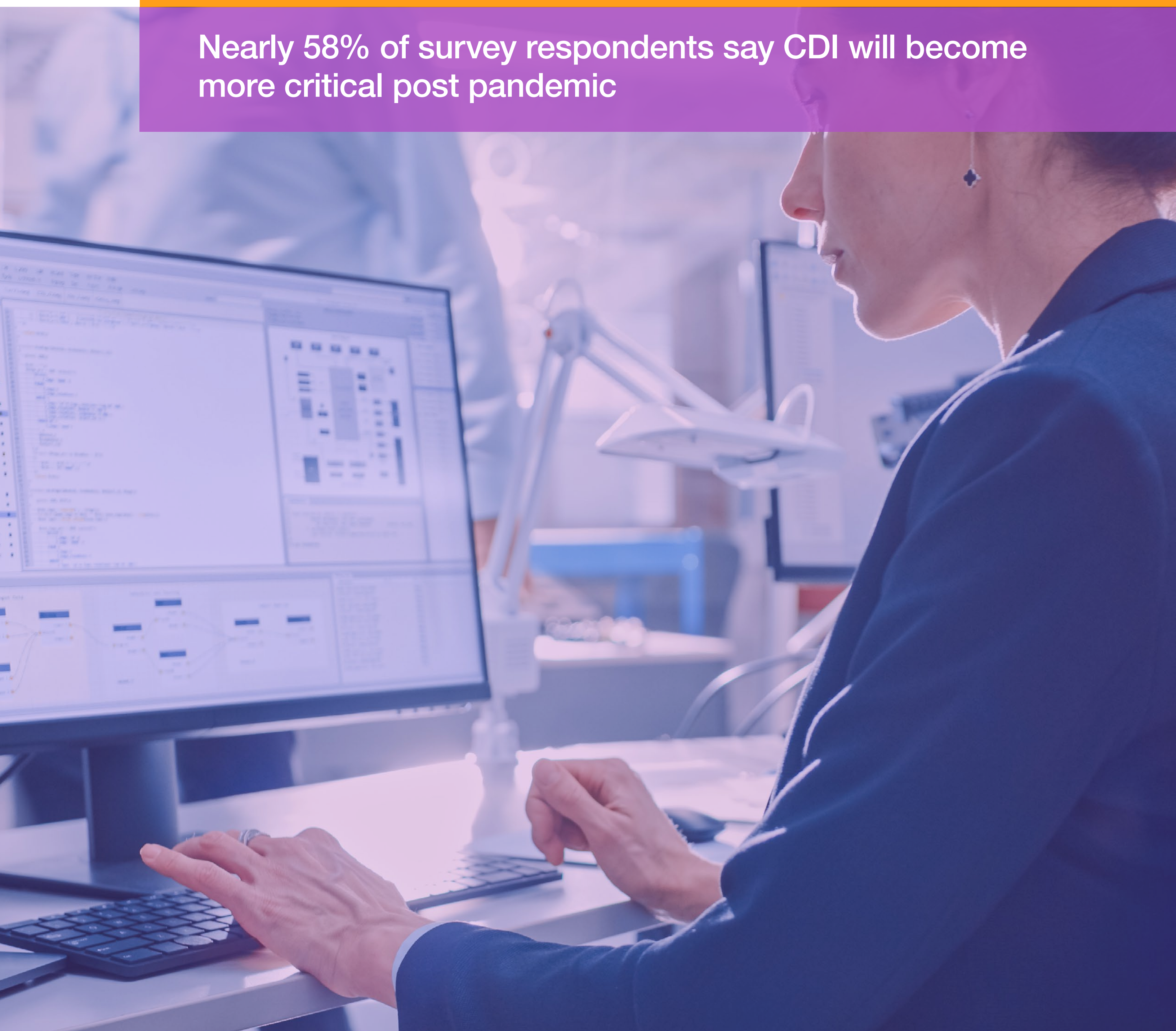
acdis
Association of Clinical Documentation Integrity Specialists

# ADVANCING CDI PRACTICES DURING COVID-19 AND BEYOND

## Nearly 58% of survey respondents say CDI will become more critical post pandemic



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## The Participants

**Janice Cromer, RN, BSN, CCDS**
*System director of CDI*
AdventHealth
Altamonte Springs, Florida

**Anthony Oliva, DO, MMM, FACPE**
*Vice president and chief medical officer*
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**Shirlivia Parker, RHIA, CDIP**
*CDI Manager*
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Like all areas of healthcare, clinical documentation integrity (CDI) programs underwent rapid change during the COVID-19 pandemic. Unanticipated fluctuations in patient volumes caused CDI priorities to shift in a matter of days. In addition, many CDI specialists were pulled into direct patient care roles, limiting resources for comprehensive CDI reviews. CDI specialists also moved from onsite to remote work environments, raising new challenges related to communication and physician engagement. Regulatory changes added a layer of complexity as organizations continued to shift from fee-for-service to value-based payment models during this time. With this shift came new CDI performance metrics, expanded review areas, and the use of technology to augment CDI specialist capabilities.

In partnership with Nuance Communications, the Association of Clinical Documentation Integrity Specialists (ACDIS) CDI Leadership Council asked several of its members to evaluate the results of a nationwide survey on advancing CDI practices and to discuss their organizational approach to this topic. Following is a review of the survey results and a summary of that discussion.

## Identifying CDI priorities

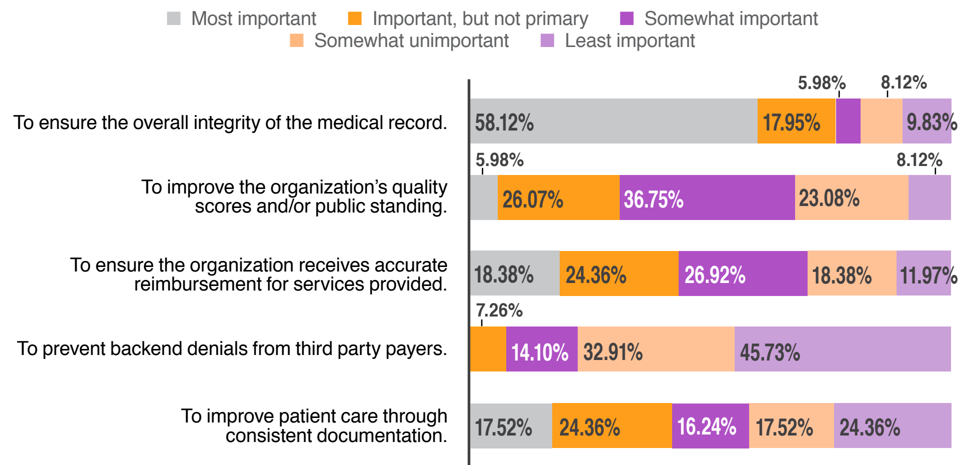
Fifty-eight percent of organizations said their top CDI priority is to ensure the overall integrity of the medical record. Improving quality scores and/or public standing, however, is a strong second—a direct reflection on the shift toward value-based payment models and a CDI focus on quality metrics, rather than strict financial impacts. (See Figure 1.)

> **We don't want to create what I call 'RAC-a-phobia.' I don't want them to be afraid to ask a pertinent clarification because they're afraid it will be denied.**
> —Janice Cromer, RN, BSN, CCDS

At AdventHealth in Altamonte Springs, Florida, a quality liaison (i.e., a CDI specialist trained in quality, CDI, and coding) performs record reviews to identify diagnoses that support risk adjustment for mortality, readmission, cost, and complications. These specialized CDI staff are usually able to capture higher risk of mortality scores in 55% of the cases reviewed, according to **Janice Cromer, RN, BSN, CCDS,** system director of CDI. "It's showing its value when we consider our CMS and **Leapfrog** scores," she adds.

Preventing back-end denials was the least important priority for organizations; however, **Shirlivia Parker, RHIA, CDIP,** CDI manager at UC Davis

**Figure 1.** CDI program objectives in order of importance




Medical Center in Sacramento, California, says there's an opportunity for CDI specialists to play a bigger role—particularly with clinical validation denials.

"Eventually, these post-payment denials become pre-payment denials," she says, citing pre-payment denials for sepsis as a common example. "This can be a lot of money that we're leaving on the table and allowing payers to take back."

**Anthony Oliva, DO, MMM, FACPE,** vice president and chief medical officer of Nuance Communications in Boca Raton, Florida, agrees that CDI specialists need to be more involved in denials management. They shouldn't let those denials affect whether and how they query though.

"The bigger concern I have over denials is that it starts to change the way in which CDI specialists approach clarifications," he says. For example, if a payer frequently denies severe malnutrition, a CDI specialist may be less likely to query for it. "When that starts to happen, you've done exactly what [the payer] wants you to do. You don't even send the query in the first place."

Cromer agrees, adding that AdventHealth created a separate CDI role dedicated to appealing clinical validation denials specifically so there wouldn't be a temptation to shy away from valid queries. "We don't want to create what I call 'RAC-a-phobia,' " she says. "I don't want them to be afraid to ask a pertinent clarification because they're afraid it will be denied."

CDI specialists can—and should—play a larger role in writing appeals, says Oliva. "Make sure you have good validation so that [clinical language] can be put right into those appeal letters," he says.

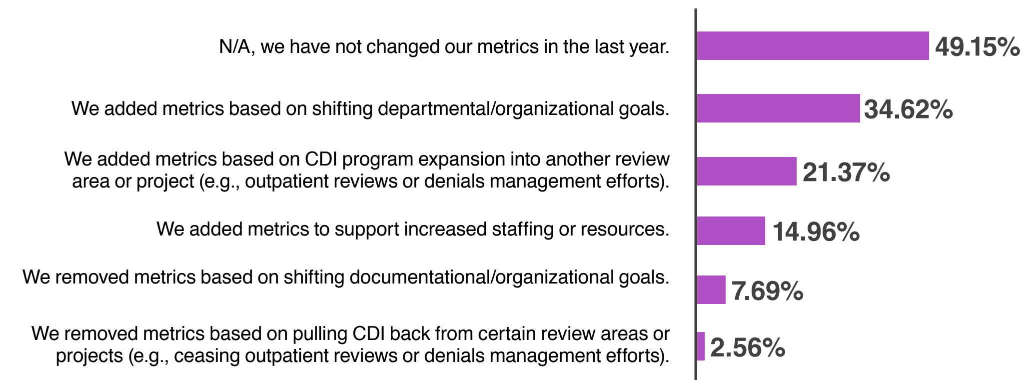
## Balancing added CDI metrics

Nearly 71% of organizations have added new key performance indicators (KPI) to assess CDI performance over the last year. Of those, 35% said they added metrics based on shifting departmental/organizational goals. Approximately 21% said they added metrics based on CDI program expansion into other review areas or projects (e.g., outpatient reviews or denial management efforts). Fifteen percent said they added metrics to support increased staffing or resources. (See Figure 2.)

Gauging CDI effectiveness requires organizations to expand beyond traditional KPIs, says Oliva. "If you look at CMI [case mix index] across Medicare populations over the last five years, it goes up every single year," he adds. "Just saying your CMI is increasing doesn't really tell you how your program is doing."

At AdventHealth, Cromer measures traditional CDI metrics; however, she also looks at new metrics that require collaboration between CDI and coding such as the number of secondary codes added to a record for risk adjustment and incidents of patient safety indicators and hospital-acquired conditions. "We know that we need to collaborate with other teams to make sure that we're not just looking at a record from a financial perspective," she says. "If we don't do this, we're not going to do well as an organization."

**Figure 2.** KPIs added or removed in the last year




**Selected added metrics:**

- GMLOS, denial rates by DRG.
- Vizient measures by service line.
- SOI/ROM shifts.
- HCC capture rates.
- Outpatient query metrics.
- Query response timeliness.
- Weekday vs. weekend metrics.
- Potentially preventable complication rates.
- COVID-19 mortality reviews.
- Commercial payer data.
- Retrospective vs. concurrent queries.
- Risk adjustment scores.
- PSI/HAC rates (and other quality measures).
- Coverage and productivity rates.
- Query impact rates.

With that said, 49% of organizations have not changed their CDI metrics in the last year. This could be because in these organizations, CDI programs are not aligned with strategic goals, says Oliva. For example, as organizations shift toward risk-based contracts, aligned CDI programs would naturally shift as well to include ambulatory metrics. As organizations strive to become surgical centers of excellence to capture greater market share, CDI metrics would evolve to help improve quality scores on which publicly reported data is based.

Roughly 8% of organizations actually *removed* CDI metrics. AdventHealth was one of them. At its CDI summit, coders, physicians, CDI specialists, and other leaders came together to identify metrics that were no longer useful. "Clarification rate" was one example because physicians felt as though they sometimes received unnecessary clarifications simply so CDI specialists could meet their goal, says Cromer.

"As your program evolves, you need to evolve and figure out which metrics makes sense to monitor," says Parker, adding these metrics must be reviewed and reconsidered in the context of any technology an organization implements. For example, organizations using computer-assisted physician documentation (CAPD) shouldn't necessarily be alarmed if their clarification rate goes down over time because that could mean the technology is working.

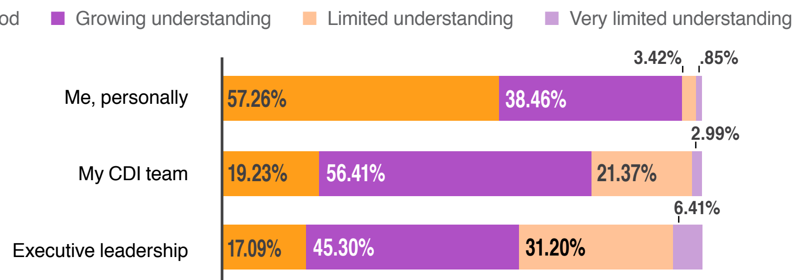
"**As your program evolves, you need to evolve and figure out which metrics makes sense to monitor.**
—Shirlivia Parker, RHIA, CDIP"

Organizations also shouldn't be afraid to retire metrics that have remained unchanged for a long period of time, says Oliva. As with any change, however, it's always important to keep a close eye on the data and reinstate the metric, if necessary, he adds.

## Making the case for artificial intelligence in CDI

Experts agree that there's a growing place for artificial intelligence (AI) in CDI—particularly as organizations face CDI staffing shortages. "You don't want the integrity of the medical record, your quality scores, or your reimbursement to fluctuate depending on your resource capacity," says Oliva. "Filling those gaps becomes pretty important. You may not be able to replace CDI specialists on the ground, but you can certainly augment what they do."

**Figure 3.** Understanding of the use of AI in CDI




Still, there's room for improvement in terms of executive leadership's understanding of the use of AI in CDI. Although according to survey respondents 45% of executive leaders have a growing understanding of AI as it pertains to CDI, approximately 31% have a limited understanding. (See Figure 3.)

"There's a huge opportunity for CDI leaders to really push the conversation forward," says Oliva. "Where can you see AI improve the work you're doing and your efficiency?"

Leverage KPIs as you're explaining AI to the executive leadership team, says Parker. For example, if CDI specialists can demonstrate that CAPD reduces physician queries while also yielding a 10% higher CMI as compared to the previous year, executives can better understand the value of this type of investment, she adds.

Physician buy-in is equally as important. "I see AI as the way of the future for CDI," says Parker. "We've done a lot of work educating physicians about how we're engaging AI. We were very intentional about how we did this."

In terms of specific AI solutions, 58% of organizations use prioritization software while 42% use CAPD. Approximately 26% use other solutions such as computer-assisted coding, encoders, auto-generated queries, and natural language understanding. (See Figure 4.)

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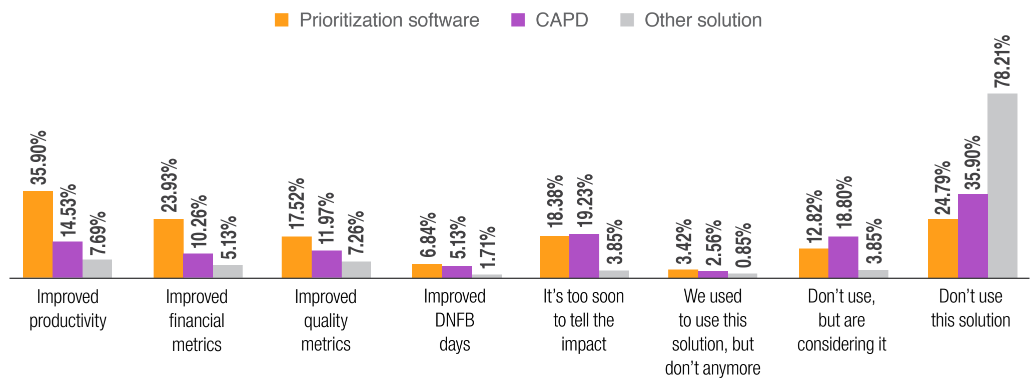
**Figure 4.** Understanding of the use of AI in CDI




**Selected "other" solutions:**

- Documentation prompting based on content within the patient's record.
- Computer-assisted coding.
- Auto-generated queries for "low-hanging fruit."
- We're working on a prioritization tool with our in-house IT department.
- NLU software.
- Quality measure indicator alerts.
- Encoder.
- Autosuggested DRGs.
- We don't have any CDI-specific software; it's all manual Excel and Access reports.

Parker says CAPD has been particularly helpful in terms of UC Davis Medical Center's risk adjustment strategy. In particular, the organization uses data modeling to strategically select certain quality measures to target. Then it deploys CAPD to trigger alerts that help physicians document with greater specificity. As part of the CAPD rollout, the CDI team partnered and continue to partner with physicians to customize nudges, inline quality measures, and identify appropriate clinical evidence on which documentation prompts are based.

AdventHealth currently uses CAPD technology on two of its campuses as well. "We've been polishing it for a year or more, and we feel like it's not ready," says Cromer. "There's room for improvement before we roll it out to all facilities. It is something to monitor and work toward, but there's still a ways to go."

Change management for CDI is critical as organizations consider any type of AI solution, says Oliva. "Reassure CDI specialists that this is not about taking their jobs away from them," he says. Instead, Oliva suggests ensuring that the solution is meant to help improve their productivity and save them some precious time.

## Preparing for changes post COVID-19

Despite potential budget cuts in the months and years ahead, 58% of organizations said they anticipate CDI will become even more critical. This is particularly true when CDI is aligned with strategic initiatives, says Oliva, adding that strategic CDI programs will continue to see investments in CDI staffing and technology. (See Figure 5.)

Thirty-two percent of organizations said they expect their focus will expand toward new review areas—something that could continue to necessitate the need for AI as organizations struggle to keep up with the sheer volume of records to review, says Oliva. “You may not be able to refill positions,” he adds. “That may just be the reality going forward. You have to potentially look to AI for support.”

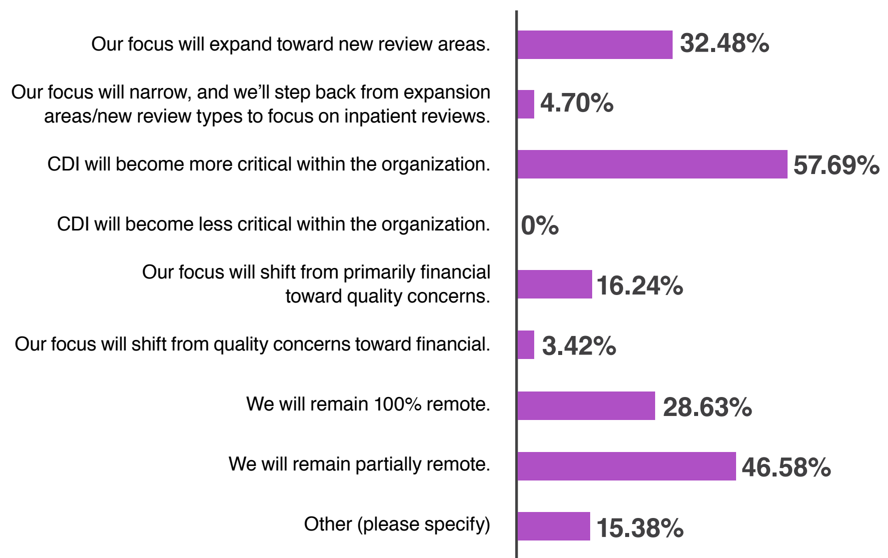
As organizations look ahead, they’re also developing long-term strategies for remote CDI workflows. Forty-seven percent of organizations said they will remain partially remote while 29% will remain entirely remote.

At AdventHealth, each region will make its own decision in terms of whether to keep CDI teams remote or bring them onsite, says Cromer. “We have seen success using both models,” she adds. “To me, it’s obvious that we can do the job either way.”

If CDI teams *do* remain remote in the long-term, managers need to ensure that staff continue to cultivate relationships with each other and especially with physicians, says Oliva.

“I think you have to sit back and ask, ‘What are we losing when we go remote?’ ” he says. “You lose that normal conversation that happens in the room between people. Upping the amount of communication can assist with that. Make it really easy for people to feel connected and communicate.”

**Figure 5.** Expected program changes post COVID-19




**Selected “other” responses:**

- I don’t expect any changes.
- Expanded quality reviews and focus.
- Not sure yet.
- Continued/expanded use of virtual physician education, regardless of remote vs. onsite.
- Expansion to all payers.
- Centralization of CDI across the system.
- CMI and mortality score importance will increase.
- Increased focus on denials management.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