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COMPLIANT CDI CONCEPTS FOR CAPD

Advancing technology expands scope and success of CDI programs

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TRAVIS BIAS
DO, chief medical officer
of clinician solutions at 3M

**TAMI
MCMASTERS-GOMEZ**
CCDS, CDIP, BS, (MHL),
Director, Coding & Clinical
Documentation Integrity Services
at UC Davis Health

CARRIE HORN
CCDS, CHFP, CRC,
MSHA, BBA, RN
CDI, Clinical Denials and
Post Payment Audit Director
at Spectrum Health

Provider organizations are increasingly adopting computer-assisted physician documentation (CAPD) and artificial intelligence (AI) for CDI, providing physicians with efficient, real-time support as they document in the EHR. "This significantly benefits CDI teams as well," says Travis Bias, DO, chief medical officer of clinician solutions at 3M. "When routine documentation deficiencies are handled upfront automatically via CAPD, CDI teams have more time to spend on complex quality reviews that require their higher-level human expertise."

Still, long-term success, including maintaining robust compliance and physician engagement, requires a thoughtful approach when rolling out CAPD. "CDI is a complex undertaking, and no two CDI programs are the same," says Dr. Bias. "As such, applying compliant CDI concepts to CAPD and AI must be part of a holistic strategy aimed at achieving program goals." Below, Dr. Bias and CDI leaders from Spectrum Health, Grand Rapids, Michigan, and UC Davis Health, Davis, California, examine best practices when adopting these rapidly evolving technologies.

The road to CAPD

Hospital and health system CDI teams adopt CAPD for a host of reasons. "They want to improve the quality of clinical documentation, accelerate the revenue cycle, and ease physicians' administrative burden by improving their efficiency the first time they are in the chart," says Dr. Bias. CAPD also helps CDI teams scale across more payers, facilities, and initiatives such as quality reviews, and can be used to deliver proactive insights to physicians on CDI, HCCs, diagnostic imaging and more.

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UC Davis Health

"We chose CAPD technology for multiple reasons, including the desire to enhance physician wellness and engagement at the point of care, while also allowing the technology to deliver more remedial queries or nudges to providers," says Tami McMasters-Gomez, CCDS, CDIP, BS, (MHL), Director, Coding & Clinical Documentation Integrity Services at UC Davis Health. "CAPD allows our team to spend more time digging into more complex priorities in records that might not lead to a nudge using AI."

In addition to CAPD, the platform includes prioritization lists, evidence sheets, and other tools for CDI staff, says McMasters-Gomez. "This application has afforded us the ability to touch more cases because the AI is doing a lot of the work on the front end," she says, adding that implementation of CAPD technology and elimination of the DRG reconciliation process has led to 33% increase in productivity. CAPD also helps address broader goals. "We are a nontraditional CDI program where we're involved in some of the key performance indicators at an organizational level surrounding length of stay, mortality, and O-to-E (observed over expected) ratios. We look at all risk models within the length-of-stay domain and the top diagnostic variables that drive the O-to-E ratios."

Spectrum Health

Adopting CAPD technology "was the next step for us in our program," says Carrie Horn, CCDS, CHFP, CRC, MSHA, BBA, RN, CDI, Clinical Denials and Post Payment Audit Director at Spectrum Health. She says before CAPD, CDI nurses were validating DRGs from a coding perspective. "We continually heard from the CDI nurses that they wanted to focus on more clinical queries and research, while supporting providers. The CAPD program allowed us to leverage technology on the front end for physicians as they're documenting, reducing administrative burdens from retrospective and even concurrent templated queries," says Horn. "It also allowed us to re-utilize CDI resources for clinical validation queries that require more thought."

As CAPD technology continues to gain momentum, Horn is looking to reduce templated

queries—which are a one-to-one match for a physician query in the CAPD engine—from 40% of overall queries to 20% or zero by the end of the year. "By reducing templated queries, we hope to do more clinical validation queries," she says. "Physicians have been very engaged with us to help write the rules and turn on nudges that make sense for each of their specialties," she adds. "Ensuring we communicated the right messages to physicians on what was in it for them was key." Horn says CAPD technology also helps optimize the revenue cycle, while ensuring that the care team has the most accurate and updated information for patients.

Best practices for CAPD compliance

Applying compliant CDI concepts to proactive documentation improvement at the point of care with CAPD technology requires a special focus on physician-CDI interactions, clinical threshold levels, visibility into how nudges are triggered, and content and workflow customization. Consider the following when introducing CAPD technology.

1. Setting clinical threshold levels for nudges. Unlike traditional CDI queries, nudges are delivered proactively as physicians document—within seconds—before they complete their note. "For common documentation deficiencies, it's more akin to having a CDI Specialist at the elbow, educating physicians at the point of care," says Dr. Bias.

Some CAPD technology has a static clinical threshold level for a given condition that determines when prompts are triggered, while more advanced CAPD technology enables CDI teams to customize clinical thresholds based on protocols established by their hospital, health system, or individual service lines. "In these cases, CDI teams typically track physician response to fine-tune the rule-based AI," says Dr. Bias. For example, if physicians are experiencing

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too many false positives, CDI leaders may add additional requirements that must be met before a nudge is triggered.

If, on the other hand, it is critical to identify every potential instance of a given condition, leaders may lower the thresholds to improve their sensitivity. "In both cases, CDI teams typically report discussions with their service lines to align on clinical thresholds, which is an ideal opportunity to engage physicians in CDI and drive adoption of CAPD," says Dr. Bias.

Dr. Bias also says having visibility into when, where, why, and how nudges are triggered is crucial: "Visibility allows CDI teams to understand physicians' interaction with nudges and with documentation integrity in general." For routine documentation gaps, it is common over time to see physicians no longer needing a nudge for a given condition because they have developed habits based on previous nudges. For example, they may specify chronic or acute when documenting heart failure, or which exact stage of chronic kidney disease a patient may have. "Alternatively, CDI teams may see that physician agreement rates for a given nudge are lower than average, indicating an opportunity to revisit the nudge wording, clinical threshold, or

other variables to continually improve the value of the nudges," says Dr. Bias.

McMasters-Gomez says UC Davis Health does not distinguish between traditional CDI queries and CAPD nudges. "The purpose is documentation integrity, regardless of how we're delivering the queries, whether it's coming from a traditional CDIS, who's done a review and feels that opportunity exists, or it's a proactive nudge that's using the clinical criteria we've built to nudge the provider."

She says UC Davis Health engages physicians in determining clinical threshold levels. "We're also a children's hospital and some clinical indicators don't apply to the pediatric population, so it's important to have adult and pediatric hospitalist champions providing us with clinical thresholds on when they should receive a nudge. We're looking for specific language and lab values in the record before something will trigger a notification to the provider," she notes.

Horn adds compliance is vital when setting clinical thresholds. "We look very methodically at the CAPD definitions, the rules, and what triggers those rules to align compliantly with our current CDI process and coding queries," says Horn. "Regardless of if it's a nudge coming from the technology or a query coming from CDI or coding, we make sure it matches our program focus from a compliance perspective."

2. Tracking and memorializing Physician-CDI interactions. Both Spectrum Health and UC Davis Health prioritize tracking and memorializing CDI interactions with physicians.

Horn and McMasters-Gomez agree that having robust data and insight into how nudges are triggered is central to working with physicians to meet CDI goals compliantly.

"It's critical to continually collaborate with physicians and demonstrate metric achievement," says Horn. "After presenting the business plan and metrics, you need to follow up with how far the needle moved forward and share potential opportunities through technology enhancement or physician education." She says CDI meets with the physician leadership team to share beneficial rules, query volumes, and scorecards for each service line.

"We show them where we can reduce current templated query volumes by utilizing the technology, which speaks volumes to physicians, and then we show them potential opportunities in their CDI metrics, including their MCC/CC capture and case mix index or their HCC capture in ambulatory spaces." Horn adds that even small nudges make a significant difference. "The small nudges are improving case mix index and

MCC capture rates. We don't have enough CDI specialists to review one hundred percent of the records, so CAPD really takes the place of CDI at the elbow."

Spectrum Health also assigns specific and dedicated focus areas for diagnostic opportunities, allowing the CDI department to track, for example, the expected reduction in a query or the increase in an HCC capture by certain diagnoses.

McMasters-Gomez says UC Davis Health tracks physician interactions through the CDI software's reporting application, including response and agreement rates. "Analytics help us ensure what we're doing is meaningful, physicians are engaging, and that we're compliant," she says. "The technology allows us to memorialize and track some of the impacts we've had on quality outcomes and on O-to-E ratios that we weren't really able to do before because we were manually sending every single query." An internal second-level reviewer also reviews queries. "We want to ensure that we're meeting the compliant query practice that's been set forth from ACDIS and AHIMA and that we're not querying unnecessarily," says McMasters-Gomez.

3. Customizing nudges and content. For both nudges and queries, the goal is to provide information paired with clinical evidence for the physician to consider. "The language of the nudge is important – hospitals and health systems typically take a very thoughtful approach to how they want to word nudges for compliance purposes," says Dr. Bias.

"One of the perks of having the computer-assisted physician documentation technology is that our organization has the opportunity to customize the queries or nudges that the providers receive to align more with how our organization adopts various different clinical scenarios," says McMasters-Gomez. "What's

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more, physicians have been very willing to help us customize some of these nudges," she adds. For example, with the help of physicians, UC Davis Health adopted a modified version of Aspen criteria for malnutrition to best meet the clinical needs of its patient population.

"We create customized nudges, including the clinical indicators and treatment we want to see available in the record before the technology nudges the provider," says McMasters-Gomez. "Compliance is also key and the foundation to having a meaningful program and one with which physicians will engage. We do not nudge a provider unless we have the clinical indicator, risk factors, and/or treatment and monitoring." McMasters-Gomez adds that the organization also follows monitoring, evaluation, assessment and treatment criteria (MEAT). "Asking questions that don't have clinical support behind them is non-compliant and leading and can hurt the integrity of the program and the trust we've established with providers," she adds.

Horn at Spectrum Health says CDI leaders worked with their vendor partner to create

customized nudges for the health system's women's health program when CAPD was first rolled out. "We saw this as an area of opportunity since CDI doesn't typically review those cases unless they're here past an extended length of time, and we also wanted to prevent coders from having to send a coding query at discharge. We created nudges that mimicked our most utilized queries and diagnoses in the women's health space that weren't documented to the highest specificity."

She says compliance, of course, is vital when customizing nudges. "We are currently re-energizing the process and looking at the entire library to understand the wording and triggers to ensure that anything going to a physician, whether it's prompted by the technology, a CDI nurse, or a coding specialist, has the same verbiage," she says.

Key lessons learned

McMasters-Gomez and Horn have learned a lot since adopting CAPD technology. McMasters-Gomez says analytics were important to getting organizational buy-in for CAPD. "We are a data analytics-driven shop, and so we presented data to our stakeholders on the benefits of investing in AI technology," she says. The department also brought in contract work for a period that reflected a 30% increase in CDI productivity and an improvement in CC/MCC capture rate, CMI, physician engagement, and quality outcomes. "We showed the return on investment and said that CAPD technology could do the same as staff," she says.

She also says the organization was well prepared for physician pushback. "Their priority is patient care and asking them to document certain things that in their perspective have to do with financial gain will not be well received," says McMasters-Gomez. "We took a different approach where it was about engaging them at

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the point of care to better document the patient acuity and demonstrate compliant outcomes with quality." UC Davis Health also piloted CAPD with pediatricians, hospitalists, surgeons, and different service lines, making several tweaks before finally rolling out the technology to its 3,000 physicians. "Out of that number, only five have said turn it off, which is a win," she says.

"It's important to understand what rules you're going to turn on when starting out," says Horn. "There's a full library of rules, but you have to have a methodical process." She recommends healthcare providers start by focusing on their highest query trends while working with collaborative physicians who have the most to gain from CAPD. "Also, look for missed opportunities for MCCs, CCs, and CMI capture as well as HCC diagnoses across outpatient CDI teams," she says.

Horn says Spectrum Health also introduced CAPD slowly to a small group of physicians before launching it across its service lines. "Today, most physicians sign up for the technology right at orientation," she adds. "This tool truly is aligned with what physicians have been educated on over the years." ■

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