  - Prescription for antidepressant?

https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

How Do We Measure Capture and Impact?

- Education and follow up is instrumental in success of accurate capture
- Use EHR to search for SDOH codes/recapture of the codes from previous year if applicable
- Month over month, is there better capture of SDOH
- Comparatively, is there an increase in level of care (E/M) for outpatient/inpatient with better capture of SDOH

Why Is Risk Important to Capture?

Documenting

- ***Documenting diagnoses appropriately to capture HCCs (Hierarchical Condition Categories). HCCs adjust risk (risk adjustment factor [RAF] score).***
  - Risk scores predict the cost of healthcare for patients for the next calendar year.
  - The higher the risk score, the more predicted care the patient requires.
  - What we capture today, will impact tomorrow.
  - Payment is dependent on the predicted risk.

Recapturing

- ***Recapturing those diagnoses year over year (gap closure).***
  - Capture of chronic disease is crucial.
  - Sometimes risk diagnoses will resolve.
  - Sometimes additional chronic disease develops.

What Documentation Impacts Risk in a CY?

- **HCCs are captured across the continuum of care**
  - Inpatient hospital care
  - Outpatient hospital care
  - Doctor visits
- **Exclusions**
  - Hospice
  - SNF
  - VNA/home health
  - Free standing ambulatory surgical centers

HCC RAF Calculation

Demographic Risk Score		Disease Risk Score		Risk Adjustment Factor (RAF Score)
• Age • Sex • Socioeconomic status • Medicaid eligibility • Medical disability • Institutional status	+	• Reported HCC Diagnosis (Mainly chronic conditions) • Interaction Factor (interactions between disease categories). • CMS has part D RAF (RX HCC's) • Commercial includes meds for RAF	=	Reflects the underlying health status and predicted/ expected costs for health care

Seems Simple Enough…

Did You Really Think It Was That Easy?

- **Problem #1:** Demographic risk score is different for every patient
- **Problem #2:** Not every patient in an ACO is hospitalized in a year (this is where outpatient CDI comes in)
- **Problem #3:** Identifying additional risk. What has been captured and not
- **Problem#4:** How to measure progress/additional risk
- **Problem #5:** Inpatient CDIs look for acute issues, not trained to look at chronic issues as much

How Do We Measure It?

- Identify HCCs
  - ~42% of HCCs are CCs
  - ~16% of HCCs are MCCs
  - ~42% of HCCs are neither CCs or MCCs
- There is no perfect system to calculate impact
- The process for queries is the same for inpatient (concurrent or retrospective)
- The outpatient process (prospective or retrospective)
- The calculation for impact is the same (before/after)

Fernandez, Valerie. "Ins and Outs of HCCs" *Journal of AHIMA* 88, no.6 (June 2017): 54-56.

How to Calculate It

- **How we calculate the impact is very different**
  - Queries are flagged as HCC's (easy to identify in a spread sheet)
  - Identify ACO patients (flagged in EHR)
  - Queries are sent regardless of payer
  - Using the CMS formula, enter all conditions minus conditions that were queried for to get a baseline (before)
  - Once calculated, enter HCC capture (after)
  - The difference is the impact at the time the query was asked

https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data

- This will give you the county benchmark rates
- The county used is the county the patient lives in, not the hospital county
- There is a formula and CMS does have a calculator

www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data

www.medicareinformatics.com/ValueBasedReimburse/RiskScoreCalculator

Mock Patient Scenario

Ms. Smith is a 66-year-old woman with diabetic neuropathy, CKD 3B, chronic HFpEF, COPD, chronic respiratory failure (2L home O2 intermittently), and recurrent depression in partial remission.

She is ordered for chronic PO steroids and is ordered for Lantis for her DM 2, last A1C one month ago was 8.2. She has frequent sinus infections and is admitted now with Decompensated HFpEF.

Based on clinical indicators, the CDI sent a query for immunodeficiency 2/2 medication.

This is a CC for inpatient and an HCC with relative factor of 0.665.

Prescott, R, MSN, CCDS, CDIP,CRC, CCDS-O, L., Manz, MD, CCDS-O, J., & Reiter, BSN, RN, CCDS, CCDS-O, CDIP, CCS, A. (2022). 2022 ACDIS Outpatient Pocket Guide. Retrieved April 18, 2022, from https://hcmarketplace.com/2022-acdis-outpatient-pocket-guide

HCC Factors (CY 2022)	HCC score
Demographic Factor	0.308
HCC total score	1.628
Disease Interaction: CHF/Diabetes	0.121
Disease Interaction: CHF/COPD	0.155
Disease Interaction: CHF/Renal	0.156
Disease Interaction: Cardiorespiratory Failure/COPD	0.363
Disease Relative Factors:	2.423
Payment HCC Counts (6):	0.077
Raw Risk Score	2.808
Normalized Score	2.512
Applied Coding Intensity Adjustment	2.364

Payment Risk score 2.364
Plymouth County Rate $1,123.03
Payment per month $2654.84
Allocated annual cost of care $31,858.11

HCC Factors (CY 2022)	HCC score
Demographic factor	0.308
HCC total score	2.293
Disease Interaction: CHF/Diabetes	0.121
Disease Interaction: CHF/COPD	0.155
Disease Interaction: CHF/Renal	0.156
Disease Interaction: Cardiorespiratory Failure/COPD	0.363
Disease Relative Factors:	3.088
Payment HCC Counts (6):	0.126
Raw Risk Score	3.522
Normalized Score	3.150
Applied Coding Intensity Adjustment	2.964

Payment Risk score 2.964
Plymouth County Rate $1,123.03
Payment per month $3,328.66
Allocated annual cost of care $39,943.93

That is a difference of $8,085.82 per year

Chart the Course

- Education and communication cannot be overstated!
- Where is your program now and what is your vision for the future?
- Don't take on too much at once. Set your program up for success.
- Evaluate team strengths, this will help direct your future state.
- Utilize technology to support your goals and produce data.
  - You never know what is possible unless you ask.
- Reach out to other facilities.
- Stay active with industry guidance/trends.
- Learn from missteps and adjust.

Step out of your comfort zone, you will be amazed at what you can accomplish!

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Thank you. Questions?

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