New CDI Challenge: Adjusting to Quality, Not Quantity

By Brian Murphy, CPC

It's no secret that healthcare is undergoing a profound transformation. While fee-for-service delivery remains the current model for acute care hospital payment, the transition to paying for quality over quantity is happening before our eyes.

In January, the Centers for Medicare and Medicaid Services (CMS) announced its goal of tying 30 percent of its traditional fee-for-service payments to quality models such as accountable care organizations (ACOs) and bundled payment arrangements by the end of 2016. CMS plans to increase that to 50 percent by 2018. The agency also announced a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016, and a whopping 90 percent by 2018, through programs like the Hospital Value-Based Purchasing (HVBP) program and the Hospital Readmissions Reduction Program (HRRP).

So what does this paradigm shift mean for clinical documentation improvement (CDI) specialists? It means their knowledge base and job description will need to broaden to adapt to these changes. CDI specialists are increasingly learning to review documentation from a quality perspective, either in addition to or as a replacement for the traditional model of DRG validation. They need to be as comfortable with acronyms like HVBP, ACO, and HRRP as they are with the old standbys like DRGs (diagnosis related group), POA (present on admission), and IPPS (inpatient prospective payment system).

Providers Upping the CDI Ante for Quality

Many CDI departments, seeing this looming change on the horizon, have begun to proactively review records with an eye on quality. For example, Yale New Haven Health System in New Haven, CT developed a brand new role called the CDS Quality and Performance Lead. Working closely with the quality department, these two staffers are focused on improving quality outcomes for the hospital as well as physician report cards by reviewing elements of patient safety indicators such as deep vein thromboses, pulmonary embolisms, iatrogenic pneumothorax cases, and accidental punctures and lacerations.

Yale New Haven has had a CDI program in place for 12 years, and prior to implementing this new role had been focused on a review of principal diagnoses and complications and comorbidities (CC) and major complications and comorbidities (MCC) capture. It also transitioned from reviewing Medicare patients only to all-payer review.

"Many CDI departments are looking for the 'next step,' i.e., how to expand the impact of CDI beyond DRG validation and leverage the expertise many CDIs possess, particularly those with a clinical background," says Cheryl Ericson, MS, RN, CCDS, CDIP, CDI education director for HCPro, Inc. and associate director of education for the Association of Clinical Documentation Improvement Specialists (ACDIS). "CMS quality metrics are an ideal fit with CDI because it encourages physician engagement, [as physicians] are often more concerned with profiling than reimbursement, and [CMS metrics] incorporates the patient care aspect of documentation."

An example of this emerging CDI-quality connection and its relationship to clinical care is the 1,069-bed NYU Langone Medical Center in New York City, NY. A few years ago NYU created hard stops for coders on hospital-acquired conditions (HAC) cases, meaning that if a condition triggers a HAC, the case is flagged and the coder cannot release the bill. Instead, the case is referred to a coding manager for a second review. If additional clarification is needed, CDI is engaged. If CDI determines that the case is a HAC, it is then sent to the department of clinical quality and effectiveness (CQE). If that department does not agree, additional discussion and follow-up is required.

Langone follows a similar review process for patient safety indicators and also has created a CDI-coding liaison position—a foreign trained physician and certified coding specialist who reviews all hospital-acquired conditions and patient safety indicator (PSI) 90 cases and works closely with the department of clinical quality effectiveness. This liaison validates coding

and educates coders and CDI specialists on the subject of patient safety indicators. The liaison also queries as needed or, if the case was previously reviewed by a CDI specialist, discusses the case and requests a query by the original reviewer.

CDI's New Core Competencies

In response to these changes, ACDIS issued a job analysis survey to its more than 2,300 holders of the certified clinical documentation specialist (CCDS) credential. The survey asked CCDSs to both confirm their current job functions and knowledge bases, as well as gauge their knowledge of the "Impact of Reportable Diagnoses on Quality of Care," a proposed new category for the CCDS exam.

Some 277 respondents completed the survey, with a more than 10 percent response rate. Respondents to the survey were asked to rate on a scale of 0-5 the importance of a series of tasks and areas of knowledge related to CDI practice. The scale was as follows: 5 = extreme importance, 4 = above average importance, 3 = average importance, 2 = below average importance, 1 = minimal importance, and 0 = not important.

CDI specialists operating in this new quality of care arena are now expected to perform the following functions and/or maintain a working knowledge of the following quality-based initiatives. Each of these 10 quality items rated a 3.5 or higher on the survey, indicating that they are now considered average to above average importance for a CDI specialist to know:

1. Demonstrate knowledge of the significance of documentation and code assignment upon mortality index
2. Demonstrate knowledge of mortality reviews and interpreting observed/expected ratios
3. Define how quality data is acquired through both record abstraction and claims data
4. Explain the significance of these different types of quality metrics used by CMS:
    - Hospital value-based purchasing
    - Hospital-acquired condition reduction programs
    - Hospital readmissions reduction programs
    - 30-day mortality measures
5. Analyze the financial impact of the Hospital Inpatient Quality Reporting Program on an organization, and the role of CDI regarding this CMS quality initiative
6. Demonstrate an understanding of CDI impact on documentation and code assignment in relation to hospital value-based purchasing
7. Identify components of PSI 90 and its impact as a quality measure
8. Identify other patient safety indicators beyond or in addition to PSI 90 and their impact as a quality measure
9. Identify coded data elements that can impact the reporting of patient safety indicators in regards to Medicare claims
10. Compare and contrast hospital-acquired infections (HAI) from documentation that supports the assignment of a "complication code"

CDI Specialists Must Know Quality Metrics

The results of this survey clearly indicate that new CDI specialists entering the field must be well-versed in quality metrics and the basics of performing a chart review that includes patient safety indicators, hospital-acquired conditions, mortality measures, and readmissions.

"It [the survey] reflects the expansion of the CDI profession beyond its coding origins as precise documentation is required to accurately capture the complexity of healthcare through coded data," Ericson says. "As CMS continues to move healthcare towards a less segmented process, CDI can be the 'glue' that creates cohesion between the complicated clinical world of healthcare and the binary world of coded data."

Brian Murphy (bmurphy@acdis.org) is the director of the Association of Clinical Documentation Improvement Specialists.

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