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Association of Clinical Documentation Integrity Specialists

# BEYOND HOSPITAL WALLS: CDI ENTERS OUTPATIENT SETTINGS, POPULATION HEALTH INITIATIVES

## Leadership research survey indicates rapid expansion, despite operational obstacles

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## The Participants

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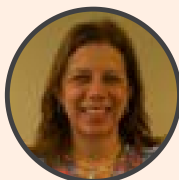

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Clinical documentation integrity (CDI) was born in the acute care inpatient setting, with most CDI departments focusing on diagnosis clarifications impacting MS-DRG assignment, present on admission status, Patient Safety Indicators, and other metrics vital to IPPS reimbursement and quality outcomes. But with declining admissions and care increasingly covered in outpatient settings, as well as the realization that social determinants of health play a major role as a predictor of costs, CDI efforts in response are moving "beyond hospital walls."

The 2018 *CDI Week Industry Overview Survey* issued by the Association of Clinical Documentation Integrity Specialists (ACDIS) revealed that approximately 40% of hospitals review some type of outpatient settings or services. Hospital clinics, emergency departments, and home health services open up a myriad of review opportunities and the ability to impact organizational quality and revenue, but they also present a host of logistical and resource challenges—including timing of reviews, adequate staff training and coverage, and prioritizing the sheer number of encounters in these settings.

We asked several CDI leaders to evaluate the results of a nationwide *CDI Research Series* survey on CDI beyond hospital walls, and to discuss their best practices from moving CDI beyond familiar inpatient settings into hospital clinics, physician practices, and post-acute settings. Following is a review of the survey and summary of that discussion.

## Outpatient challenges

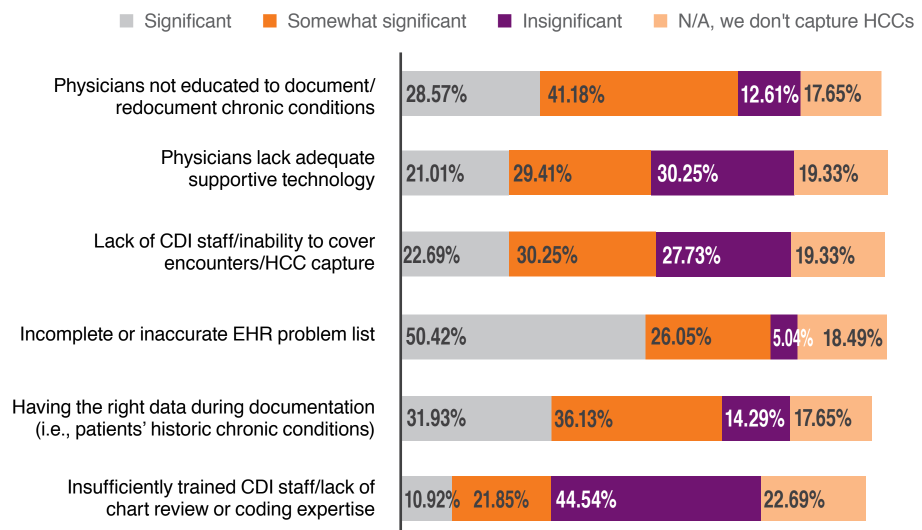
It's often been said that no two inpatient CDI departments are exactly alike, and that is even more true in outpatient settings. For some, "outpatient CDI" is placing a dedicated CDI professional in the ED focusing on observation cases. In clinics, outpatient CDI staff audit records post-bill and provide education on missed opportunities. Other organizations review charts pre-visit, prompting physicians to address chronic conditions previously documented in the problem list to ensure complete and compliant capture of Hierarchical Condition Categories (HCC), a methodology used to forecast costs for Medicare Advantage members for the subsequent year.

HCCs provide a mechanism for adjusting capitation payments to health plans (not providers) according to differences in the total expected costs for their plan members each year. They are also used to assess quality of care. Accurate capture of ICD codes in this model leads to a higher risk adjustment and can result in a higher incentive payment or lower penalty to organizations and providers.

But capturing chronic disease burden across so many settings presents numerous logistical difficulties. The 119 respondents to the 2019 *CDI Research Series* were asked to rate the difficulty of various components of HCC capture in their organization. An incomplete or inaccurate EHR problem list was identified as the greatest challenge, with more than 76% of respondents describing this issue as “significant” or “somewhat significant.” Approximately 70% of respondents stated that their physicians were not adequately educated to document or redocument chronic conditions, while 68% of respondents reported not having the right data during documentation (e.g., patients’ history of chronic conditions). See Figure 1.

Covering the sheer number of outpatient reviews is a challenge. Adventist Health, for example, has 21 acute care hospitals staffed with 52 CDI specialists, and with these numbers it can review 98% of all inpatient cases. But the organization has just five outpatient reviewers to cover more than 300 clinics, says **Laura J. Werner, DC, RN, BA, BSN, MSN, CDIP, CCS, CRCR,** executive director of CDI for Adventist Health West in Roseville, California. “That’s been a little bit of a challenge figuring out exactly how to approach that,” Werner says. “We’re taking an educational approach to start with, and then we’ll probably move in and be a little more specific as we learn more about how to do this.”

**Figure 1.** Of the below obstacles related to accurate capture of Hierarchical Condition Categories (HCCs), please indicate whether these are significant, somewhat significant, or insignificant in your organization.



OhioHealth has some 60 inpatient CDI professionals to cover 10 hospitals, but similar to Adventist, it has just four outpatient staff to cover its numerous clinics. Technological obstacles and inadequate tools have hampered a faster rollout, according to **Tonya Motsinger, MBA, BSN, RN,** system director of CDI for the organization.

But organizations are forging ahead and making progress. Yale New Haven Health System got a leg up by partnering with a vendor that provided analytics of claims data at the payer level, allowing the health system to focus its limited resources on certain practices and physicians. “They [the vendor] were able to drill down, looking at our physician’s risk adjustment factor [RAF] scores and where we had the biggest gaps from not capturing diagnoses over the last three-year period,” says **Tonia Catapano, RN, BSN, CCDS, CCS, RHIA,** director of coding and CDI for the organization.

From this audit, the organization performed retrospective reviews of charts, adding and/or removing diagnoses as supported by the documentation, and supplemented this effort with a physician champion who provided 1:1 education with physicians to improve capture of chronic conditions. Yale New Haven is next planning to roll out a physician-facing electronic tool to help with its concurrent pre-visit review efforts. Prior to patients arriving, this tool scans their histories and prompts physicians to address possible HCCs during the encounter. “We’ve seen that piece of our outpatient CDI program be really successful, and we plan to continue to grow that over time,” says Catapano. “There are just so many accounts that human eyes cannot possibly be on all of those.”

## Proving, tracking return on investment

Outpatient CDI programs often start due to the expansion of population health initiatives and associated risk-based contracts. St. Cloud, Minnesota–based CentraCare started with a focus on its Medicare population receiving care under an accountable care organization, says **Kay Greenlee, MSN, RN, CNS, CPHQ,** the organization’s senior director of performance improvement, value, and analytics. The effort quickly expanded to include Medicaid patients covered under an Integrated Health Partnership, protecting dollars at risk related to that population. CDI staff in conjunction with IT built a tool within Epic that provides reporting on HCC gaps, and the team works 1:1 with physicians whose RAF scores are significantly lower than other like providers, providing this data in clinic-specific scorecards.

Although shifts in RAF scores can occur due to multiple variables, a baseline CMI pre-and post CDI intervention allows CentraCare to demonstrate

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>
> —Kay Greenlee, Senior Director Performance Improvement, Value & Analytics, CentraCare

a strong return on investment of staff time and effort. "The true first year (calendar year 2018) resulted in significant improvement and probably doubled our return on our total cost of care contracts," Greenlee says. "We—CDI—share in the shared savings to the organization, between the work that we do with the work that is done either with care management or population health."

Winston Salem, North Carolina–based Novant Health focuses its reviews on high-cost providers with low HCC scores, providing education and queries as needed. It also reviews the providers' patient panels for potential HCC scores, actual HCC scores, and gaps in order to assist with education. CDI staff also help with reviewing clinic reports, including patients who have outstanding HCCs requiring recapture and who lack a scheduled appointment with their PCP in that calendar year. CDI staff perform prospective queries focusing on opportunities for capture of new HCCs, then review the visit post-query to verify the specificity of diagnoses and supporting documentation.

All this work is tracked in a detailed spreadsheet that tallies the following information:

- # of patients with change in HCC score (positive or negative)
- % of patients with change in HCC score
- Average change in HCC score per patient
- Per member per year pre-query (per patient)
- Per member per year post-query (per patient)
- Query impact on per member per year
- Overall query impact for all patients with change in HCC score

"We're able to turn that difference in that patient into a dollar amount, and it gives an idea of showing the impact of what our queries can do overall," says **Yvonne Whitley, RN, BSN, CPC, CRC, CDEO, CCDS-O,**

ambulatory CDI manager for Novant Health. "It shows how much we've increased our yearly expected cost, which is huge because it raises the benchmark so that, along with performance in quality measures, there is more opportunity for shared savings. This can also impact the [physician] fee schedule."

## Staffing, skills, and support for the CDI specialists of tomorrow

Survey respondents were asked to weigh in on the types of initiatives CDI specialists of the future would be asked to perform. The largest group of respondents (75%) indicated review of outpatient settings/services, with 69% stating that education of physicians would be increasingly critical and commonplace. Technology and analytics also rated highly, with an equal number of respondents stating that auditing cases prioritized by software (54%) and reviewing organizational data trends and analytics (54%) will be important functions of tomorrow's CDI profession. See Figure 2.

These types of activities require the acquisition of new skills, additional training, and hiring staff with diverse knowledge bases. Respondents indicated overwhelmingly that knowing the impact of diagnoses on quality care measures/hospital value-based purchasing (91%) is critical to appropriately align CDI reviews with changing reimbursement mechanisms linked to quality over volume. Knowledge of outpatient codes/coding guidelines (77%) also rated highly, along with the ability to educate physicians (66%), deeper clinical knowledge for resolving complex cases (56%), and the ability to evaluate broad data trends and analytics (55%). See Figure 3.

**Figure 2.** In which of the following initiatives do you anticipate CDI specialists being used in the future? Select all that apply.

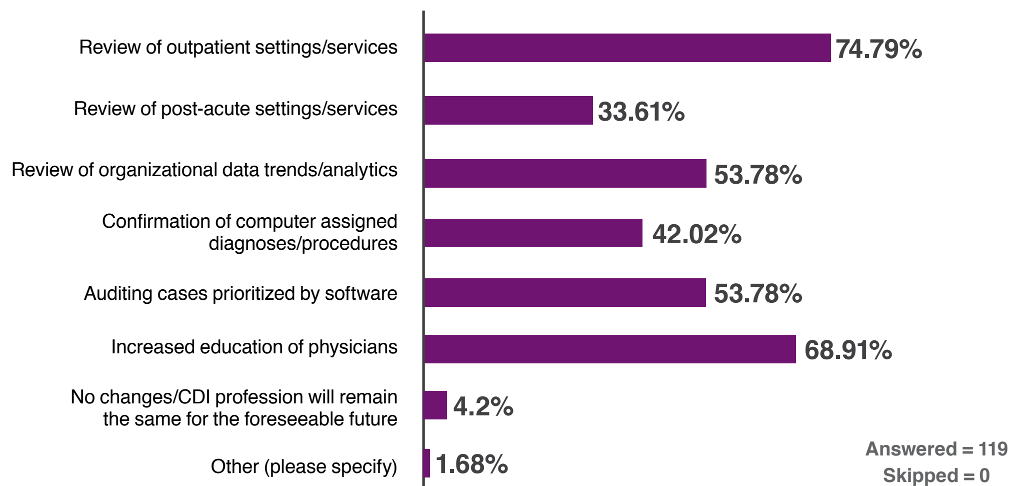
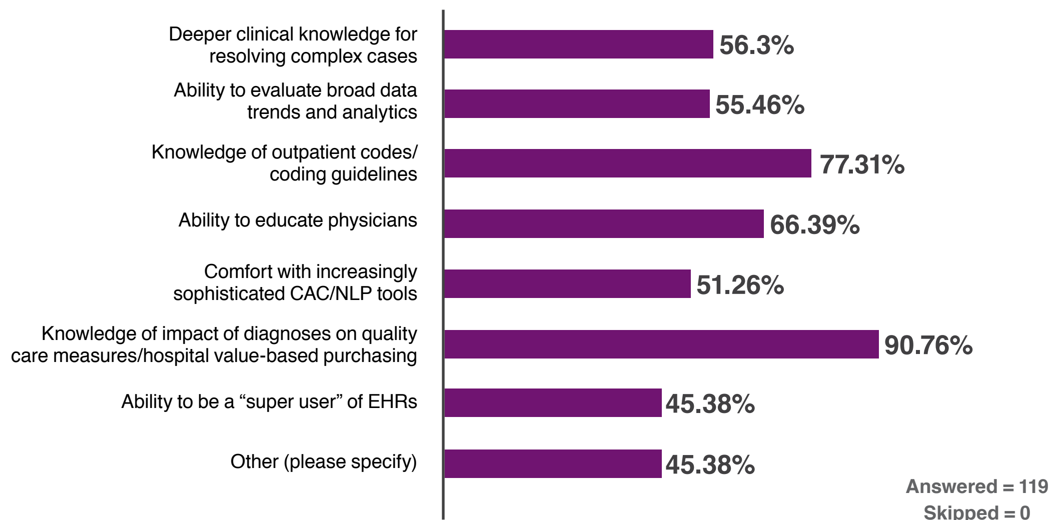


**Figure 3.** What changing skill sets or knowledge bases do you think CDI specialists of the future will require? Select all that apply.




Increased physician education and data analytics were a key component of the rollout of the outpatient CDI program at Penn State Hershey Medical Center. "What we found with our providers is they wanted no part of the query process. We had to go to a focus of reviewing and then educating to work on that impact," says **Deanne Wilk, BSN, RN, CCDS, CCDS-O, CDIP, CCS,** CDI manager for the organization. CDI specialists provided the results of chart audits, including impact on physician RVUs, all while ensuring minimal disruption to provider workflow. "Our education is provided during a lunch session at the office, or we meet with them one-on-one at their convenience."

Novant Health is piloting a new service to help providers with their charting while leveraging the CDI staff's clinical and coding expertise. If a provider has a complex patient with a lengthy and problematic problem list, the physician will write an order for a CDI consult. This triggers a CDI professional to review the case and supply some diagnostic recommendations with supporting clinical indicators. The provider would then review the CDI work, indicate agree/disagree, and update the problem list.

The outpatient CDI program at Christiana Care Health Services in Newark, Delaware, performs no querying whatsoever. An HCC tool within Cerner presents documentation opportunities to physicians in their workflow, freeing up CDI staff to focus on retrospective education, auditing, and elbow-to-elbow support. "Our staff are in the office at least once every six weeks, all day, and do their work in the office that day," says **Karen Frosch, CCS, CCDS, CRC, CPHQ,** CDI program manager. "The office

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staff knows when they are coming, and they will sit with the physicians during time in between patient visits." A dedicated physician champion reinforces the education.

Most of the panelists agree that technological solutions and support for outpatient CDI have improved over the last couple years, but lack some of the necessary features. "Overall, I don't think we're going to be able to be as successful as we could in the ambulatory setting without technology, because the volume is way too high," Greenlee says.

Further adding to the challenge of technology developers is the broad scope of outpatient CDI, which is not just HCC capture but also can include review of ED encounters and observation stays, review of medical necessity for expensive drugs and procedures, and improving physician evaluation and management (E/M) documentation. "There still remains this challenge: What is the scope of outpatient CDI? You hear different flavors, all over the place, and having a single technology solution that can help solve all of those problems is probably more challenging than an inpatient solution," says **Diana Ortiz, JD, RN, CDIP, CCDS, CCDS-O,** marketing manager for 3M Health Information Systems.

Because ambulatory CDI is so new, staffing is still very much an open question. Panelists agree that having knowledge of query guidelines is helpful, but these can be quickly learned. Harder to teach is clinical and coding knowledge in the right balance, as well as a comfort level educating physicians. Often this requires a blended approach. Yale New Haven uses certified outpatient coders, while Novant principally employs RNs in the role. Christiana Care Health Services currently employs two RNs, but is actively seeking a coding professional to fill a vacancy. Adventist Health has had success employing a foreign-trained physician.

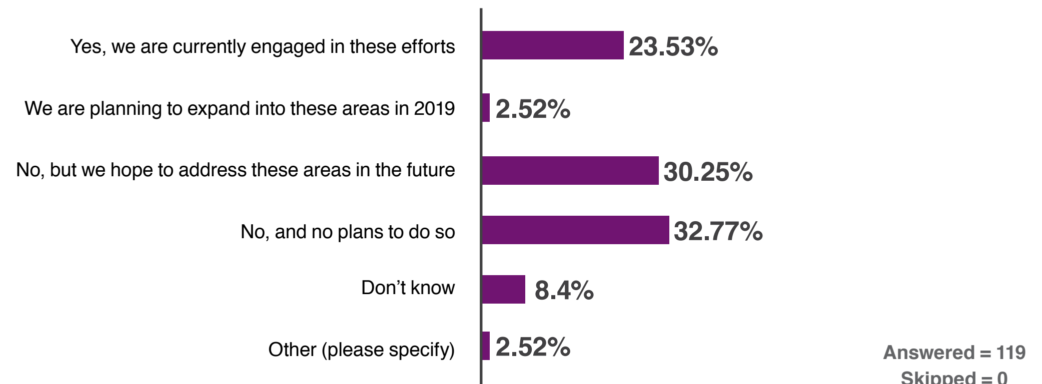
"I think that mix is really important. Some nurses do a lot better with communicating and educating the physician than the coders do, but my background is coding and I'm fine with educating physicians," Frosch says. "I think it depends on the coder's skill level and their comfort. It's not a novice coder's position."

"There is room for both. You need someone clinical who can look for things that are hidden—they see the signs and symptoms, they understand the clinical indicators of something that is not being said, and the coder is the one who has that expertise on the elements of an E/M level," notes Wilk.

## Stretching into population health, social determinants

Outpatient CDI and HCC capture is a new initiative, but an even greater stretch area for CDI departments is improving population health and social determinants of health. Some 24% of respondents to the 2019 *CDI Research Series* survey indicated that they are currently engaged in these efforts. But about a third of respondents indicated that they are planning to expand into these areas immediately or hope to do so in the future. Another third have no plans to do so. See Figure 4.

**Figure 4.** Is your CDI department involved in educational efforts to improve population health/social determinants of health?




Of those involved with population health improvement efforts, the largest number of respondents (40%) cited identifying opportunities to improve organizational quality measures as an area where CDI can make an impact, followed by capturing/clarifying chronic disease burden when diagnosis has no other impact on the case (37%) and ensuring accurate documentation for better population data capture (34%). See Figure 5.

Penn State is currently in the early stages of population health/social determinants of health documentation improvement. Early on it focused on Z codes and HCCs, but the medical center is now getting involved with documentation to assist with capture of Five-Star (quality) measures and Merit-based Incentive Payment System (MIPS) reporting, which draw from

**Figure 5.** In what ways has your CDI department been able to assist with population health improvement efforts? Select all that apply.

other fields of the EHR. CDI staff are also assisting with review of patients' seven-day follow-up appointments after a hospitalization, going so far as to make sure these appointments are ordered and scheduled. These appointments can have a significant impact on reducing readmissions to the hospital.

Novant Health's CDI team helps collect and extract data for quality measures reporting that Epic cannot retrieve, a laborious process that can take 4–5 weeks of focused work. But this work has come with a payoff: It's revealed sizable room for improvement in physician documentation of elements like MDD (major depressive disorder) diagnosis, depression screening including use of PHQ-9 (a patient health questionnaire), morbid obesity, BMI > 40, and diet planning.

Most panelists are just getting started with education and plan to ramp up quickly. OhioHealth is starting efforts to capture homelessness caused by the opioid crisis to produce necessary data for potential grants. Yale New Haven is in the early stages of CDI and coding education to capture social determinants of health. "Our inpatient and outpatient coding departments as well as the CDI department have all been receiving some education on that, and looking to other parts of our medical record we weren't typically looking at in order to capture some of those codes," Catapano says. "I do imagine that we will be involved at some point."