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Association of Clinical Documentation Integrity Specialists

REDEFINING KEY PERFORMANCE INDICATORS FOR CLINICAL DOCUMENTATION INTEGRITY

Leadership research survey indicates shift from financially focused to quality-centric KPIs

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When the clinical documentation integrity (CDI) field began, professionals reviewed paper charts and sent paper queries, largely to capture comorbid complicating conditions (CC) and major CCs (MCC) for reimbursement purposes. Over the years, the role of the CDI department has expanded to denials management, outpatient settings, quality measure capture, and so much more. CDI programs have shifted focus and taken on innovative efforts, and leaders need to adjust their expectations for staff performance accordingly.

In partnership with 3M, the Association of Clinical Documentation Integrity Specialists (ACDIS) CDI Leadership Council asked five of its members to evaluate the results of a nationwide survey on key performance indicator (KPI) use and discuss their organizational approach to data collection and sharing. Following is a review of the survey results and a summary of that discussion.

KPI importance

One of the biggest and most challenging decisions a CDI leader makes is choosing which KPIs to track and report to organizational leadership. Limited time, resources, and technology mean that leaders need to focus on the most valuable KPIs for their organization and CDI program.

CDI leaders felt tracking query response rate was the most important metric, according to 96.46% of survey respondents, followed by chart reviews per day (82.30%), query rate (78.76%), and severity of illness (SOI)/risk of mortality (ROM) (72.57%). (See Figure 1.)

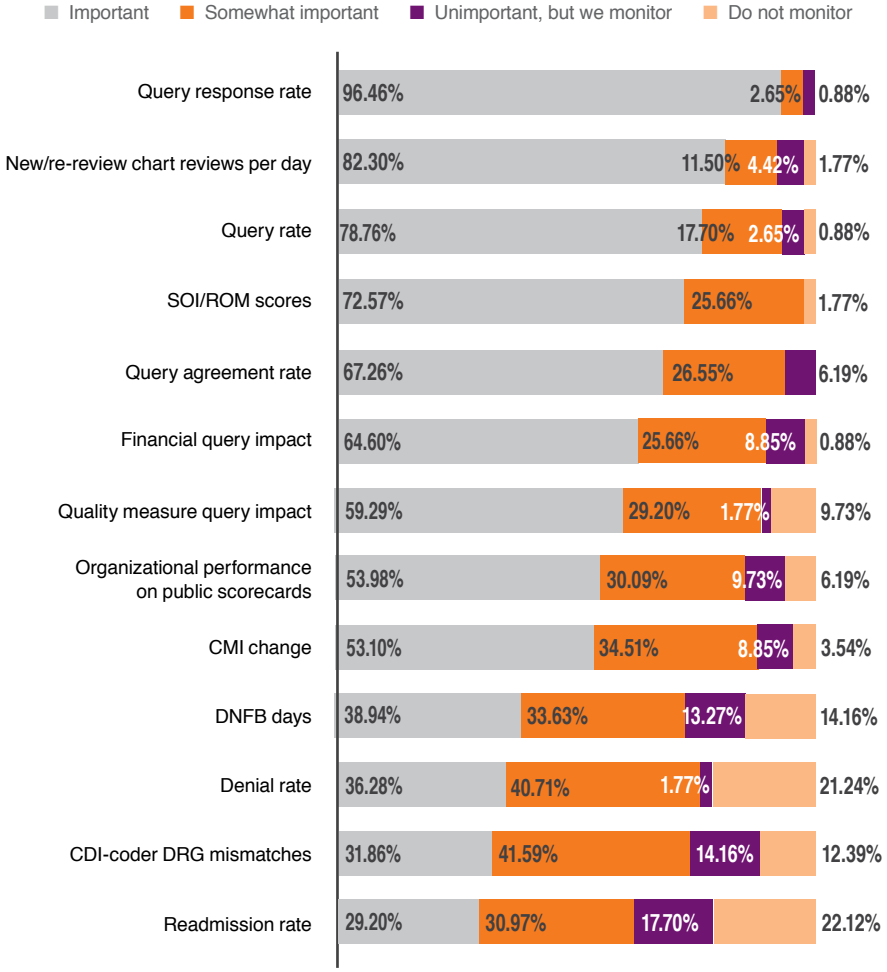
Tracking query agreement rate ranked lower than about half of the KPIs listed in the survey (less than 70% said it was important).

"I was really surprised," says **Deb Jones, MSN, RN,** director of CDI at Brigham and Women's Hospital in Boston. "In my opinion, [agreement rate] is one of the more important indicators to monitor. It doesn't matter how many cases you open or queries you send; if they're not getting agreed to, then you're failing. An agreed-with query is the final product in my mind."

Part of the agreement rate's perceived importance comes from the difference between internal CDI-facing metrics and outward organization-facing ones, according to **Madhu Subherwal, MHA, MBBS, CCDS, CDIP,** CDI manager at Torrance (California) Memorial Medical Center.

"We look at the agreement rate too, but we don't really report it out to our administration (C-suite) because they don't really understand the rate," says Subherwal. "They're more traditional in what they're interested in,

Figure 1. KPI metric importance



such as seeing how the CMI [case-mix index] changes and how many queries we're sending out. They do want to know about financial impact."

"Response rate, chart review rate—those are more CDI performance indicators rather than outcome measures," Jones agrees. "So, when sharing the information with our C-suite or our upper-level leadership, I find they're more interested in the outcome measures than in the performance measures."

Of course, while CDI leaders need to keep an eye on the inward-facing CDI metrics, the organizational leadership are the ones funding and supporting the program. While things are shifting toward a more holistic documentation integrity focus overall, many organizational leaders are still interested in financial indicators such as CMI and CC/MCC capture rate.

Some of those metrics, however, can be subpar indicators of actual CDI efficacy, which may be why just over half of survey respondents said CMI is an important metric for their department; 12.39% said it's either unimportant or they don't monitor it at all.

"I think CMI is still important, but organizational leadership needs to understand the factors at play," says **Kalena Britt, BSN, RN, CCM, CCDS,** director of CDI at Rochester Regional Health in Middleport, New York. "A lot of high-weighted surgeries are moving to the outpatient setting. We've done a lot of exercises in the last two years to identify the exact things [driving CMI], so our C-suite understands it's outside of the CDI team's control."

Cheryl Manchenton, RN, a senior quality consultant at 3M in St. Paul, Minnesota, agrees that CMI's importance as a CDI metric is fading. Instead, it's viewed primarily as "an organizational metric."

Tracking the denial rate also ranked low, with 21.24% of respondents saying they don't monitor the rate at all and only 36.28% saying it's an important KPI for their program. Manchenton, however, says this is an important metric for CDI programs to at least monitor. Program leaders should reach out to their colleagues in the denials management program and ask for access to those numbers.

"I think the denial rate should be tracked by the CDI team, whether or not we actually contribute [to denials management and appeals]," Manchenton says. When the CDI team queries physicians and ensures that the documentation is complete and accurate, the denial rate should go down, she says, because the documentation will accurately support the coding.

"It's really important for the CDI team to understand what and why things are being denied," adds Jones. "If we don't know what's being denied and at what rate and by whom, then we can't appropriately respond."

When deciding which KPIs to monitor, it can be daunting to determine which ones are worth a program's limited time and resources. Leaders should start with the "easy" metrics and then move on to bigger concerns as they get a reading on where their program stands, says **Pooria Jazy, MHA, RHIA, CCDS, CDIP, CCS,** regional director of CDI at Alta Hospitals System in Norwalk, California.

"Query response rate is your entry road. When you're sure that your numbers are optimized, then the next level is to see how your queries were answered. Then it goes to query concurrence rate. Then you can move on to your query timelines," he says.

Emphasizing quality versus financial gains

While organizational leadership may still be interested in the financial implications of CDI work, the industry's focus is shifting toward quality, according to survey results. Nearly three-quarters (73.45%) of respondents said their organization emphasizes non-financial KPIs at least as much as financial ones. Another 23.01% said that financial KPIs take precedence, but that their program still monitors and reports non-financial KPIs to organizational leadership. (See Figure 2.)

While the CDI team may be shifting their focus, organizational leaders who decide which programs receive facility funding and support may take longer to come around, according to Subherwal.

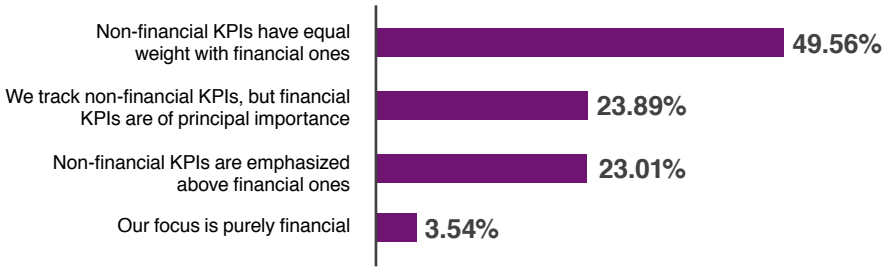
"It is difficult. If we can't show a financial impact almost week to week, we're not going to get the additional staffing resources we need," she says.

"We do still need to butter our bread, so to speak, and showing the success of the program is how we get support for other initiatives," Jones adds. "For instance, we are looking at starting an outpatient program, and we're finding that it's really difficult to show any ROI [return on investment] for that, but we're having more success getting buy-in for it because leadership knows we've shown financial success in the past."

Regardless of which KPIs your program tracks, CDI leaders need to tailor the data's story to illuminate the important points the audience needs to understand, Subherwal says.

"We do track both [financial and non-financial KPIs]. They do have equal importance, but it depends on who's seeing the dashboard," says Subherwal. "The C-suite is […] still focused on CC/MCC capture rate, but they are seeing the impact CDI can have on other areas."

Figure 2. Financial versus quality KPIs



"It depends on who from the C-suite is seeing your information because they will be asking different questions," agrees Britt. For example, the chief medical officer (CMO) may want to see the physician response and agreement rates, whereas the chief financial officer (CFO) may want to see CMI and MS-DRG movements.

One of the hardest parts of helping organizational leaders understand the importance of quality-related KPIs is that quality outcomes won't be evident immediately. Quality payments, such as those associated with value-based purchasing efforts, are based on retrospective performance. According to Jazy, CDI leaders should work to educate their C-suite regarding how CDI improves organizational health from both a quality and a financial perspective.

"For me, we need to be patient to harvest the results of quality-related KPIs," Jazy says. "That's a challenge for us as CDI leaders: to educate the C-suite and shift their attention in the right direction, which is quality, which will ultimately result in financial gains."

CDI leaders sell their programs short by not emphasizing and reporting the program's effect on quality measures and payments, Manchenton says. Though it feels less direct than CMI shifts and CC/MCC capture rates, the financial gains from quality performance improvement can be at least partly attributed to the CDI team's efforts, she says.

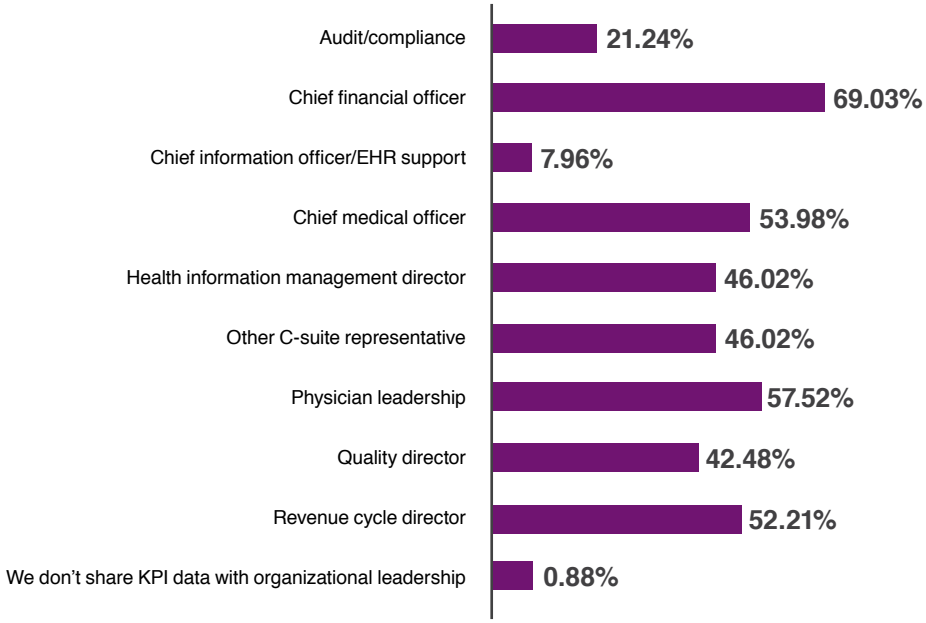
"Why don't CDI programs use their value-based purchasing financial wins as a KPI?" Manchenton asks. "A great portion of that is based on documentation and HCC [Hierarchical Condition Category] capture, but remember that it is data that's based on two years of information."

Reporting KPI information

KPI data doesn't get a CDI department far if it's not put to good use, so leaders need to determine whom to share their data with and on what cadence to do so. Despite the increased emphasis on non-financial KPIs, nearly 70% of survey respondents said they report their KPIs to the organization's CFO, and more than half said they report their data to the revenue cycle director. (See Figure 3.)

Additionally, echoing the focus on physician engagement KPIs, as seen in Figure 1, 57.52% said they report their KPI data to physician leadership and 53.98% said they report to the CMO. While those reporting KPIs to finance could be doing so because of their department's overall reporting structure, sharing data is a great way to build bridges with your physician staff as well, says Britt.

Figure 3. Reporting KPIs to organizational leadership



"I do think reporting structuring influences it," she says. "At my health system, we are working much closer with our chief medical officer, even though we don't report up through them. […] Even though our KPIs are going straight to our CFO on a monthly basis, our CMO is now starting to collaborate more with the rest of the C-suite and the revenue cycle team."

If the CMO or physician service line leaders know how their staff responds to CDI efforts, and the outcomes such efforts provide, they'll likely become an advocate for CDI, help to spread the information, and encourage best practices.

Providers who hear from their directors and other providers about the importance of CDI efforts will be more likely to support and promote those efforts themselves, Jones says.

And, of course, a little competition among providers can't hurt either. With this in mind, reporting physician response data specific to each service line or physician group can help inspire better practices, adds Britt.

"We share our data with all the different physician groups, and they all get individual scorecards," she says. "We have three different hospitalist groups here, and we share with them how they compare to one another, which does create a good healthy competition between them."

While CDI programs report their data to various departments, the survey indicates that only a very small percentage (less than 1%) don't report their data at all. This shows a great deal of transparency among CDI leaders and their overarching organizations.

In reality, "it doesn't matter who you're reporting to," Jazy says. "The important thing is that whoever you're reporting to understands what you're reporting and encourages you and your CDI staff to expand."

KPI presentation style

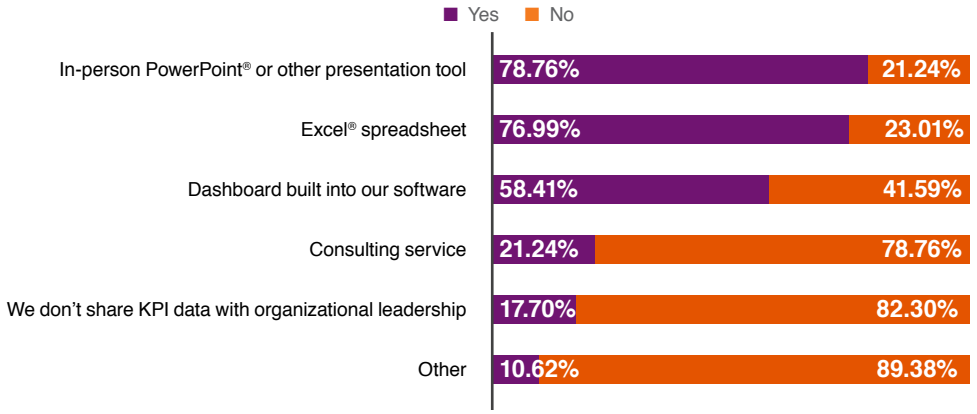
Not only do CDI leaders need to determine whom to report to and what KPIs to share, but they also need to land on the best possible presentation method—or mix of methods—to get that data across.

Most respondents use in-person PowerPoint® presentations, and the majority of those using that method present for one hour per month. Those who present less frequently (quarterly, annually, etc.) said they give longer presentations. (See Figure 4.)

Using simple homegrown Excel® spreadsheets is also popular, with nearly 77% of respondents employing this method. Generally, respondents employing this method spend more time per month compiling data—anywhere from five minutes to three days per month, depending on how manual their process is.

Nearly 60% of respondents said they use a dashboard built into their CDI software, and most of those respondents said it takes a matter of minutes each month to pull reports. Another 21.24% said they use a consulting service that pulls reports for them.

Figure 4. KPI presentation method



While some programs may have the organizational funding to use a consultant company or a software solution and others need to use more affordable options, the important thing to remember is that each group will have a method that works best for it.

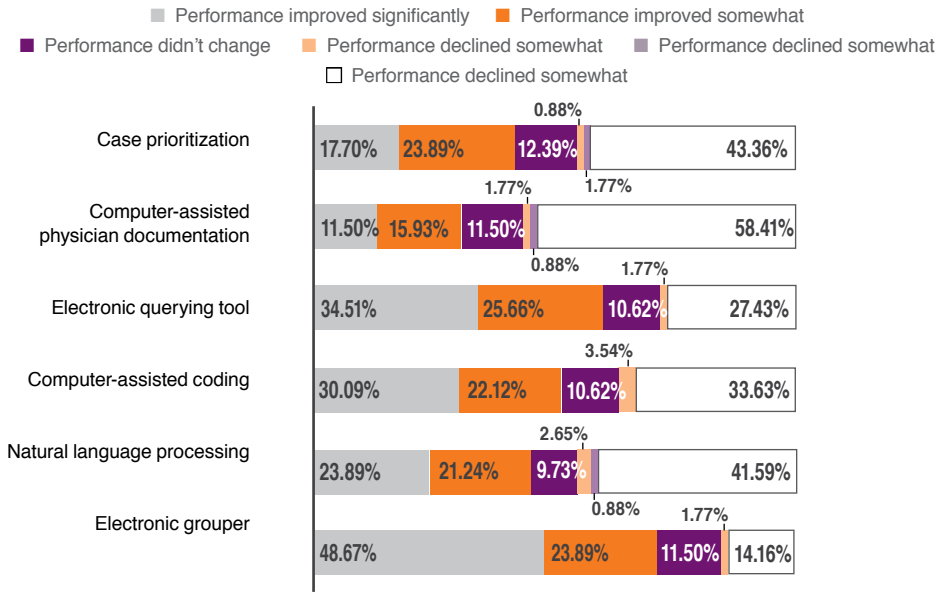
"After understanding the problem, the tactic should match that," says Jazy. "I've used all these tools. I'm constantly using in-person PowerPoints with our physicians, but in some circumstances, you may need something else. […] All these solutions are appropriate if you understand what the problem is."

Technology's effect on KPIs

Technology influences overall CDI KPI performance as well, according to survey respondents. The most beneficial software addition has been the electronic grouper, with nearly half of respondents saying it improved their KPI performance significantly and nearly 24% saying the technology improved performance moderately. Groupers, interestingly, are also the most widespread tool, with only 14.16% of respondents saying they haven't adopted one. (See Figure 5.)

Electronic querying tools also improved CDI performance, according to respondents, with 34.51% reporting significant improvement and 25.66% reporting moderate improvement. Like electronic groupers, electronic querying tools have been around for some time and are used throughout the industry, with only 27.43% saying they don't have access to these tools.

Figure 5. Technology's effect on KPI performance



Newer solutions such as computer-assisted coding (CAC), natural language processing (NLP), case prioritization, and computer-assisted physician documentation received lower marks for improving KPI performance than more established software solutions.

It's important to note that these solutions—CAC, NLP, prioritization, and computer-assisted physician documentation—tend to be newer additions for many organizations. Thus, CDI teams have had less time to acclimate to them and may not fully understand their efficacy. In fact, more than half of respondents have not adopted computer-assisted physician documentation, more than 40% are yet to adopt case prioritization or NLP, and more than 30% haven't adopted CAC.

For those looking to adopt these solutions, the hope is that after the initial learning curve, the team's KPI metrics will begin to improve, says Jones.

"The KPIs I hope to see improve are certainly efficiency. I'm thinking that with case prioritization, our review rate might go down as we focus our reviews," she says. "We're all expecting to see fewer query opportunities with physician-assisted documentation."

As organizations adopt new tools for the betterment of their CDI programs, Jones says to remember that your success with the tools will depend on how comfortable your staff are with them. Because of this fact, CDI leaders need to pay special attention to their change management tactics and ensure that staff knows how to use the tools effectively.

"A big challenge when we're changing software is the comfort level of the end user," she says. "We have [CDI specialists] here on the team from all different age groups, and some may find it harder to change and get accustomed and comfortable with new software systems. It's so individual as far as how long it takes to get up and running."

While it may be a daunting task to implement a new solution and train staff on it, Manchenton says that the process may be faster than you think, provided you have adequate support from leadership and any outside consultants your organization has employed.

"The learning curve is real, but within a week or two staff can become proficient. In the beginning, you're going to be slower, but then you'll be the same, and around the second month, you'll be quicker," she says. "Just make sure you're repeating the training."