CDI LEADERSHIP EXCHANGE

Insights Report

DECEMBER 2018

CDI DEPARTMENT EXPANSION: GROWING SMARTER TO MEET NEW DEMANDS

In-depth discussion among health system leaders at the ACDIS 2018 CDI Leadership Exchange

An independent ACDIS report supported by OPTUM360®

Discussion

CDI department focus expanding to include outpatient encounters, denials prevention

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Director
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Healthcare payment models are changing from fee-for-service to pay-for-performance, and in response CDI leaders are being asked to expand their department's scope of work. Many supervisors, managers, and directors have branched out their chart reviews to include new service lines, all payers, and outpatient encounters and services provided in clinics and physician practices. Organizations are also being leveraged to combat the increasing problem of audits and denials, both preemptively and through the appeals process.

As a result, CDI is often a victim of its own success, as finance and administration realize its value and want CDI leadership to do it all. But how do you expand your influence while growing smartly? In November, ACDIS invited 28 CDI managers and directors to the 2018 CDI Leadership Exchange in Orlando, Florida to discuss how they have expanded the reach of their traditional inpatient CDI departments.

Two of the major initiatives for CDI expansion discussed at the CDI Leadership Exchange include outpatient CDI and denials management. The following is a recap of the discussion around these exciting developments.

OUTPATIENT CDI: BUILDING THE CASE

Rebecca Willcutt, BSN, RN, CCDS, CCS, CRC, director of CDI at Cooper University Health Care in Camden, New Jersey, led the design and implementation of a hybrid CDI program with on-site and remote CDI specialists. She also designed and implemented point-of-entry CDI in the emergency department and directs the ambulatory program with the expertise of an on-site supervisor.

Knowing that it could not touch every outpatient chart across its more than 100 outpatient offices throughout South Jersey and Pennsylvania, Cooper University Health Care opted to staff its outpatient program with educators, including E/M educators and surgical educators. But finding qualified staff at affordable salaries proved very difficult. The organization needed a surgical educator to train physicians in

ON THE COVER - Attendees of the 2018 CDI Leadership Exchange discuss ways in which their departments have expanded their focus to adjust to the migration of services to outpatient settings.

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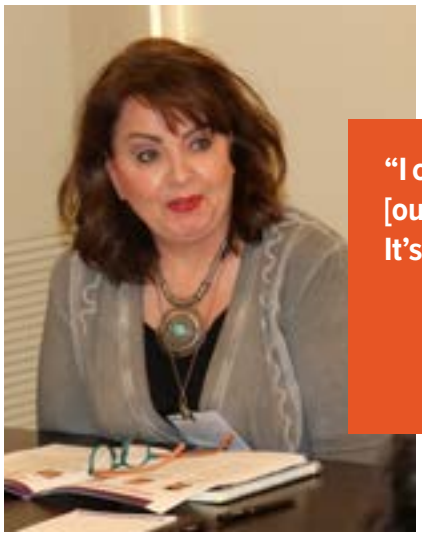
the documentation requirements for proper Current Procedural Terminology (CPT®) surgical coding, and that meant finding someone with a clinical background who also understood outpatient coding guidelines and professional billing. One recruiter described this mythical candidate as the equivalent of a "pink zebra."

Willcutt also needed to train the entire inpatient coding and CDI staff, so she decided to send them to a mandatory risk adjustment class. Currently, 100% of her inpatient CDI specialists and her ambulatory supervisor are certified in risk adjustment coding, with the newer ambulatory staff working toward that goal.

To prove the return on investment (ROI) for new staff and additional training, Willcutt started by finding the program's current baseline and growth potential. She had all the Medicare Risk Adjustment Factor (RAF) scores pulled from 2014 to 2017, which were used to risk-adjust plan payments to the accountable care organization it belongs to. The RAF score for an individual patient represents all of the Hierarchical Condition Categories (HCC) that have been submitted for that patient during the course of a calendar year.

This required her to roll up her sleeves and get to work, as she could not find a vendor who provided the service. "I knew nothing about the outpatient world, but I could not find any [vendor] who could say, 'A, B, C, D, E, bullet point by bullet point, here's what you need to do,'" she says. "We had a baseline broken down by location and then per doctor, by patient, by HCC, and by diagnosis."

By showing the baseline data, then the ROI potential after appropriate diagnosis capture and the resulting improvements to HCC capture, RAF scores, star ratings, and outpatient quality scores, Willcutt was able to expand the ambulatory staff to seven people, including a supervisor, an RAI (return for additional information) expert, two E/M educators, a surgical educator, and two orthopedic coders, with further institute coders planned. Currently the inpatient CDI team is made up of six on-site CDI specialists and 12 remote dual-certified CDI specialists (coding and CCDS).



"I can already tell you where [outpatient CDI] is going to go: It's going to be huge."

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CDI staff review patient charts prior to their clinic visit and prompt physicians to address and document chronic conditions that the physicians are still monitoring, evaluating, assessing, or treating. The CDI staff also review surgical appointments and notes for missed coding opportunities, and they review emergency room encounters, tests, and procedures for medical necessity. Identified opportunities to improve risk scores include:

1. Past assessments (previous diagnoses not found on the current year's claims)
2. Problem list events not assessed or claimed in the current year
3. Historical events (which imply undocumented conditions)
4. Medications (which imply undocumented conditions)
5. Claims (billed events that may not have been submitted to CMS)

Willcutt also enjoys the support of two strong medical directors—Nicole Fox and Adam Holzberg. The two bring a combination of outpatient experience and an interest in informatics and the EHR. Their status as practicing physicians, well-known and well-liked by the medical staff, helps ensure buy-in.

Tonia Catapano, RN, BSN, CCDS, CCS, RHIA, director of coding and CDI for Yale New Haven Health System (YNHHS) in New Haven, Connecticut, implemented an outpatient CDI program with her management team that includes six FTEs. She was able to get it off the ground through a pilot program, which allowed for a test window to determine if the effort was warranted. Catapano collaborated with Northeast Medical Group leadership to implement a dual focus to the outpatient CDI program: HCC capture, and outpatient clinical denials prevention for high-cost drugs and cardiac procedures.

To kick off the HCC portion of the pilot, YNHHS hired a vendor to perform an analysis of the claims data for its Managed Medicare population. It needed a full assessment of the RAF gap in

"It's like years ago when [inpatient] CDI first started—we started out with one or two people, and every year we kept growing it and growing it, anywhere that there's an opportunity for improvement."

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Left to right: Brenda Etefia, Theresa Burchfield, and Rachelle Buol listen to discussion at the 2018 CDI Leadership Exchange.

order to focus its pilot efforts and increase its scores in the pursuit of shared savings. Review staff conducted retrospective reviews, which led to additional capture of missed HCCs and correction of HCCs that were captured but did not have documentation to support the codes. YNHHS utilizes two HCC coders as auditors and employs a physician who provides oversight and physician education based on the outcome of the retrospective audit findings.

The second portion of the outpatient CDI pilot tapped four FTEs with a focus on identifying high-cost outpatient services, procedures, and drugs that were denied and could not be appealed due to a lack of documentation to support medical necessity. YNHHS opted to use coding professionals to perform the chart reviews, submit queries, and revise the codes per guidelines to ensure the presence of supporting documentation.

Regardless of how a program is staffed, Catapano believes outpatient CDI requires its own focus; it can't be an add-on responsibility for someone already performing inpatient chart reviews.

"I think, in an ideal world, your inpatient CDI professionals should be educated on HCCs. They're already looking for those secondary diagnoses—they know all about those clinical indicators and what needs to be there to support it," she says. "Inpatient CDI already has so much on their plate, it's too much to do both, but as long as you understand what the gaps are and can provide education to the physicians with a level of comfort, it'll be good."

Catapano says the principal struggle with the new program is a time-consuming manual process of reviewing charts and visit documentation, compiling data for use in reports, and presenting the data to physicians and finance. As a result, the YNHHS outpatient CDI program covers just a small sliver of its patient universe. But the pilot has proven successful enough to

warrant expansion in both HCC capture and denials prevention, and it is moving toward qualifying for shared savings payments under the Medicare Shared Savings Program.

"We're already looking to expand," she says. "It's like years ago when [inpatient] CDI first started—we started out with one or two people, and every year we kept growing it and growing it, anywhere that there's an opportunity for improvement."

Willcutt agrees, stating that the sky is the limit for outpatient CDI.

"I can already tell you where it's going to go: It's going to be huge," she says, predicting expansion to labs, surgery centers, and other outpatient places of service.

DENIALS MANAGEMENT: PROTECTING REVENUE

While organizations are looking to enhance revenue and keep up with the migration of services to outpatient settings by starting outpatient CDI departments, many are also feeling the bite of auditors—and watching revenue go back out the door. As a result, CDI resources are being increasingly shifted toward denials management, including front-end denials prevention and back-end appeals.

Denials management has historically been a function of the business department or HIM, but CDI professionals—with their clinical acumen, knowledge of coding guidelines, and good provider relationships—are proving to be a natural fit, according to CDI Leadership Exchange attendees.

Jeanmarie Roth, BSN, RN, CCDS, director of clinical documentation at St. Francis Hospital in Roslyn, New York, had 2.5 FTEs working denials full time in her hospital until the CDI director of the larger organization centralized the function. Now they are working appeals organizationwide and have incorporated an auditor's mindset into their chart reviews. "[The CDI director] saw the good work of how we had done it at our hospital and centralized it. I learned so much from the RAC and the denials," Roth says. "Now we do it concurrently and retrospectively, and we also make sure that each of our diagnoses is supported. 'Could you write an appeal letter? How would you defend that chart?' That's how our CDIs train."

Another source of revenue leakage for hospitals is weekend admissions, which frequently go unreviewed by CDI professionals working traditional Monday–Friday hours. These short stays are also a juicy target for auditors, who deny them on the basis that the patient should have been placed in observation. Willcutt has found success using CDI specialists with ED utilization review

Left to right: Rebecca Willcutt, Jeanmarie Roth, and Faisal Hussain.

experience, as these professionals help shore up medical necessity for the entire inpatient stay.

Some CDI specialists push back against weekend work, especially those who moved into the profession from nursing in an effort to avoid long shifts and nontraditional business hours, or who are used to working the Monday–Friday shift in HIM. But some hospitals are experimenting with rotating weekend shifts—asking staff to work one Saturday every two months, for example, or an occasional 3–11 p.m. second shift to capture patients admitted later in the day—and experiencing great results.

Rachelle Buol, RHIA, director of coding and CDI for UW Health in Madison, Wisconsin, got buy-in by asking her CDI specialists to co-develop a policy for weekend work. "Our nurses were opposed, so we brought them into weekend work and said, 'This is what the organization needs from you,' and they actually created the policy and helped us work through what that scheduling would look like. They're all on board," she says.

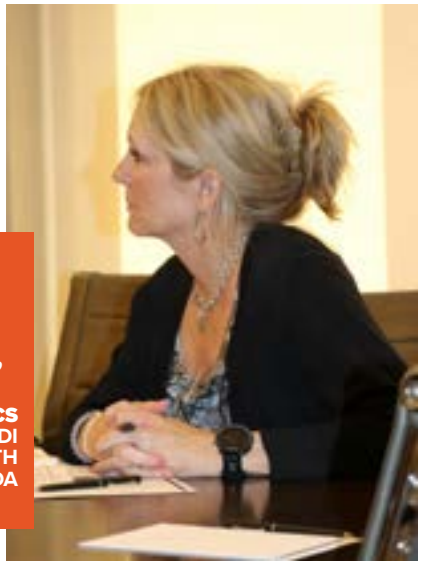
Sometimes the work of CDI specialists can bump up against other departments, in particular quality, if the CDI department has been tasked with review of Patient Safety Indicators (PSI) and hospital-acquired conditions (HAC), for example. This can result in disagreements over whether a condition should be reported as present on admission. Buol's facility has solved this with a hard stop in its PSI/HAC workflow in Epic prior to billing, allowing both sides to perform a secondary review when these conditions are triggered.

Despite experiencing successful program growth, CDI Leadership Exchange attendees also warned against an overabundance of "scope creep." Collaboration with case management, UR, and quality professionals is a must, but doing the jobs of these professionals in their entirety can overwhelm a CDI specialist or dilute the focus of their clinical reviews.

"Being a partner is one thing, and doing another one's job is completely different," one participant said. "I think the most important thing is to come up with a process that involves the terms of engagement for all the parties at the table."

"At the end of the day, when you're dealing with medical necessity, everything on the CDI side comes after," says **Sheri Blanchard, RN, MSN, FNP-BC, CCDS, CCS,** corporate executive director of CDI for Orlando Health in Orlando, Florida. "In a past life, we kept CDI roles separate from case management, and a consulting company came in and kind of reevaluated, and said, 'What if we combine CDI with case management and do both jobs?' But in case management it's all about UR, it's all about admissions; CDI falls to the side [in that arrangement]. It's very unique—we look at the same chart, but we look at it differently."

A better fit for CDI denials prevention in the ED is looking at the chart on the front end and querying for documentation of respiratory failure, which can help "buy the bed" for the patient. "Think about … getting the same respiratory failure documented in the H&P, the progress notes, and the discharge summary—all the resources on the back end—when we could be moving that forward," Blanchard adds.



"At the end of the day, when you're dealing with medical necessity, everything on the CDI side comes after… CDI falls to the side."

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Connect and Share with Peers.

Leading a CDI department within a hospital or a broader multisystem organization requires the exchange of ideas from trusted sources. The CDI Leadership Exchange is that perfect intersection. Come share successes and solutions with CDI supervisors, directors, and managers from the best healthcare providers in the country.

Our members say:

"Wow! This was my first year and all the information was invaluable. I connected with several different people on initiatives that I want to put forth. I can't thank you enough for this opportunity!"

"I would love to come back and enjoy these sessions in the future."

"The sessions provided an opportunity to hear the struggles, achievement, and courage of my peers."

"What an incredible opportunity. The best part is learning and sharing best practices and networking. Very meaningful!"

"The sharing of ideas is priceless. I was able to start a remote program for my CDI staff, which has increased my CDI productivity. During this Exchange, I have gained insight on how to start an outpatient CDI program."

acdis exchange

You may qualify for this invitation-only event, which is open to CDI managers, supervisors, and directors of mid-size to large healthcare organizations. Learn more by emailing Brian Murphy at bmurphy@acdis.org.

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The Association of Clinical Documentation Improvement Specialists (ACDIS) is the nation's only association dedicated to the CDI profession.

ACDIS' mission is to serve as the premier healthcare community for CDI specialists, providing a medium for education, professional growth, program recognition, and networking. Since its inception in 2007, ACDIS has grown to more than 6,000 members nationwide.

ACDIS members enjoy the benefits of a membership journal, dialogue with their peers through a CDI forum, helpful forms and tools, a CDI job board, quarterly membership calls, the biweekly ACDIS Radio talk show, and much more. They also receive discounts to the CDI Boot Camp line and the annual ACDIS Conference. ACDIS provides guidance and advocates on behalf of its members and the CDI profession through its staff leadership, elected advisory board, local chapter leadership, and boards and committees. ACDIS also hosts the Certified Clinical Documentation Specialist (CCDS) program.

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