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Association of Clinical Documentation Integrity Specialists

CDI and Quality Improvement

The most popular method for CDI involvement in mortality reviews, according to survey respondents, is to have the quality team responsible for all mortality reviews with occasional support from CDI as needed.

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Quality metrics and measurements are a crucial and prominent feature of CDI work. Because claims data is increasingly used to determine performance metrics on quality measures, and because the clinical criteria for the inclusion or exclusion of a given patient are determined by the accuracy of the medical documentation, CDI specialists and departments must pay scrupulous attention to quality improvement during reviews. Facilitating effective collaboration between departments and tracking benchmark information cultivated from databases are also integral aspects of CDI and quality improvement.

The Association of Clinical Documentation Integrity Specialists' (ACDIS) recent CDI Leadership Council survey, produced in partnership with 3M Health Information Systems, explored the current state of CDI quality reviews, the use of external databases for benchmarking, tracking quality-related impact, reviewing mortalities for risk adjustment and severity of illness (SOI)/risk of mortality (ROM) capture, and collaborating with other departments on quality concerns. The Council members were then asked to take a closer look at the survey data and discuss how CDI leaders handle quality-related reviews and impact. The following is a review of the results and a summary of the discussion.

Quality measures and metrics

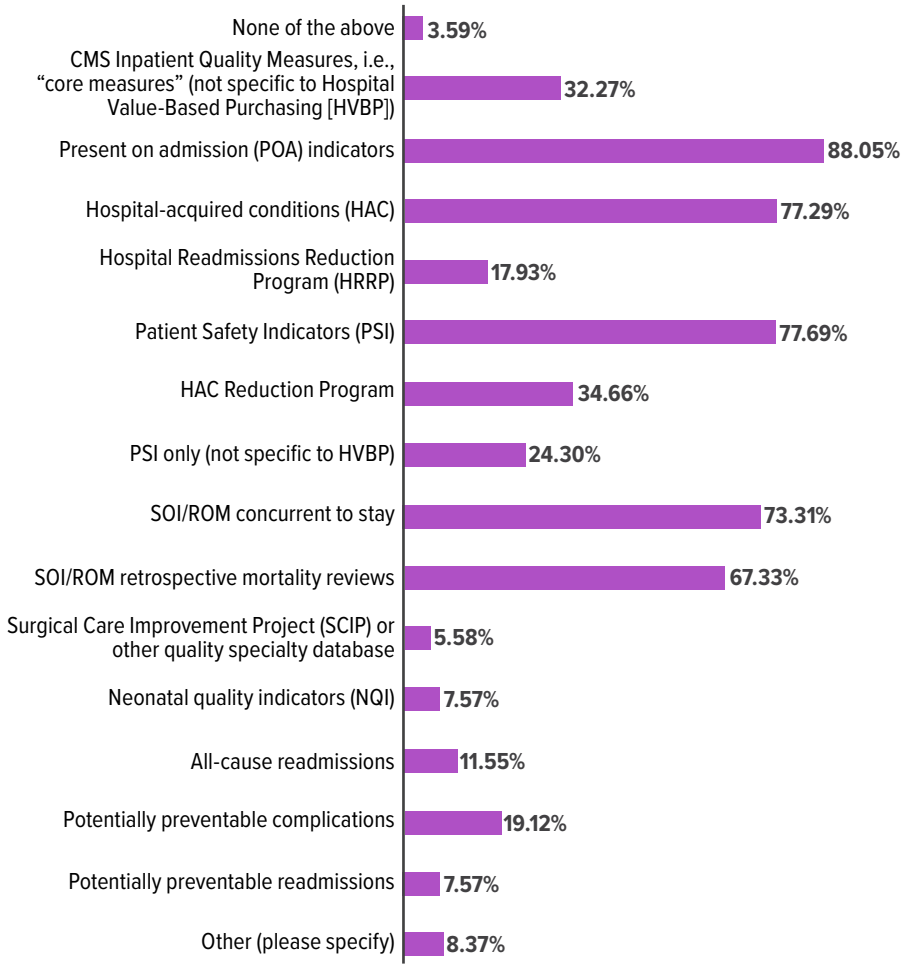
According to survey respondents, the top three quality measures reviewed by CDI departments are present on admission (POA) indicators (reviewed by 88.05% of respondents), Patient Safety Indicators (PSI) (77.69%), and hospital-acquired conditions (HAC) (77.29%). On the other hand, the three least common quality measures reviewed are surgical care improvement projects or other quality special databases (5.58%), neonatal quality indicators (7.57%), and potentially preventable readmissions (7.57%). (See Figure 1.)

Due to the sheer number of quality measures and the number of patient reviews to conduct, CDI specialists are often forced to home in on a select number of impactful quality measures. According to **Schimanya Sullivan, RHIA, CCDS, CCS,** CDI director at Prisma Health in Columbia, South Carolina, considering the cited quality measures is of vital importance, especially as far as risk adjustment is concerned.

"When reviewing for appropriate severity of illness [and] risk of mortality, the correct present on admission status is key as POA impacts risk adjustment, PSIs, and HACs. This is true for patients who are discharged alive and/or transfer to inpatient hospice, in addition to mortality cases," she says.

All the top metrics cited by survey respondents—but particularly POA status—are crucial for both quality improvement *and* financial reimbursement. For **Karen DiMeglio, RN, MS, CPC, CCDS,** director of clinical documentation at Lifespan Corporate Services in Providence, Rhode Island, part of her organization's reasoning for focusing on certain quality measures has been determined by what is useful in the "literature," as well as what has been successful for other CDI leaders and staff.

Figure 1: Quality measures and/or quality-related items reviewed



Selected other responses:

- •Participating in mortality reviews for specific high-risk diagnoses
- •Vizient and Elixhauser
- •ACR, PPC, and PPR within 3M
- •CDI doesn't review quality issues directly
- •Perinatal care and newborn measures
- •ClinIntell data
- •Length of stay reviews
- Outpatient quality measures and patient satisfaction
- •isk adjustment/HCCs
- MI, CHF, and stroke metrics
- Discharge to hospice reviews
- HEDIS gaps, star ratings

Though CDI departments try to be selective in their quality metrics to maximize the depth of quality reviews, sometimes the clinical situation requires an investigation into new areas of focus and review. Of course, the necessity of synthesizing more data can cause productivity metrics within a CDI department to decline. To mitigate that decline and maintain a well-functioning team, DiMeglio argues that it's critical to give CDI staff strategies so they can prioritize the most important work and can set reasonable, achievable goals.

Another option, if the financial resources are available, is to increase the number of CDI specialists. To manage the growing workload at Prisma Health, Sullivan's team doubled to 60 frontline team members and CDI specialists. However, she also says that the department has gradually decreased productivity expectations to give staff more time for in-depth chart reviews.

"You want to make sure that the expected mortality is better, and that the length of stay is appropriate," Sullivan says. "And then you have these risk adjustment diagnoses that may not necessarily change the MS-DRG or the APR-DRG, but you know that they will impact your observed over expected ratio.

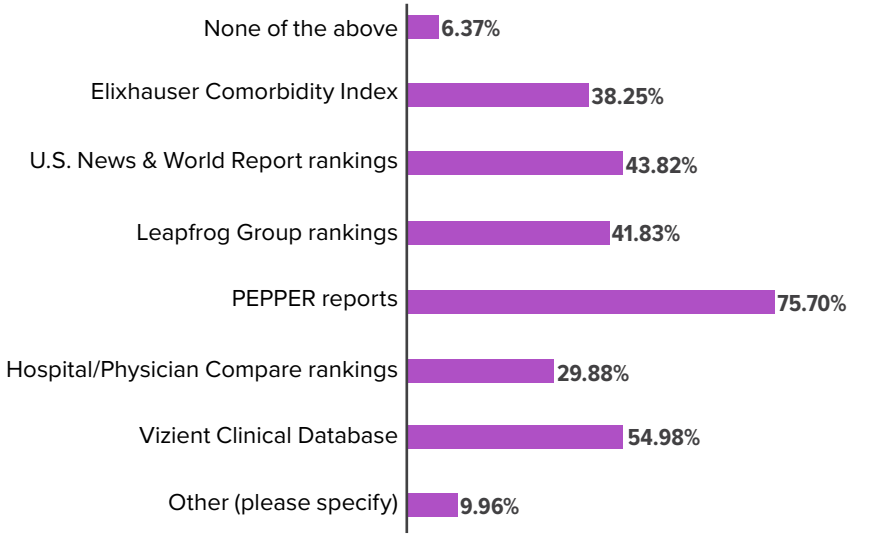
We just want to make sure that the denominator is appropriate for each of those cases."

According to **Shawn Dickinson, BSHCM, RHIT, CDIP,** CDI product content specialist at 3M Health Information Systems in Silver Springs, Maryland, some CDI teams push back when asked to move into SOI/ROM, risk adjustment, and other measures, as they feel they "don't have enough bandwidth to do those things and be productive in their review." As such, some organizations have attempted to prioritize caseloads in different ways so that their teams are seeing and reviewing the "right type of case first." Dickinson says that cases approaching their maximum length of stay expectation with a low SOI, for example, are the types of cases that reviewers should "gravitate" toward as they are often the most impactful and in line with the goals of an organization.

External databases used for benchmarking

According to survey respondents, the top three external databases CDI departments use to benchmark their quality measure success are PEPPER reports (75.70%), Vizient Clinical Database (54.98%), and *U.S. News & World Report* rankings (43.82%). (See Figure 2.)

Figure 2. External databases used for quality measure benchmarking



Selected other responses:

- Unsure
- Premiere
- ClinIntell
- Midas
- MedPAR
- Strategic Analytics for Improvement and Learning
- PHIS
- Truven/IBM Watson
- 3M

Quality measures for many prominent hospitals around the country are found on these databases and readily available to the public. While the databases are a reliable source for informing healthcare-related decisions on the patient side, they are also of great import to the CDI professional, as they present a host of external data to compare with one's own metrics and organization.

In terms of the benefits accrued from utilizing databases, DiMeglio says the knowledge gained from comparing the problems and solutions of similar hospitals to one's own organization can be powerful. "What I find the most valuable is that you get to connect with those hospitals that seem to be doing somewhat better than you and really understand how they got to where you haven't gotten to," she says. "And because we're all up against the same issues and challenges, being able to benchmark and then follow up with those organizations that are willing to speak with you is just to me the most valuable part of it."

This is, of course, an *external* benefit in that its ultimate goal is improving the public-facing perception of the organization. According to Sullivan, *within* the hospital, this type of benchmarking data can also serve the much-needed

function of underscoring the importance of CDI/coding work to organizational leadership.

Dickinson stresses, however, that in meetings and conversations with leadership, it is important to explain that the benefits of conducting these benchmark analyses may not be immediately evident. "In some instances," he says, the data is "extracted two or more years ago," meaning the types of outcomes leadership desires may not be "visible in the data [until] several years down the road."

Additionally, while these surveys could be—and often *are*—useful for assessing the quality metrics of a given hospital, some databases contain information that a CDI professional cannot impact (procedure types and patient satisfaction, for example), and information that is also, in the absence of search parameters, partial and irrelevant.

"Another thing to consider is that not all hospitals participate in some of these, so we're limited in some of these surveys," Dickinson says. "A lot of these benchmarking [surveys] we have listed here may be great for those who are looking to be in the top 10 hospitals in the country, but really CDI is not looking at that. The documentation integrity team is focusing on that complete medical record, and they want to see improvement over time."

Tracking quality-related impact

There are several ways—digitally or manually; internally or externally—to track the performance of an organization in terms of its quality-related impact. Many hospitals are outfitted with CDI software that allows specialists to calculate and categorize the level and type of quality-related impacts; others use simpler, homegrown tracking solutions. According to the survey, the top three methods to measure quality-related impact are categorizing types of impact in CDI software (38.25%), manually tracking impact using a spreadsheet (22.71%), and using an external vendor service to track and monitor impact (11.95%). Additionally, 18.33% said they do not track quality-related impact at all. (See Figure 3.)

In general, technology can help CDI to easily track quality-related impact and can eliminate some of the manual work homegrown solutions often require. That elimination of manual work, however, does not preclude CDI leaders from tracking the metrics that are helpful for their organization, according to Dickinson.

"I don't like manual work. Automation technology is the way to go," he says. "I would want to move toward that technological side of

"It's the CDI department's job to make sure we have accurate documentation in the record," she says. "So, if that means a DRG downgrade and doing a good current review, then it just ensures accurate reimbursement for the quality of services that was provided."

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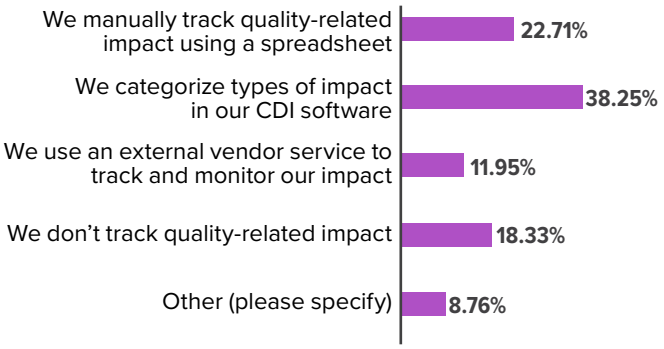
CDI Director, Prisma Health

it where the software can do the work for you. […] Software could have some types of custom impact or key impact indicators that you can use later in reporting the drilldown for those internal initiatives."

No matter the system used to track quality-related impact, according to Sullivan, leaders should share that information with different areas of the hospital, including nursing, registered dietitians, and wound care. Additionally, according to DiMeglio, it's critical to share data with providers too.

"[The provider leadership are] wanting that data and wanting to know how they can change

Figure 3. Tracking and measuring quality-related impact methods



Selected other responses:

- We use Vizient to track quality scores and rank against cohorts
- Quality department tracks and owns/we lean on the quality department
- We only track mortality SOI/ROM impacts
- We developed an internal program
- CDI quality indicators with 3M
- Payer reporting
- Currently Epic in specialized work queues
- Data analyst tracks everything
- SPS
- We track manually in outpatient

to make the quality better, which I think is all we've ever wanted for the past 10 years. And so, we're finally seeing that come to fruition: where the work we do is being seen. Everybody wants a part of it and to understand what we're doing and how they can help impact that more," she says.

As noted previously, however, quality reviews can sometimes result in a lower reimbursement rate as opposed to if the CDI specialist hadn't intervened and demonstrated a patient safety or quality breach. This facet of CDI work is sometimes perceived as a "negative" impact because it means backtracking on payments to the hospital. Sullivan says that even though compliant reviews sometimes have a lower financial impact, as far as CDI specialists are concerned, accuracy is paramount.

"It's the CDI department's job to make sure we have accurate documentation in the record," she says. "So, if that means a DRG downgrade and doing a good current review, then it just ensures accurate reimbursement for the quality of services that was provided."

Mortality reviews

Over the past few years, many CDI teams have found themselves in the curious position of participating in the mortality review process. According to survey respondents, 31.47% make their CDI staff responsible for reviewing all mortalities, and 14.74% have CDI staff reviewing only mortalities that have SOI/ROM scores below a 4. The most popular method for CDI involvement, however, is to have the quality team conduct all mortality reviews with occasional support from CDI as needed (37.05%), followed by having CDI second-level reviewers review all mortalities (36.25%). (See Figure 4.)

Though the methods of involvement differ, mortality reviews have a definite impact on the accuracy of risk adjustment and SOI/ROM metrics, and consequently on overall financial reimbursement. As previously noted, publicly reported data allows patients to evaluate hospitals based on a star rating system, one that can be further broken down into performance on elective procedures. If one organization has lower quality scores or higher mortality for a specific elective procedure than a neighboring organization, it's likely patients will seek care at the higher performing facility.

"Today, hospital data can be purchased. It's made public, so there's greater transparency in the hospital's performance. If I saw [the data on elective procedures at a certain organization] publicly, and I saw that the mortality rate is higher

for the procedure I was going to have, I would consider going elsewhere. So that can change the population that hospitals are seeing, which can include changing the financial outcomes and what dollars are bringing in," Dickinson says.

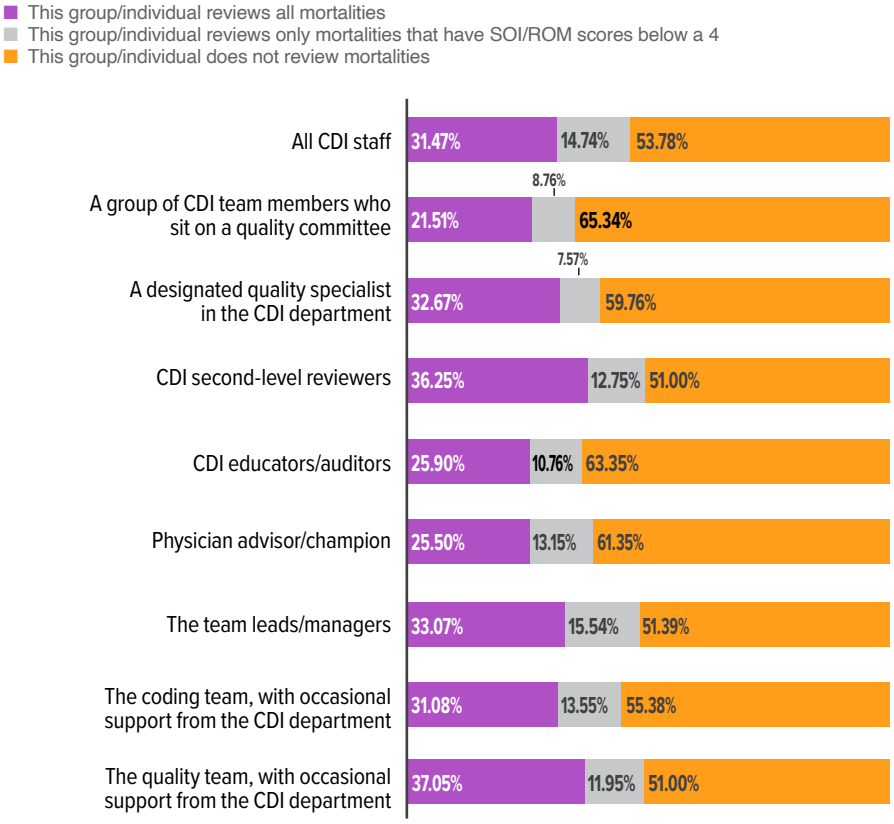
Consequently, the role of the CDI specialist—as a "bridge" between HIM and quality—is more important than ever for ensuring the completeness of the medical record, the proper subclassification for expired populations, and the accuracy of procedure dates required for the calculation of APR-DRGs. In highlighting the utility of mortality reviews, DiMeglio says that though CDI professionals can't necessarily know the nuances of every single quality program, they can establish which diagnoses improve the expected mortality rate when added appropriately to a patient's record.

"When patients do unfortunately pass away, those cases are totally coded by our coding staff and then sent to a group that has specialized education in this process," DiMeglio says. These staff members know the ins and outs of mortality variables, and can make sure that "everything that should be identified as POA is POA and any diagnosis that truly needs to be captured is captured."

Sullivan also says that outside of the regular review and coding process, CDI staff and leadership attending mortality review committee meetings can provide a valuable educational opportunity to shore up documentation on future mortality cases.

"We all do participate in a couple of our campus mortality committees," she says. "Any cases that they bring forth within those committees each month, we'll take a look at them, see what happened, and then the coordinator is able to speak to it from a documentation perspective [and see] whether there were query opportunities."

Figure 4. Primary responsibility for mortality reviews



Selected comments:

- The healthcare improvement department with support from CDI staff on the HIM team
- A second-level CDI and coding team with the support of a physician advisor and the quality department
- Reviewing mortality using Vizient REM
- Working on building a team
- Quality team and quality physician lead
- Each facility in the organization has its own mortality team
- CDI leaders
- Clinical effectiveness
- Collaborative effort between multiple departments
- Use a vendor

Collaboration in quality reviews

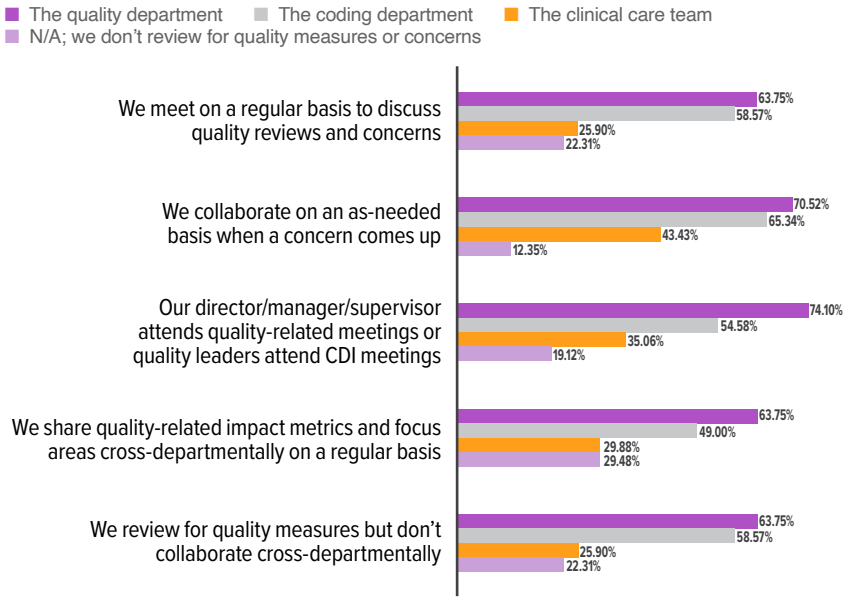
The results of the survey suggest that quality reviews are not only an interdisciplinary process, but a collaborative one as well. Most of the CDI departments surveyed maintain multiple methods of communication with quality, coding, and clinical care departments. The most popular method for collaborating with quality is to have the leadership from each department attend the other's meetings (74.10%), and the most popular method when collaborating with the coding department and the clinical care team is to collaborate as needed when a concern comes up (65.34% and 43.43%, respectively). (See Figure 5.)

Historically, most of the collaboration regarding quality reviews has occurred between CDI, HIM, and quality departments. Though organizations have typically left out providers, Dickinson insists that they are key in providing "insight on the cases and documentation to CDI, HIM, and quality," as well as education efforts predicated upon quality data. DiMeglio reiterates this sentiment, arguing that it's important for providers to "understand their data" and their quality metrics so that they may continue refining their qualitative impact.

Additionally, for Sullivan, collaborating with physician advisors, nursing leaders, and even revenue cycle leadership is critical for conducting retrospective reviews. "At times you may have to update coding and submit a corrected claim," she says. "You must have the collaboration with revenue cycle in understanding why a corrected claim is needed and the claim is not a duplicate. It is vital to have the most accurate coded data submitted to CMS and other payers."

Of course, for those getting into quality reviews for the first time, the sheer number of factors, policies, and processes can be overwhelming to say the least. For those just getting into the quality trenches, Sullivan says that data is the key not only for educational efforts, but for illustrating the importance of CDI to revenue cycle leaders. "[Meet] with the department leaders, whether it's quality, revenue cycle, or physician and nursing leaders, and bring that data with you. Bring any industry best practice data that's out there and then come with your thoughts for how you can create process improvements based on that data," she says.

Figure 5. Interdepartmental collaboration



Selected other responses:

- Working on developing a collaborative relationship this year
- CDI leaders handle the collaboration
- The educator attends quality review meetings and reviews data and then assists with documentation questions
- Use a vendor to review quality items
- CDI reports to quality, so they share data all the time

It's also important to remember to align CDI practices with the goals and mission of one's department, and to facilitate open, transparent dialogue between departments. "Understanding the mission and the goal and then knowing who the essential players are, what they bring to the table, and how that collaboration will play out and what the outcomes will be—getting that up and running and understanding those unique differences, that will be the first thing that I would recommend," Dickinson says.

Lastly, according to DiMeglio, demonstrating the importance of CDI work to other departments and working with them to optimize quality metrics is of prime importance.

"I would say—for so many reasons—get out there. Depending upon your role and your organization, don't be afraid to contact somebody if you see a data point that you know CDI can really improve," she says. "And again, make sure that it's an important data point. Talk about why it's so important and talk about how you can collaborate and what can CDI bring to the table to help improve this." ■

"It's the CDI department's job to make sure we have accurate documentation in the record," she says. "So, if that means a DRG downgrade and doing a good current review, then it just ensures accurate reimbursement for the quality of services that was provided."

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