A Guide to CDI

AAPC National Conference 2013
Let patient centric, patient driven, patient quality of care guide needs
Objectives

- Identify the Purpose of an effective CDI program
- Understand the Needs and Impact
- Develop a ‘team’ concept
Program Needs

- Comprehensive reviews, on-going reviews, retro reviews
- Training
- Tracking
- Daily Interaction
- Interactive Queries
- Coding Involvement
- Measure Impact
CDI Program

- Program Staff
- Program Objectives

**Quality Driven**
- BOTH CRITICAL TO SUCCESS

**Finance Driven**
- CDI ≠ CMI

- Instill Accountability
  - Set Expectations
  - Monitor
  - Review Progress
- Improve Physician Compliance
Successful Program

- Production and Accuracy Measures
- Performance Metrics
- Tracking tools
- Consistent data
- Key Performance Indicators
## Quality vs. Finance

### Quality
- All charts accurately capture all services rendered to the patient
- Documentation provides a clear clinical picture of the patient
- Documentation allows for clear communication between providers for continuity of care
- All cause and effect relationships of disease processes are captured
- All notes are legible, timely, and authenticated

### Finance
- All codes are accurately captured to the highest degree of specificity
- Admitting diagnosis is appropriately captured
- Primary diagnosis is accurately captured based on ‘after study’ the main reason for the hospitalization
- All co-morbidities and complications addressed are appropriately captured
- Allowing accurate DRG to be paid

Appropriate reimbursement based on the correct DRG for the patient is imperative; but quality documentation allows for quality patient care, not just potential financial gains.
Communication

CDI

Finance  Quality  Physicians
Focus and Energize

- All players must be engaged
- Must focus on both quality and finance, as both are critical
- Evolution of auditors: RACs, ZPICs, CERTs, RADVs have put pressure and emphasis
  - Documentation not all about the money
- Quality of documentation supports quality of the patient care
Center of Multiple Functions

- Quality
- Safety
- Medical Necessity
- Coding Impact
- Length of Stay
Chart

- The medical record is a legal document that is required by law and regulatory bodies.
- Communication vehicle for healthcare providers.
- Tells the patient’s story:
  - Tells the health status, severity, and medical needs of the patient.
  - Tells the quality care provided.
- It is used for implementing quality-improvement initiatives, determining appropriate level of care, and research and education.
- It also is the most credible evidence in a legal proceeding. Inaccurate or incomplete documentation can mean lead to risk and exposure of the provider and the facility.
Translation

Clinical Language

• Physicians focus on cause but often make inferences which do not translate to coding

Coding Language

• Can’t make assumptions
• Can’t determine relationships between disease processes
• Can’t interpret labs or utilize to determine code
Physician Involvement

- Must have buy-in from the physicians
  - supportive-engaged-accountable
- Need physician advisor/champion
- Best form of physician education is physician involvement
- The medical staff most closely linked to a particular condition should assist in determining best clinical indicators and best and most appropriate queries
Create the TEAM

- Administration
- Physician
- Utilization Review or Case Management
- HIM (Coding)

Need to understand the philosophy of the program and the rationale
Benefits

♦ What’s in it for me?
  ♦ Documentation peer-to-peer communication
    ▪ Can identify what has been done, why, thought process-continuity of care
  ♦ More accurate Case-Mix Index
    ▪ Patient population based on publicly available quality data, if data not accurate, information not accurate
  ♦ Quality scores improve with better accuracy of treatments, severity, acuity
Physician Needs

- Accountable to Attention to Detail
  - Both on the diagnostic side and the procedure side
    - Renal Insufficiency
    - Respiratory Insufficiency
    - Heart Failure
    - Pneumonia
    - Anemia
    - Debrided wound
    - Lysed Adhesions
Differentials

- Justifies medical necessity
- Helps meet standard of care
- Opens the door to better coding
- Helps with continuity

IMPACT ON PATIENT CARE AND QUALITY
Needs to Achieve

- Healthcare is a team effort
- There is no down side to better documentation
  - Nonspecific documentation leads to nonspecific coding of the medical record
    - True severity of illness, mortality rate, and intensity of service goes un-captured
    - May not accurately capture the case-mix index
    - May not accurately capture the true acuity of the patient’s being served
    - May not accurately identify the true mortality risk if patient’s severity not accurately captured
    - The lack of specificity in documentation affects the quality of patient care, compliance risk, data integrity, and reimbursement
Staffing Determinations

- Resource Driven
- Ratio Driven
- Input Driven
Query Needs

✔ Physician involvement
  - Concurrent queries
  - Clarify common problems
  - Ongoing help
  - Retrospective queries
  - Measure responses and percentage of agreement to determine efficacy of queries
Set Target Goals - Measure

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
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<tbody>
<tr>
<td>Total Charts</td>
<td>6.2</td>
<td>14.4</td>
<td>33.1</td>
</tr>
<tr>
<td>Query</td>
<td>.3%</td>
<td>1%</td>
<td>25%</td>
</tr>
<tr>
<td>Response</td>
<td>58%</td>
<td>82%</td>
<td>93%</td>
</tr>
<tr>
<td>Agree</td>
<td>61%</td>
<td>84%</td>
<td>93%</td>
</tr>
<tr>
<td>DRG Change</td>
<td>.3</td>
<td>.7</td>
<td>1.5</td>
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</table>
Targets

- Determine the most likely ‘return on investment’ both from known problem areas and known documentation risk areas
  - Return on investment can be increased DRG payment
  - Return on investment can be reduced risk on RAC or other third-party audits
  - Return on investment can be found making best use of staff time

All will not find a higher weighted DRG or have a potential impact on the Case-Mix Index; but if you ‘plug a hole’ in poor documentation practices it may protect your facility from RAC auditors and paying back money + fines
Top Five Common Findings

- Congestive Heart Failure
  - Acute or Chronic or Acute on chronic
  - Systolic, Diastolic, combination

- Sepsis
  - Severity
  - Sepsis, Severe Sepsis, SIRS, UTI, Bacteremia

- Renal Failure
  - Acute or chronic or acute on chronic
  - State of kidney disease (stage, supported by labs, etc)
  - Failure vs insufficiency

- Pneumonia
  - Organism?
  - Aspiration
  - Simple vs. Complex

- Respiratory Failure
  - Acute or Chronic; acute on chronic
  - Insufficiency; distress; failure

Specificity is KEY
Measure

- Benchmarking
- Population health management
- Risk management
- Severity, acuity, case-mix index
- Comparability
  - Not just reimbursement
Meaningful Use and EHR technology drives the tools of documentation; however, the HUMAN involved (physician, ancillary staff) drive the quality, specificity and depth of the documentation.

EHR’s do NOT solve the problems, although when used correctly can improve documentation:

- Copy and Paste
- Copy Forward
- Nurse note reviewed
- See meds
- PSFH reviewed

- Type of non-specific and ‘cloned documentation’ can increase risk and prevent accurate picture of each individual and unique patient.
Added Benefits

- ICD-10 Awareness—*Don’t instill FEAR, instill knowledge*
- ICD-10 Readiness
  - One of the keys to ICD-10 is improved documentation by the physicians to allow for capture of the most correct and most specific code
  - Increased specificity is built into the coding system
    - Laterality
    - Severity
    - Relationships
ICD-10 Example:

Procedure Code Structure: In ICD-9-CM: Lithotripsy 98.51: Extracorporeal shockwave lithotripsy of the kidney, ureter and/or bladder

<table>
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<tr>
<th>OTF4ZZZ</th>
<th>Lithotripsy</th>
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<tr>
<td>Section</td>
<td>Body System</td>
</tr>
<tr>
<td>O</td>
<td>T</td>
</tr>
<tr>
<td>Medical</td>
<td>Urinary</td>
</tr>
</tbody>
</table>
ICD-10 Example 2

Today: Patient presents for closed greenstick fracture of right radial shaft:
in ICD-9-CM:

813.21 Fracture of radius and ulna; shaft, closed radius (alone)

<table>
<thead>
<tr>
<th>S52.311A</th>
<th>Greenstick fracture of shaft of radius, right arm, initial encounter for closed fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Root</td>
<td>Root</td>
</tr>
<tr>
<td>S</td>
<td>5</td>
</tr>
<tr>
<td>Injury, poisoning and certain other consequences of external causes</td>
<td>Injuries to the elbow and forearm</td>
</tr>
</tbody>
</table>
Future is NOW

- PPACA (Patient Protection and Affordable Care Act) – Obamacare
- VBP (Volume Based Purchasing)
- Pay for quality or pay for performance, not volume
Keys to Success

- Define the program
- Set up an invested task force or committee with clearly defined roles and goals
- Clearly defined work-plan and assignment of responsibility
- Good analysis of severity of Case-Mix index and risk of mortality index to determine true picture of patient population
- Implement best possible communication, feedback and education
- Incorporate CDI into quality initiatives
- Success depends on cooperation
  - CDI initiatives that run smoothly not only provide better information that can be used for a variety of purposes, but also promote cross-departmental collaboration between CDI, concurrent review, compliance review, and performance improvement efforts. “With this sharing of information is where you start really seeing gains being made”