From Finance to Quality: CDI Departments Expanding Their Reach

Touted for their ability to improve case-mix index and ultimately facility finances, clinical documentation improvement (CDI) programs now need to expand reviews for quality indicators related to hospital value-based purchasing and other CMS pay-for-performance programs—not just because it’s the right thing to do but because, with multiple healthcare reform measures in play, such efforts could mean the difference between keeping a facility open or closing its doors.

By Melissa Varnavas, Associate Editorial Director of ACDIS

In 1999, the Institute of Medicine reported that medical errors represent one of the leading causes of mortality in the United States and noted that medical error-related deaths resulted in more than 50,000 preventable deaths and $20 billion in associated costs annually. Since then, the government has increasingly looked for ways to improve patient care and move away from its traditional fee-for-service reimbursement model. Still, many CDI program leaders agonize over how to make the case for expanding their program efforts into quality-related record reviews, says Dee Banet, RN, MSN, CCDS, CDIP, director of CDI at Norton Healthcare in Louisville, Kentucky, and a past ACDIS Advisory Board member.

That’s because CDI programs typically start with a promise of a large return on investment (ROI)—improving a facility’s case-mix index and capturing higher-weighted Medicare Severity (MS) DRGs. The CDI program’s ROI is less directly correlated to quality measures, however, says Laurie L. Prescott, MSN, RN, CCDS, CDIP, AHIMA-approved ICD-10-CM/PCS trainer and CDI education director with BLR Healthcare in Middleton, Massachusetts.

And yet, as government increasingly ties payment to quality with initiatives like pay-for-performance, the dividing line between patient care and fiscal concerns is slowly dissolving, Banet says.

Beyond CC/MCC capture

Although documentation improvement efforts have been around for years under various guises such as DRG optimization, the need for a concentrated examination of medical record information exploded in 2007 with CMS’ implementation of new MS-DRGs. Based on statistical analysis, CMS determined that during the first years of MS-DRG implementation, better documentation would lead to increased reimbursement. It assumed hospitals would rush to improve their documentation, and they did.

In these early days, CDI efforts were principally tied to improving physician documentation concurrently, while the patient remained under the hospital’s care, in order to clarify the patient’s principal and secondary diagnoses.

Such information could capture complications and comorbid conditions (CC) or major complications and comorbid conditions (MCC) and ultimately improve the reimbursement afforded with the MS-DRG code assigned. So, along with MS-DRGs, CMS imposed a documentation and coding adjustment to recoup such payments—one of many carrot-and-stick programs the agency would employ over the next decade.

Since then, CMS has implemented a number of new initiatives. To the uninitiated, the parade of associated acronyms may seem like sets of hieroglyphics. Shortly after MS-DRG implementation, CMS outlined plans for its Hospital Value-Based Purchasing Program, which set penalties and bonuses for...
Lorri Sides, RN, senior director of product management for Optum360 in Bellevue, Washington, is a registered nurse with more than 20 years of healthcare experience. Lorri has worked in many different aspects of healthcare, affording her a unique view of the problems the industry faces today. She spoke with ACDIS Associate Editorial Director Melissa Varnavas about the benefits of expanding clinical documentation reviews into the quality arena. You can get in touch with Lorri at Lorri_Atkins@Optum360.com.

Q: What do you believe is driving organizations to think beyond the traditional scope of CDI programs?

Medicare is moving beyond its traditional fee-for-service reimbursement model to focus on paying for the quality outcomes of the care that facilities and physicians provide to beneficiaries. CDI programs need to change their focus, too, and move beyond the traditional program goals, benchmarks, and impact success metrics. We have all these new reasons to look at the record related to value-based purchasing—hospital-acquired conditions (HAC), present on admission (POA), Patient Safety Indicators (PSI), and readmission reduction, to name a few. CDI programs simply can’t have a limited focus anymore. This is where technology comes in, key to the success of program growth is technology that assists in automation of the review process and reduces manual data entry.

When I sit down and try to look at the underlying problem for all these measures, I come back to a common theme—the complete and accurate documentation of a patient stay that is reflective of the patient’s condition, the medical necessity of the care provided, and the overall response to and outcomes of that care. By leveraging technology as part of 100% documentation review and review throughout the patient stay, the likelihood of documentation deficiencies can be greatly improved.

If 45% of the value-based purchasing domain calculation stems from code assignments on the claim, then we—from facility administrators down to CDI specialists and coding teams—need to make sure those negative effects are not based on documentation deficiencies or coding errors and instead accurately reflect care.

Q: What type of risks does this change present to the organization?

There’s a risk of overloading CDI programs. CDI staff cannot be all things to all people. There needs to be collaboration between the various departments. Processes and procedures need to be fully developed to identify common themes across departments and to identify where CDI efforts can have the greatest effect.

The chief financial officer or the vice president of revenue integrity also needs to understand that the CDI program isn’t backing away from the focus on CC/MCC capture. There is a tangible return on investment to those CDI efforts that cannot be put at risk.

Q: Can you explain a little bit more about where CDI programs should be looking to expand?

CDI program managers need to almost retrain their staff. In the beginning, they were encouraged to put blinders on and focus on CC/MCC capture, and now they’re starting to realize that there’s more to the story. For example, technology can identify documentation deficiencies, which might lead to query opportunities, and add them to the queue for CDI review.

Q: Can you provide some of the keys to success?

Move beyond the silos of historic thinking. We have to bridge the gap between the clinicians and the rest of the organization. We must become proactive, not simply retrospective, and put the pieces in place to facilitate the process. When everyone had ICD-10 implementation on their minds, most implemented some form of technology, and that’s a powerful piece of the proactive solution. An organization is no longer dependent on post discharge coding to know the coded picture of the encounter, but instead can leverage real time coding by the technology to facilitate concurrent intervention and communication.

For CDI programs looking to expand into some of these areas, first assess the current state of program efforts. Many programs are performing, but not well positioned for growth. Move to the next level by demonstrating the positive effect of your CDI program on current metrics, and map out how you might move your program into additional quality-related areas. Draft out how those efforts could affect record review productivity, but also identify target areas using public reporting to show the administration how CDI can help.
facilities based on the value of their care. Hospitals could demonstrate improvement of that care under two domains—clinical measures and patient experience.

Each year, CMS adds to its growing hieroglyphic set, incorporating the Hospital Readmissions Reduction Program (HRRP), hospital-acquired conditions (HAC), present on admission (POA), and Patient Safety Indicators (PSI), among others. Also annually, it adds and subtracts to the list of conditions included or excluded in these measures.

When it comes to success in pay-for-performance facility leadership needs to be data skeptics and dig deep enough to understand the root cause of why the data portrays particular outcomes. In this regard, CDI programs can prove invaluable, because they can show whether documentation may be at fault and work to identify opportunities for improvement.

**How can expanding the CDI program help?**

In general terms, one of CDI’s most important roles in an acute care setting is to establish the clinical diagnosis and/or conditions that were POA. A close second is ensuring clear representation of patient acuity in physician documentation to depict the true severity of illness and risk of mortality when coded data is risk-adjusted for comparison.

One way to do this is to incorporate CDI staff into committee activities, education, and the development of new initiatives related to quality-based payment methods, says ACDIS Advisory Board member Judy Schade, RN, MSN, CCM, CCDS, clinical documentation specialist at Mayo Clinic Hospital in Phoenix.

To begin, CDI programs need to work with departments such as coding, quality, and infection control to understand the conditions that drive scoring metrics, says Prescott.

“It seems that CDI professionals are on a never-ending chase to keep up with the regulatory changes and demands associated with clinical documentation,” says ACDIS Advisory Board member Wendy Clesi, RN, CCDS, CDIP, executive director of CDI services with Enjoin in Eads, Tennessee.

Armed with that knowledge and backed by the support of the departments they serve, CDI staff can more closely examine the record with an eye toward these conditions, looking for documentation opportunities that can risk-adjust the case or prevent it from counting against the facility. For example, if the facility has poor readmission reduction rates, CDI can strive to capture secondary diagnoses and better depict the complexity of the patient’s condition so it doesn’t hurt the hospital’s bottom line, Prescott says.

“CDI needs to immerse themselves in this information,” she says, “and be aware of areas where the hospital may be struggling.”

**Mission creep and staffing expectations**

Hospital leadership need to fully understand the benefits and limitations of expanding the CDI program’s scope, however. Core responsibilities must be maintained and key metrics (number of records reviewed, CC/MCC capture rates, initial versus final-coded MS-DRG assigned, case-mix index fluctuations, and so forth) continuously monitored. Adding specific quality targets to the review process likely will increase the amount of time it takes a staff member to review a record. Collaborating across departments, educating physicians, and analyzing data to track progress and opportunities all takes time and talent.

And, Prescott cautions administrators, there’s no clear way to demonstrate a one-to-one ROI related to CDI efforts in the quality realm.

“Yes, you will likely see an improvement in your facility’s quality measures with CDI collaboration and focus in the mix.”

“Personally, I think the most important thing to remember is to understand the global aspect of the patient experience and understand the continuum of care. We all need to work together and partner for the best outcomes for our patients. Yes, at times this is a monumental task. However, our expertise, experience, and knowledge is paramount to better outcomes and patient satisfaction,” Schade says.

“A CDI program that broadens its focus to include quality indicators can still be described as a program with a financial focus,” says Banet, because of the indirect financial effects stemming from the penalties levied against organizations. “We want to continue to drive our efforts around direct financial impact and enhance our CDI program by adding to our indirect financial impact as well.”

**Editor’s note:** Varnavas is the associate editorial director for ACDIS, the Association of Clinical Documentation Improvement Specialists. Contact her at mvarnavas@acdis.org.
The business of healthcare in the U.S. is changing. Public and private payers are increasingly linking payment and reimbursement to clinical outcomes, quality care and overall costs. Regulators penalize providers for care that is inefficient, substandard or unsafe. In this new environment, delivering quality care is a continuous challenge, particularly with changing rules and expectations about how to document, measure and follow best practices in patient care.

Physicians and hospitals must prove they are meeting or exceeding prescribed quality standards, treating patients more effectively and controlling costs. This new value-based healthcare economy requires accurate clinical documentation and a reliable method for measuring quality outcomes.

Study confirms value of clinically-focused clinical documentation improvement in transitioning to quality-based care. A study conducted in 2015 by Nuance Communications, Inc. and Quantros, Inc. evaluated the quality performance of hospitals using the Nuance Clinical Documentation Improvement (CDI) program against other U.S. hospitals. The research looked at quality ratings as represented in the Quantros CareChex® national database. Results showed hospitals with a clinically-focused CDI program consistently outperformed benchmarks for hospital care quality standards by more than three times the national average.

Proper identification and documentation of a patient’s principal diagnosis and severity changes impact key quality and performance ratings, most notably improving expected mortality ratings. Considering 80 percent of hospitals have some form of CDI program in place, the study shows the move to a clinically-focused program engages physicians in documentation quality improvement efforts in a meaningful way.

For hospitals and health systems, value-based payment and reimbursement models raise the stakes for demonstrating and achieving sustainable quality improvement. At the intersection of quality improvement and reimbursement lies CDI and composite quality measurement. When converged in practice, these provide a more accurate reflection of quality and therefore value, and they are the impetus for looking beyond Case Mix Index (CMI) as the sole arbiter for measuring the impact of CDI.

Study Findings

The 2015 study, based on industry-leading CareChex hospital quality ratings methodology, examines the quality impact of a clinically-focused approach to CDI at more than 300 U.S. hospitals.

- Expected Mortality performance ratings were up to seven times better in hospitals with clinically-focused CDI.
- Every CDI-related correction led to a better clinical understanding of the patient’s severity, intensity, complexity and risk.
- Clinically-focused CDI dramatically improved how well physicians were able to document the patient story.

Outcomes before and after implementation

Averages for all hospitals in the two years prior and one year after Nuance CDI implementation

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