



OUTPATIENT CDI AND RISK ADJUSTMENT

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“Outpatient CDI” can mean a myriad of things. From outpatient clinics and physician practices to hospital-based outpatient services, CDI leaders looking to expand their program’s footprint have many avenues to explore. Leaders need to determine the top opportunities for their outpatient CDI program, how they’ll realize a return on investment (ROI), and how to track the program’s impact. Though some CDI programs have been reviewing outpatient records for years, no approach applies to all settings and organizations, making the task even trickier.

In partnership with 3M, the Association of Clinical Documentation Integrity Specialists (ACDIS) CDI Leadership Council asked several of its members to evaluate the results of a nationwide survey detailing the most common outpatient expansion areas and the ways leaders are showing a positive impact for their fledgling programs. The Council members were then asked to discuss their organizational approach to outpatient CDI. The following is a review of the survey results and a summary of the discussion.

Settings currently reviewed, expansion plans

Depending on the type of organization, the CDI program’s goals and bandwidth, and the organization’s needs, CDI professionals may find themselves involved with reviews for a variety of outpatient settings. According to the survey results, nearly 19% of respondents currently review physician practices/clinics/Part B services, followed by 14.69% who review medical necessity of admissions and 11.37% who review observation stays. The outpatient areas with the most growth potential are the emergency department (ED) and observation stays, with 15.64% and 14.22% of respondents respectively planning to review these services in the next 12 months. (See Figure 1.)

“You need to understand what your pain points are, where the biggest opportunities are, and get insight from different areas within your organization. [...] Assess those pain points and put a plan together where you start with something small. You can’t do everything, but you can do something, and you can start somewhere.”

—Colleen Deighan, RHIA, CCS, CCDS-O, a consultant at 3M Health Information Systems in Cleveland, Ohio

While reviewing ED and observation records is not easy, it may represent a natural entry point for inpatient CDI teams looking to make an impact in the outpatient space, according to **Colleen Deighan, RHIA, CCS, CCDS-O**, a consultant at 3M Health Information Systems in Cleveland, Ohio.

“To me, they’re both intuitive entry points. A really good way to start an outpatient CDI program is to keep it under your inpatient CDI leadership,” she says. “A good starting place would be to review the patients that have been in the ED for more than eight hours and that have a consult on a case, who are likely not going home. Observation is similar. [...] And there’s an opportunity for collaboration with case management, to be a second set of eyes, for patients in observation status, to verify the clinical criteria for observation status is still appropriate or has the patient not improved and now meets inpatient criteria.”

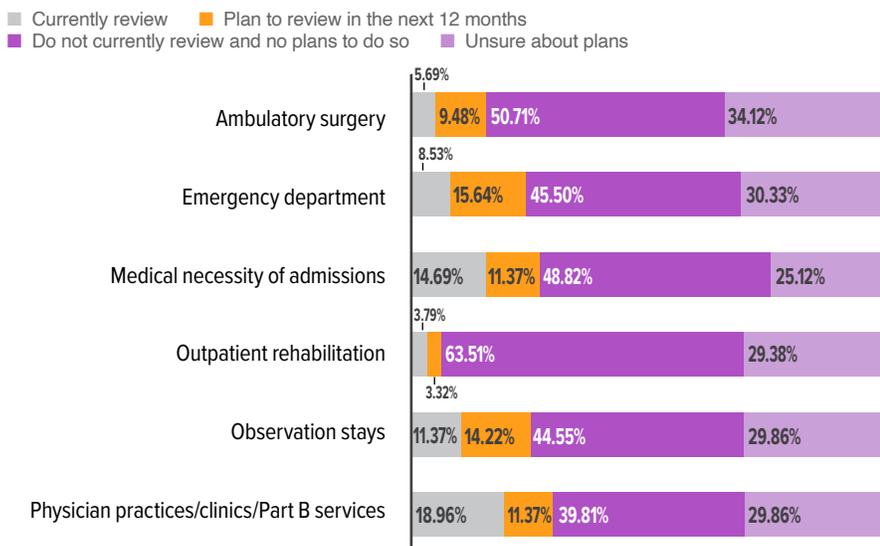
Those who *are* looking to branch out beyond their hospital’s walls are entering a very different world, according to **Rhonda Burke, RN, CRC, CCDS, CCDS-O, CDEO, CRC**, CDI manager at

MaineHealth Medical Group in Alfred, Maine. In addition to the different payment structures, accompanying documentation guidelines, and patient volume, the CDI review process and even mindset differs substantially.

“Physician practices are a totally different cup of tea, and the guidance is different. Even the physician thinking is different, because at least in my role, we work prospectively ahead of the patient’s visit,” says Burke. “It’s a whole different mindset. I have a member on my team who moved from inpatient to our team on the ambulatory side, and she was overwhelmed with the learning curve for a little bit.”

Even if a CDI team only reviews inpatient records, there’s still merit in learning a bit about the outpatient needs and processes. This ensures that the inpatient CDI reviewers are attuned to the documentation opportunities that carry between the settings and can contribute to their outpatient colleagues’ efforts. **Yvonne Whitley, RN, BSN, CPC, CRC, CDEO, CCDS-O**, CDI manager at Novant Health in Winston-Salem, North Carolina, suggests that a great way to help your outpatient CDI colleagues is to ensure the hospital problem list for each patient is updated at the time

Figure 1. Settings currently reviewed, plans to expand



Selected comments:

- Outpatient CDI has been moved to the population health department
- Team reviewing documentation in the clinic setting isn’t under my oversight
- Strategic planning has outpatient added in 2023
- Ambulatory/physician practices are reviewed by a separate group of CDI specialists
- The outpatient coding department sends emergency department queries
- Depends on the facility
- Currently only focused on inpatient due to resources

of discharge. That way, when the patient goes to see their primary care physician in follow up, that physician has the most up-to-date information at their fingertips.

“I think what frustrates our primary care providers the most is that inpatient providers are not necessarily updating the problem list,” she says. “I think there’s a lot of unnecessary effort put into finding out more information back and forth that could already be there if the patient’s problem list was updated when they were discharged from the hospital.”

Review focus

Regardless of what outpatient setting CDI teams choose to review, several focal points can direct their efforts. The most common outpatient review focuses, according to respondents, are E/M coding and Hierarchical Condition Category (HCC) capture, with

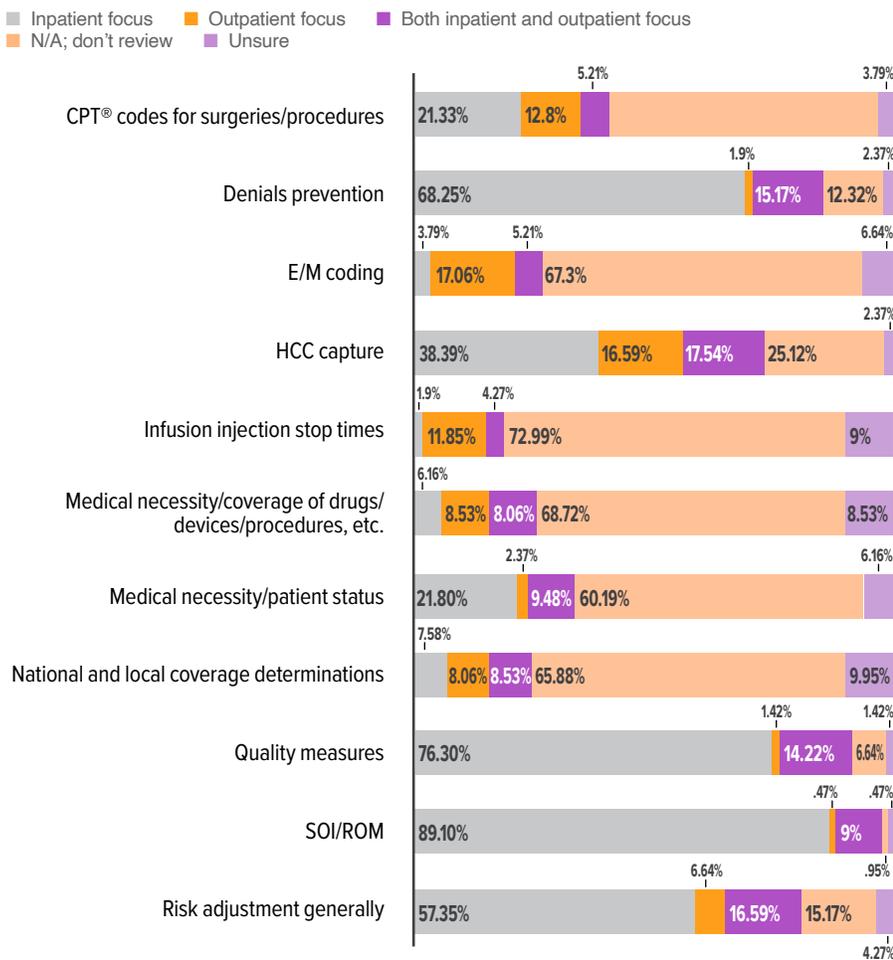
17.06% and 16.59% saying they focus on these areas. More than 17% and 16% of respondents, respectively, also said they focus on HCC capture and risk adjustment generally for both inpatient and outpatient reviews. (See Figure 2.)

HCC capture has become a popular focal point, according to Whitley, partly because it’s a financial metric, making it easier for CDI teams to show their ROI over time than it would be if they focused on a less financially connected area. Of course, much like CC/MCC capture in the inpatient setting, HCC capture doesn’t stop with finances.

“HCCs are part of risk adjustment formulas that predict your expected costs. We’re talking about potential future reimbursement here,” says Whitley. “Really, it’s part of quality too, though. If you’re capturing diagnoses that are accurately portraying how sick your patients are, not only will you get reimbursed accurately, but you’ll also be getting an accurate picture of the patient so they can receive the appropriate care.”

Though HCC capture provides a clear entry point for many programs, Deighan suggests assessing the setting you plan to review prior to launching an outpatient program to see

Figure 2. Review focus



where your greatest opportunity lies. While down the line your program and reviews may expand to more focal points, you can't start by boiling the ocean, she says.

"You need to understand what your pain points are, where the biggest opportunities are, and get insight from different areas within your organization," says Deighan. "Start with an assessment and a good collaborative team that's also aligned with organizational goals. [...] Assess those pain points and put a plan together where you start with something small. You can't do everything, but you can do something, and you can start somewhere."

In addition to investigating opportunities, Burke suggests considering where you already have investable resources and engagement from the necessary parties. For example, if you don't have the manpower to launch a full-scale CDI process in the primary care setting, but you could add some observation or ED reviews to your existing inpatient program, start with the latter.

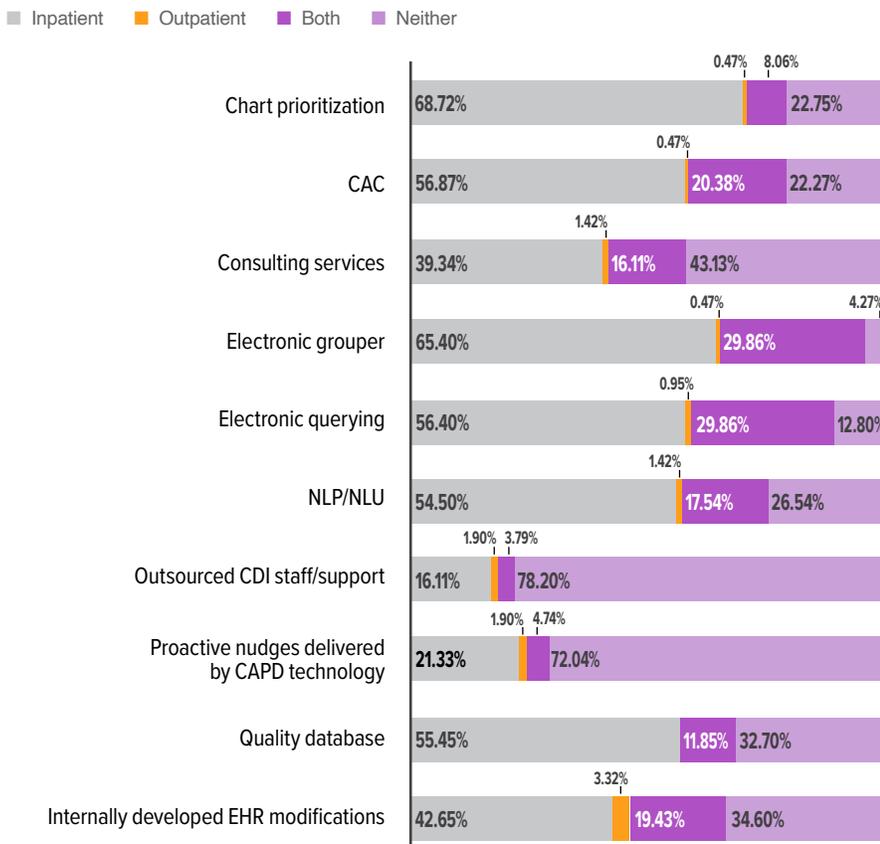
"Evaluate your resources and where you already have engagement," says Burke. "When we looked at ambulatory, we knew it required a greater number of human resources. Our population is so huge on the ambulatory side, [...] so resources are important."

Technology, consulting service use

While most respondents reported having technology and/or consulting services at their disposal for inpatient reviews, few have those resources specifically for their outpatient efforts. More commonly, CDI programs share technology for their inpatient and outpatient reviews, with nearly 30% saying they have electronic groupers and electronic querying and 20% reporting they have computer-assisted coding (CAC) on both sides of the house. Though computer-assisted physician documentation (CAPD) is becoming more common on the inpatient side, with 21.33% of respondents reporting they have that technology, less than 7% total have access to CAPD on the outpatient side. (See Figure 3.)

The dearth of solutions designed for outpatient CDI programs is likely due to the relative newness of the outpatient CDI industry. Vendors and consultants have

Figure 3. Technology and consulting service use



“The most important measure for myself and our team is our physician engagement, which we measure based on the query response. We want to know, if they’re not answering a particular query type, why that is, and how we can educate and help them to better understand the information we’re asking in the query.”

—Rhonda Burke, RN, CRC, CCDS, CCDS-O, CDEO, CRC, CDI manager at MaineHealth Medical Group in Alfred, Maine

had decades to iterate their inpatient CDI solutions and adapt to the industry’s needs, which is not the case for outpatient CDI. Because the technology is still in its infancy, outpatient CDI programs often create home-grown solutions to meet their needs.

“It just hasn’t caught up to us yet,” Whitley confirms. “We’ve built a lot of our own home-grown reporting and worked with our IT department to build some BPAs [best practice alerts] for providers around HCCs.”

Though the options may be more limited, Burke suggests still talking to your inpatient vendor to see what solutions may be available or customizable. These companies are often happy to work with their customers to find a solution that works for everyone.

“I think the technology industry is working hard to develop a system for the ambulatory or the clinic side that’s effective,” says Burke. “Some of the larger vendors have worked on building a subset of their inpatient program. So, you might be able to use the same vendor, but it’s a different arm of their program.”

Opening a conversation with your vendor or your internal IT department is the first step to getting a technological solution that will suit your program. Not only is outpatient CDI younger than its inpatient counterpart, but the needs are also substantially different. An inpatient solution likely won’t work well for outpatient reviews.

“There are different needs,” Deighan says. “If you talk about ED and observation as an extension of inpatient reviews, you can evaluate how to utilize all of what’s used on the inpatient hospital

setting in those settings. If you’re talking the physician clinic? That’s a very different technology solution.”

Metrics for proving outpatient ROI

Unsurprisingly when viewed in conjunction with the data presented in Figure 3, more than 25% of respondents said they use risk adjustment factor (RAF) scores year-over-year to show their outpatient ROI; nearly 24% said they use HCC capture rate. (See Figure 4.)

A common issue cited with measuring ROI based on RAF scores and HCC capture is that the timeline for getting the final outcomes is much longer than, say, CC/MCC capture in the inpatient setting. Reviews conducted today will generally not impact the RAF score or HCC capture rate for at least a year. According to Whitley, communicating this timeline to your organizational leadership and setting up methods to track estimated impact in the short term will help CDI teams identify where they stand on a more regular basis.

“Our leadership understands how risk adjustment works, so they know that what we do now may not give us final stats for a couple of years,” says Whitley. “We monitor a lot of information through our EHR data. While it may not tell the

whole story that we'll see after a year or two, we like to say that it's directionally correct."

In addition to the more concrete RAF and HCC metrics, Burke says she tracks and trends physician engagement metrics closely to ensure buy-in. These metrics help to identify educational opportunities.

"The most important measure for myself and our team is our physician engagement, which we measure based on the query response," she says. "We want to know, if they're not answering a particular query type, why that is, and how we can educate and help them to better understand the information we're asking in the query."

"Physician engagement and physician response are both really important," echoes Deighan. "You should work to reward those that do well and work closely with those who are struggling."

Impact tracking methods

Perhaps unsurprising given the relatively low usage of technology specific to outpatient CDI, the largest percentage (just over 15%) of respondents said they manually track their impact using a spreadsheet, and another 7.58% said they use an internally developed tool from their IT department. Despite reviewing

outpatient records, 4.27% of respondents said they don't have a way to track their impact at all. (See Figure 5.)

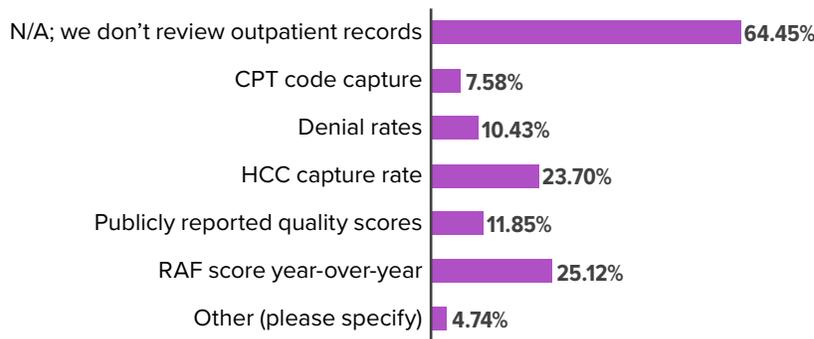
While tracking and trending data can be a time-consuming responsibility, it shouldn't be neglected. Without that data, CDI teams have no way to prove their ROI and identify opportunities to provide greater impact, Whitley says.

"There are huge risks to not tracking your impact," she says. "First, how are you going to find out where you've got problems to address for certain providers? Second, if you don't show what you're worth, why will they keep you on?"

When you're initially developing a tracking system, Burke suggests starting by focusing on what you really want to measure based on your organizational goals. Tracking and reporting data could be a full-time job, but in reality, it's only a portion of what an effective leader does, so you won't be able to track and report on *everything* all the time.

"I think you need to work with your leadership team to pinpoint what they're looking for in the data. Are they looking for return on investment or value from your team? Outcomes? Are you looking for your physician engagement? Are you looking

Figure 4. Metrics to show outpatient ROI



Selected other responses:

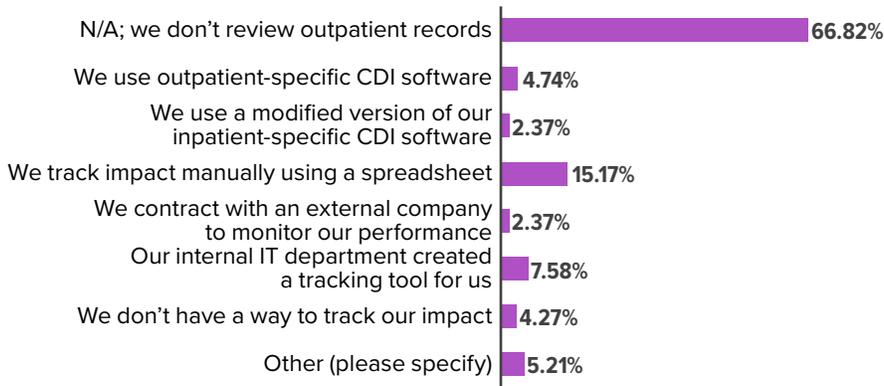
- We have outpatient, but it's not under my management
- Unsure
- We close HCC gaps in payer portals
- Physician engagement with NLP/NLU CAPD
- Query impacts
- We implemented a program with one CDI specialist at one primary care clinic without any software. We started with prospective reviews.
- Metrics are the same as for inpatient except for a more precise CPT code impact
- Increase to expected costs due to CDI queries

for that increase in RAFs?” says Burke. “My best advice is to not underestimate the time you’ll need to tally the data and present it.”

Whether you think you’ll end up using a vendor tracking solution or building one in-house (or using a spreadsheet), it’s important to take time to evaluate the options available to you. Just like starting an outpatient program and choosing a focal point, doing the research on available tools up front and having conversations with your IT department and relevant vendors will ensure you end up with the most useful solution.

“Whether you’re developing a tracking tool internally or partnering with an external vendor, assess multiple options. I think that’s really healthy to do. Find out what [each option] can and can’t do for you, vendors develop and refine their products with their customers,” says Deighan. “You are the ones doing the work every day, so you know your needs.” ■

Figure 5. Tracking outpatient CDI impact



Selected other responses:

- Our program was newly implemented
- We use Excel spreadsheets
- We have outpatient CDI, but not under my supervision
- Unsure
- We use external tools to track year-over-year RAF scores
- We're currently working on a plan to automate reporting with our resources here
- We pull data directly out of the EHR