Steps for successful ambulatory CDI implementation

By Ellen Jantzer, RN, MSN, CCDS, CCS, CRC

CDI specialists who have been around for a while might recall how in 2007 CMS implemented the Medicare Severity Diagnosis-Related Group (MS-DRG) system. This variation to the inpatient prospective payment system (IPPS) linked reimbursement to accurate documentation and coding. For many hospitals, an effective CDI program became the solution, and the profession grew as a result.

As found by the Berkley Research Group in 2017, changes to the Medicare physician payment model—such as the implementation of the Medicare Access and Children’s Health Insurance Program Reauthorization Act (MACRA) and its two tracks, the Merit-based Incentive Payment System and Advanced Payment Models—are poised to have a similar effect on outpatient and physician payment systems. In fact, interest in outpatient CDI appears to be growing. As noted in the 2016 ACDIS white paper, “Outpatient clinical documentation improvement: An introduction,” a 2016 survey found that only 10% of hospitals had an outpatient CDI program. In contrast, two years later, the 2018 CDI Week Industry Survey found that 50% of respondents reviewed outpatient or ambulatory records.

In 2015, my organization decided to implement a CDI program in the primary care setting and quickly discovered just how complex and confusing this process can be. After two and a half years and many lessons learned, the program launched in January 2017. The Asante ambulatory CDI team currently consists of four RN CDI specialists who review documentation and coding related to Hierarchical Condition Categories (HCC) for approximately 80 primary care providers. As found by the Asante team, here are the elements necessary for successful implementation of a CDI program in the ambulatory clinic setting.

Executive leadership

Creating an ambulatory CDI program takes coordination between multiple departments, so a vision from the top is essential. At Asante, executive support was the starting point for implementing an ambulatory CDI team. Asante leaders recognized the value of population health and desired to create a healthcare delivery system that was more than just a collection of hospitals and physician offices. This drive for excellence across the continuum meant documentation and coded data needed to be consistent between the inpatient and outpatient settings.

Some health systems might need to look outside their own walls to understand the need for outpatient CDI. In organizations without a top-down initiative, inpatient CDI specialists can research the potential benefits to better understand how such efforts might benefit the organization. To float the idea from the bottom up, CDI leaders will likely need to speak to the organizational and administrative needs of the system. CEOs and chief financial officers worry about many things, some of them conflicting: return on investment (ROI), demand on staffing resources, quality of patient care, and physician and employee engagement, among others.

Consider networking with department leaders to learn about the organization’s priorities. Colleagues in operations, finance, or quality may have initiatives that an outpatient CDI team could help advance. Ask yourself, “How could outpatient CDI help solve these problems?” Just like on the inpatient side, accurate coding and documentation can improve reimbursement as well as promote accurate reported quality scores on the outpatient side, but be prepared to prove it with data—administrators want to see numbers.

Identify a patient population and intended outcomes

On the hospital side, patients are readily identified by their admitted status; in the ambulatory clinic setting, it
can be harder to know who your patients are. Check with your payer contracts department to see if your health system has any shared risk plans, and conduct research to determine whether your state participates in innovative payment methodologies where CDI could have an effect.

For instance, Oregon is one of 18 regions participating in Medicare’s Comprehensive Primary Care Plus (CPC+) program, which is a “national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation.” To support the delivery of quality patient care, providers who participate in the CPC+ program are eligible to receive a Care Management Fee (CMF) in addition to the Medicare fee-for-service payment. Since CMF payments are risk-adjusted based on HCCs, CDI specialists can work with the providers to ensure appropriate reimbursement through accurate documentation and coding of chronic conditions.

Outpatient CDI can mean different things to different people. In addition to determining a patient population to focus on, there needs to be clarity around intended goals before an organization can move forward. Do you envision outcomes related to HCC capture or E/M levels—or both? Will your CDI team work to solve issues related to the problem list, or will the focus be on the documentation in the encounter note? Of course, any CDI program needs to adhere to guidance from ACDIS and follow the ACDIS/AHIMA “Guidelines for Achieving a Compliant Query Practice” brief, updated earlier this year.

Asante chose to focus its ambulatory CDI team on chronic conditions and HCC capture. The goal was, and still is, to ensure that documentation and coding accurately depict the patient’s clinical condition(s) and the provider’s medical decision-making. The key word here is accuracy: The documented conditions need to be clinically supported and adhere to the ICD-10 Official Guidelines for Coding and Reporting and applicable issues of Coding Clinic.

**Input from compliance**

Compliance should be consulted prior to introducing any new program or process, but you will need an idea of what’s being proposed first. Be prepared to educate the compliance team on the role of CDI. You may be asked to supply documentation from ACDIS or AHIMA that demonstrates how the program you intend to build is compliant with industry standards.

Since outpatient CDI is still in its infancy, finding resources can be a challenge, so networking outside of your organization can come in handy. Attend your local ACDIS chapter meetings to learn how other organizations are structuring their programs. If you have the budget for it, consider attending larger national events such as the ACDIS conference or the ACDIS Symposium: Outpatient CDI to connect with others on the outpatient CDI path. At Asante, we were able to set up a phone meeting between our leaders and leaders at other health systems who were further along than we were, which helped our compliance and executive teams verify our direction was consistent with what other organizations were already doing.

**Build the team**

Dedicating some inpatient CDI specialists to the outpatient setting is not enough; successful implementation of an ambulatory CDI program is a team sport. As a first step, involve an operations staff member to confirm that any CDI processes or workflows will not hinder patient care. Ask for introductions to the clinical staff. The incoming CDI team will need to know which staff member processes what type of information in each physician office. For example, some offices have an office manager who could help the CDI team identify which records need to be reviewed or fast-track physician queries if necessary.
Furthermore, physicians can have different ways of interacting with the electronic health record (EHR). Ask the IT department to show the “provider view” in the EHR to give the CDI team a better understanding of how and why the encounter notes look the way they do. This can help generate empathy for the providers who are responsible for the actual documentation. Over time, CDI professionals may be able to identify trends related to EHR drop-down menus, problem lists, and other matters. In some cases, working with IT may help streamline the documentation process for physicians. In other cases, CDI staff may be able to educate physicians on how to more effectively manage the EHR tools.

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And, of course, coding professionals are an integral part of any CDI initiative. On the inpatient side, a coder touches most, if not all, encounters; this may not be true in the ambulatory clinic setting, where providers may generate their own codes. Monthly meetings between CDI and coding can increase everyone’s knowledge and promote collaboration. In organizations where providers do their own coding, input from CDI can facilitate a balance between the need for provider education and advocating for increased coder support.

**Recruit a physician champion**

A dedicated physician champion is a must for any successful CDI program, but finding the right person can be tricky. Often, the best choice in a physician champion is someone who is initially a bit doubtful about the value of CDI, but who will become your strongest ally once convinced. When recruiting a physician champion, look for someone who is respected by other physicians, willing to advocate for change, and committed to the organization.

**Hire and train CDI specialists**

Asante employs an all-RN inpatient CDI team and elected to hire RNs for the outpatient setting as well. Many outpatient programs choose to hire outpatient coders for their CDI team, and ACDIS supports the idea that CDI efforts can be undertaken by people with a variety of professional backgrounds. Since Asante’s goal for CDI is accurate documentation and coding across the healthcare system, the inpatient and ambulatory teams report to the same leadership. Both teams attend weekly staff meetings to promote collaboration and idea sharing.

Over the last year, Asante has found it helpful for CDI specialists to be trained first on the inpatient side. This allows new CDI specialists to learn in an established program that is supported by software applications and to work with physicians who are familiar with CDI efforts. The CDI specialists participate in ongoing training to develop comprehensive clinical knowledge, understanding of coding rules, and knowledge of payment and quality reporting methodologies.

**Establish a chart review process**

Visits in the clinic setting are measured in minutes rather than days, there is no time for a concurrent review; chart review is done prospectively before the day of the encounter. At Asante, CDI nurses run a report each morning showing the upcoming visits. Two or three days before the scheduled visit, the CDI nurse conducts a medical record review, including most recent clinic notes, consultations with a specialist, the problem list, and claims submission. The chart review process identifies areas where documentation could be improved to achieve accurate quality measure reporting, compliant coding, and appropriate reimbursement, as stated in the ACDIS white paper, “How to conduct a medical record review.”

When there is an opportunity to clarify based on the ACDIS/AHIMA query practice brief, the CDI specialist will send a query to the provider, who responds by addressing the condition with the patient and documenting information in the encounter note. For instance,
CDI can query the physician to clarify if active cancer has been eradicated and is now “history of,” or ask the provider to further specify the type and acuity of the patient’s heart failure. CDI specialists are available when providers have coding questions or want help updating the problem list to the most accurate diagnosis.

After the scheduled visit, the CDI team conducts a follow-up review, retrospectively, to evaluate the effect of the CDI query. Asante follows the AHIMA practice brief, “Documentation and coding practices for risk adjustment and hierarchical condition categories” when determining if the documentation supports coding HCCs. The acronym MEAT (monitor, evaluate, assess, treat) can be a helpful tool for evaluating the integrity of clinical documentation in the ambulatory setting. At Asante, CDI is about building a working relationship with the provider; CDI specialists round in the clinics each week to answer questions, provide feedback, and offer ongoing education.

**Reporting tools/ROI**

The March/April edition of the *CDI Journal* included an article titled “Measuring success: DIY outpatient tracking tools,” which suggested most CDI teams rely on homegrown reporting tools, often based in Excel, to track CDI metrics. While these tools can be clunky, CDI teams should expect that administrators will want numbers to support ROI before investing in a vendor-provided, ready-made software solution. Additionally, CDI managers should collect data to establish standards related to the productivity and quality of the CDI team.

Just as on the inpatient side, programs will need to track the number of records reviewed, the number of query opportunities identified, the number of queries generated, and physician response and agreement rates, as well as the effect on HCC capture if that’s one of the program’s stated goals.

**Outcomes and future state**

The Asante ambulatory CDI program is still in its infancy, and as every parent knows, raising a toddler can be an eye-opening experience. Asante has seen the most success in physician engagement. Some primary care providers appreciate queries because they highlight clinical information from the chart, which can decrease the provider’s chart-prep time. Since the providers often select their own diagnosis codes, they see value in CDI when they are unsure of proper ICD-10 code selection or they want to better understand documentation requirements.

Currently, the team is working to decrease obstacles related to patient access. Having identified the patient population—CPC+ patients—the goal is to create a process for effectively managing this group of patients through accurate diagnosis coding so that every patient gets the right access to the right resources at the right time. Problem list bugbears seem to plague most facilities, and the Asante CDI team is a part of a physician-led initiative to address these challenges. (For some tips on dealing with problem list difficulties, read this article, titled “EHR’s troubled path: Three persistent problems,” from the March/April edition of the *CDI Journal*.)

The CDI team has learned to develop priorities and processes over the years that help the organization reach its goals. Understanding organizational priorities and developing an ambulatory CDI program aligned with those goals has occasionally proved challenging; however, strong executive and physician leadership can mitigate the madness. Flexibility and fostering a culture of change is critical to the successful implementation of an ambulatory CDI program.

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