Closing the Loop on Quality and CDI: Refocusing Programs to Ensure an Accurate Picture of Clinical Care

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The ultimate goal of most CDI programs is to improve the quality of patient care through more accurate and complete clinical documentation. A potential increase in revenue is, of course, a positive byproduct of doing so—which makes sense. If organizations can demonstrate severity of illness (SOI) more completely, reimbursement should follow suit.

Although some CDI programs continue to narrowly focus on CC/MCC capture solely to drive revenue increases, the healthcare industry as a whole has started placing greater emphasis on clinical communication, provider collaboration, and quality outcomes. For example, value-based purchasing (VBP) provides financial incentives for care that yields better clinical outcomes over time and across care settings. VBP promotes a more holistic approach that places patient safety and quality of care at the forefront—and relies heavily on clinical documentation.

What role does CDI play in these evolving reimbursement models and quality programs? To start, CDI programs can refocus priorities to align with the healthcare industry's overarching goals mentioned above—including the Institute for Healthcare Improvement's Triple Aim Initiative, which aims to improve patient quality and satisfaction, improve the health of populations, and reduce the cost of healthcare. CDI specialists are strategically placed to help drive this effort.

By reviewing clinical documentation concurrently and identifying communication gaps as they occur, CDI specialists are best positioned to gather additional details necessary for better clinical handoffs and improved quality of care while also supporting HIM's coding initiatives. CDI helps the healthcare industry close the loop on quality.

Reasons for a Quality Focus

CDI programs nationwide have experienced a growth spurt thanks to ongoing third-party auditor scrutiny of documentation as well as the impending transition to ICD-10-CM/PCS. Organizations that couldn't afford a CDI program in the past have found the budget to create one. They've realized that a lack of specificity and clinical validation to support documented/coded diagnoses guarantees more claims denials and future payment recovery audits. Working to ensure quality data, produced through the clinical documentation process, is seen as the "golden ticket" for long-term success in an increasingly regulatory-driven environment.

Congruent with CDI expansion is broader acceptance and implementation of EHRs. With 4,811 hospitals and 530,756 total providers now registered in the Centers for Medicare and Medicaid Services' (CMS') "meaningful use" EHR Incentive Program, the healthcare industry has spurred a "Big Data" revolution.[1] Today's coded data is used to calculate reimbursement as well as paint pictures of the quality of care provided. Easy access to quality outcomes data increases the power of consumer choice.

Organizations must ensure their data accurately reflects quality care and is of the highest quality—and CDI specialists play an important role. Below are three specific examples.

Consumer Comparisons

CMS' Hospital Compare is a website where consumers can "shop around" to select healthcare providers online. The website presents easily accessible provider information on 27 inpatient quality measures, including 24 clinical processes of care measures and three clinical outcome measures. If hospitals don't capture these measures via quality documentation and accurately coded data, the information portrayed to consumers is erroneous.

For example, one process of care quality measure pertains to aspirin at arrival. Patients who present with an acute myocardial infarction must receive an aspirin within 24 hours before or after hospital arrival, assuming there are no aspirin contraindications. If this measure isn't performed, documented, and coded, then it may appear as though the hospital doesn't comply with safety protocols.

CDI specialists can ensure documentation reflects the fact that aspirin was prescribed within this timeframe. Doing so enhances the data on which measures, outcomes, and public profiles are based.

Safety Indicators

Outcomes measures are driven, in part, by Agency for Healthcare Research and Quality (AHRQ) patient safety indicators (PSIs). In particular, PSI 04 (death among surgical inpatients with serious treatable complications) and PSI 90 (complication/patient safety for selected indicators) play an important role in the data used to generate information on consumer comparison websites.

CDI specialists can play a key role in the capture of PSIs. The Leapfrog Group uses 28 national performance measures—many of which are drawn from CMS data—to assign a single composite safety score that denotes a hospital's overall performance in keeping patients safe from preventable harm and medical error. Healthgrades relies on similar data, including data from AHRQ, to recognize hospitals for excellent performance in safeguarding patients from potentially preventable conditions during hospital stays.

Case Mix Index

A final reason to take a more holistic approach to CDI is to ensure an accurate case mix index (CMI). CDI specialists must capture all CCs and MCCs regardless of their impact on reimbursement. Doing so guarantees that an organization's CMI reflects its patient population. A lower—and inaccurate—CMI can lead to a lower base rate for payment, which can be catastrophic for the organization over time.

Whether for quality outcomes, patient safety, or case mix, incorrect data casts a negative light on patient care and represents a false reality—one that is much bleaker than occurs in most hospitals today. Quality-focused CDI programs help mitigate this risk.

Expanding the CDI Scope

Many CDI programs begin with a focus on recovery audit contractor (RAC) and other auditor findings. Although this is an effective way to ensure an immediate return on investment and target high-risk areas of compliance, programs can—and should—expand beyond this scope to include:

SOI and Risk of Mortality (ROM)

These calculations are based on the interaction of multiple comorbidities and disease progressions, and are vital for public reporting as well as APR-DRG reimbursement methodology. Conditions can affect SOI and ROM regardless of whether they are CCs and MCCs. Therefore, CDI specialists should focus on accurate documentation for all diagnoses that affect a patient's stay rather than those that simply increase the DRG weight.

Present on Admission (POA) Indicators

These indicators denote whether a condition was POA or developed during the hospital stay. If the POA is not documented and/or coded correctly, a hospital's patient safety indicators rate could be improperly inflated. It's not realistic for CDI specialists to focus on reviewing POA accuracy for every diagnosis. Instead, they should focus on capturing the correct POA for infectious diseases, hospital-acquired conditions, and cases in which patients are transferred from another facility.

Patient Safety Indicators (PSIs)

Through concurrent reviews of PSIs, CDI specialists can quickly notify case managers and providers in real time to ensure clinical protocols are followed. For example, PSI 90 is a composite indicator that includes data compiled from the following other PSIs, each of which can be improved with the help of CDI:

- PSI 03: Pressure ulcer rate
- PSI 06: Iatrogenic pneumothorax rate
- PSI 07: Central venous catheter-related blood stream infection rate
- PSI 08: Postoperative hip fracture rate
- PSI 09: Perioperative hemorrhage or hematoma rate
- PSI 10: Postoperative physiologic and metabolic derangement rate
- PSI 11: Postoperative respiratory failure rate
- PSI 12: Perioperative pulmonary embolism or deep vein thrombosis rate
- PSI 13: Postoperative sepsis rate
- PSI 14: Postoperative wound dehiscence rate
- PSI 15: Accidental puncture or laceration rate

For PSI 03, CDI specialists can check for documentation that reflects whether the pressure ulcer is POA. This involves ensuring that a thorough skin assessment is performed and documented on the first day of the patient's stay.

For PSI 09, CDI specialists can clarify whether a hemorrhage or hematoma occurs during or after the operation. They can also clarify whether the patient had ecchymosis (flat bruising of the skin) or an actual hematoma (bruising with mass).

Related to PSI 13, CDI specialists can ensure that documentation supports a confirmed diagnosis of sepsis.

For PSI 15, CDI specialists can ensure that documentation supports whether the patient truly experienced a laceration as a complication or whether the laceration was intentional. They can also clarify whether any diagnoses that could potentially trigger PSI 15 were eventually ruled out (i.e., rule-out pneumothorax vs. actual pneumothorax).

For more information about coding and documentation issues pertaining to each PSI, refer to AHRQ's guide "Documentation and Coding for Patient Safety Indicators" available at www.ahrq.gov/professionals/systems/hospital/qitoolkit/b4_documentationcoding.pdf.

Outpatient/Emergency Documentation

Many organizations are turning their attention toward outpatient documentation as it directly impacts medical necessity justification for inpatient care. With emergency medicine documentation, CDI specialists can ensure that residents and others provide a thorough history of present illness as well as documentation to support the POA indicator.

Three Strategies to Build a Quality-Driven CDI Team

There are many ways in which organizations can refocus CDI programs to better incorporate the above mentioned types of data that will directly affect quality measures and quality-related public reporting.

Consider the following three strategies:

1. **Rebrand CDI as clinical documentation integrity.** Quality-focused CDI is all about the integrity and accuracy of the data. Make sure providers understand CDI is not about increasing revenue for the hospital even though it may be an indirect byproduct of quality enhancement.
2. **Align CDI with coding and quality.** In many organizations, CDI, coding, and quality staff report to entirely different departments. CDI often reports to case management or utilization review. Coding may report to HIM or finance/revenue cycle. Quality may be an entirely separate department of its own. Even though these silos may exist, organizations should strive to break down the walls that prohibit collaboration and communication.

   Consider forming a task force including the HIM, nursing, quality, and CDI departments, and a physician champion. Having a consistent message across multiple departments is essential. Ideally, this team would be led by the CFO,

resulting in a "top down" approach to CDI.

3. **Be mindful of CDI specialists' limitations; successful CDI programs are a team effort.** Organizations may need to consider hiring additional CDI staff to accommodate for a longer list of documentation elements to be reviewed. As that list expands to include quality elements, CDI specialists may become overwhelmed and inadvertently compromise quantity over accuracy. Providing sufficient support can help mitigate this risk.

Also keep in mind that CDI shouldn't fall on the shoulders of one person or one department. It's about taking a team approach to what is considered a complex and detailed process. Other members of a CDI task force can further foster a quality-driven CDI program.

For example, coders can share their knowledge about coding guidelines and sequencing with CDI specialists. Coders working concurrently can also bring documentation challenges to CDI specialists' attention to resolve the issue jointly. In addition, case managers and utilization review specialists can work closely with CDI to remind providers of timely clinical protocols and other measures.

Finally, physicians are an important part of CDI because they provide the documentation upon which all coded data is based. The most successful CDI programs are those that incorporate quarterly physician education to avoid repeating the same mistakes or omissions. If physicians don't receive this education, organizations won't reap the rewards of their CDI programs regardless of how effective those programs may be.

Listen to What the Data Are Saying

Quality-driven CDI programs provide significant insight into a hospital's performance, including areas for improvement. As organizations continue to focus on quality, it's equally important to look at the stories behind the numbers—what the data are saying and why. For example, an increased focus on the POA indicator could suggest a rise in hospital-acquired conditions. This may have nothing to do with the clinical care provided. Rather, it could have everything to do with employing a more intense data review.

When tying CDI with quality, be sure to develop clear communication strategies with patients, insurers, and others to avoid misinterpretation of information. Understanding the context of the data is critical.

Note

[1] Centers for Medicare and Medicaid Services. "EHR Incentive Program: Active Registrations." March 2015. www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/March2015_SummaryReport.pdf.

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