Outpatient CDI

More than 18% of survey respondents focus on HCC capture and more than 17% focus on denials prevention on both the inpatient and outpatient sides of their CDI program.

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As CDI has expanded from the inpatient to the outpatient space, questions regarding workflows, solutions, technology, and interdepartmental collaboration have also cropped up. If outpatient expansions are to be successful, these topics and their thornier aspects require further investigation, even if the work only reveals partial illuminations rather than definitive answers. The Association of Clinical Documentation Integrity Specialists' (ACDIS) recent CDI Leadership Council survey, produced in partnership with Solventum, explored respondents' focus areas within outpatient, conducting outpatient reviews, outpatient technology, metrics, and tracking, as well as navigating the lack of outpatient technology.

Several Council members were then asked to take a closer look at the survey data and discuss how CDI leaders and specialists can best address these topics and provide for the most efficient solutions in the outpatient domain. The following is a review of the results and a summary of the discussion.

Settings reviewed, plans to expand

According to the survey, just over 15% of respondents currently review physician practice/clinics/Part B services, followed by 12.25% who review medical necessity of admissions and 10.60% who review emergency department records. The outpatient areas with the most growth potential were observation stays and medical necessity, with 12.25% and 8.94% of respondents, respectively, planning to review these services in the next 12 months. (See Figure 1.)

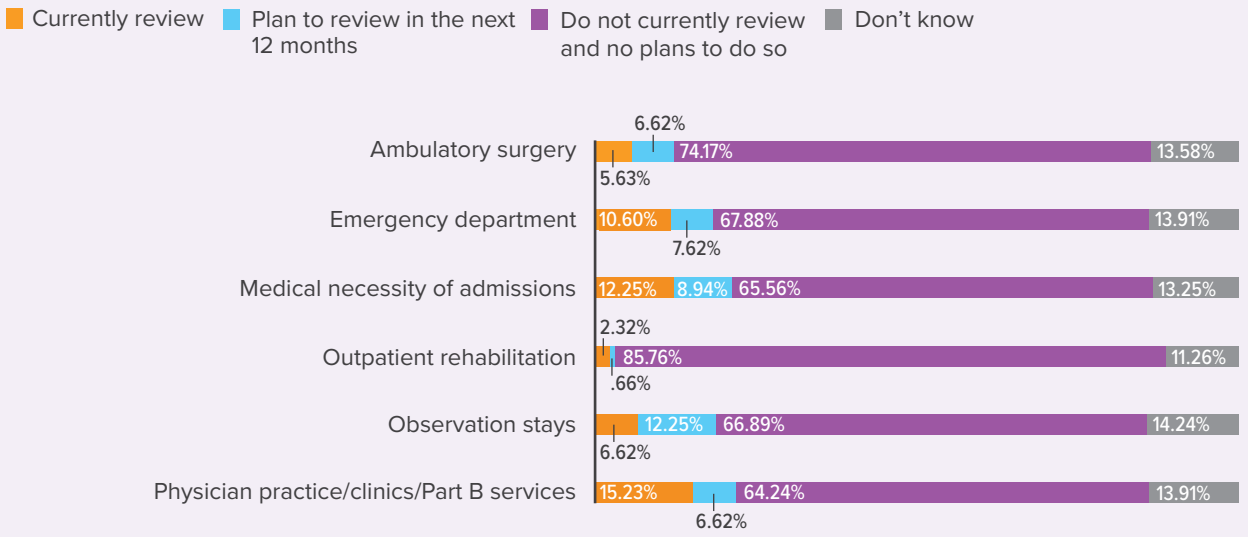
Outpatient program nuances, as well as their origin stories, are varied and—in many cases—are determined by the needs of the health system at any given time.

For instance, many outpatient programs, like the one at West Virginia University (WVU) Medicine, have nestled themselves in more common areas like ambulatory primary care: "We do prospective reviews, focusing on RAF [Risk Adjustment Factor] scores and HCCs [Hierarchical Condition Categories]. We try to close those gaps and send those messages as soon as possible to those providers," says **Tanna Lambert, RHIA, CCS,** the outpatient CDI manager, enterprise information management, at WVU Medicine in Morgantown, West Virginia.

On the other hand, some "nontraditional" outpatient programs have taken a more unconventional path. **Mary Alice Dewees, BSN, RN, CCDS, CRC**, director of CDI at Hartford HealthCare in Hartford, Connecticut, explains how her outpatient program came to be in the ambulatory surgery space: "We were asked to come into our bone and joint institute because they felt that their data was lacking and, because we had success in that area, we were asked to expand to the preoperative testing center for all different surgeries, not just the orthopedic surgeries."

For those seeking to expand into areas such as observation and medical necessity, some programs may possess an internal department structure that already handles this information, rendering

Figure 1: Settings reviewed, plans to expand



the services of CDI unnecessary. For example, WVU's CDI department has no need to expand, as the system has a dedicated utilization review/management (UR/UM) department that handles observation and medical necessity already.

However, those systems that do not have dedicated departments for reviews of observation cases and medical necessity—and that have also expanded into the outpatient realm—tend to be well established in terms of inpatient staff, workflows, and processes. According to Dewees, programs seeking to expand into these outpatient areas should, therefore, focus on cultivating the necessary CDI staff/skill sets for the job, focusing on education as the first step.

"I would say that what you really need to do is to carefully evaluate the skill sets of the folks that want to do these reviews," she says. "We have had UM nurses come forward that, though they were very highly experienced clinical nurses, they did not have the CDI knowledge that they needed to understand how documentation was affecting their medical necessity and their leveling of care."

Getting physicians on board early is also an important step for an outpatient program. Being able to document to the highest level of specificity possible is a skill that will be "applicable across all places of service," says **Kristen Viviano, MHA, CPC, CRC-I**, a product manager of outpatient CDI at Solventum in Albany, New York. Focusing on improving the continuum of care demands that such education be consistent, so that providers are best equipped to generate accurate and compliant documentation across all settings.

Review focuses

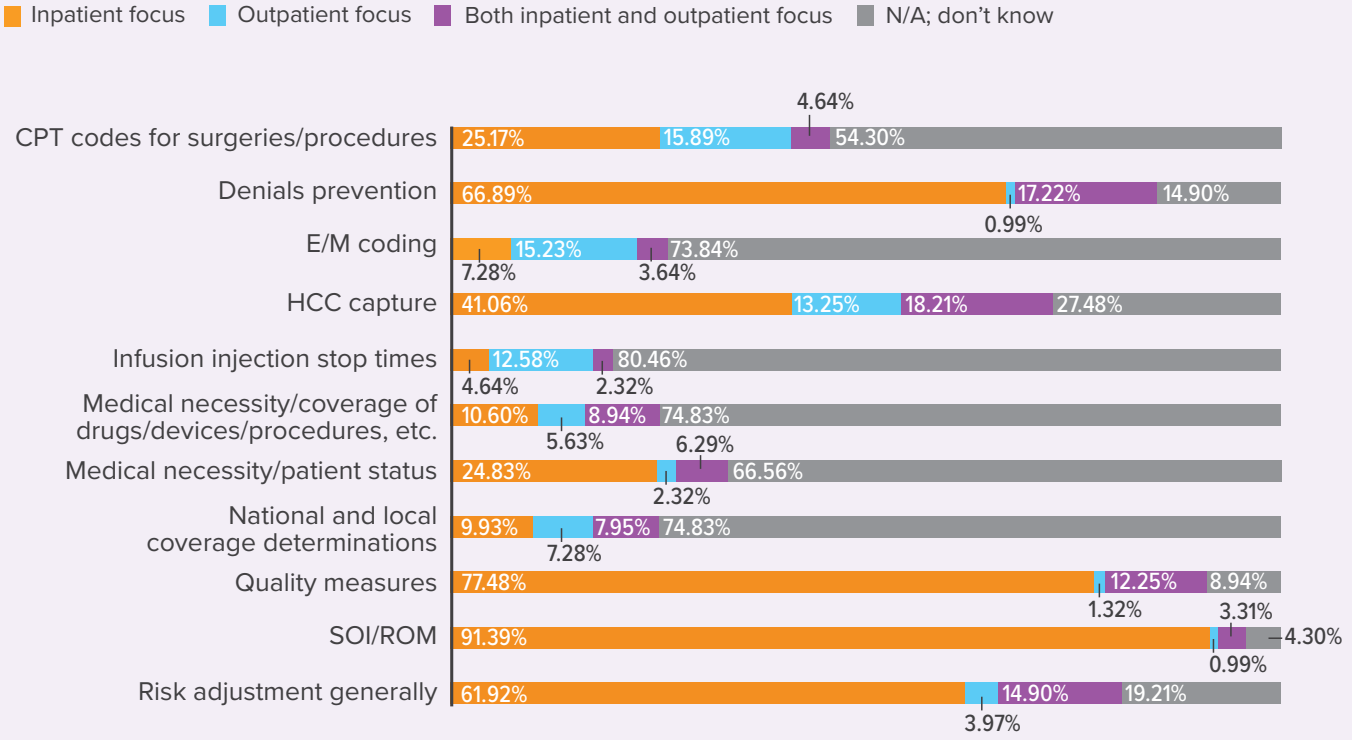
According to respondents, the most common focus areas for outpatient reviews were Current Procedural Terminology (CPT®) coding, evaluation and management (E/M) coding, and HCC capture with 15.89%, 15.23%, and 13.25%, respectively. More than 18% of respondents also said they focus on HCC capture and 17.22% said they focus on denials prevention on both the inpatient and outpatient sides of the house. (See Figure 2.)

The prevalence of those three focuses—CPT codes, E/M coding, and HCCs—is, in many ways, unsurprising: These are typically the areas where return on investment (ROI) can be best demonstrated.

"When you're looking at CPT coding, E/M coding, you want to make sure that you're correctly capturing the financials as well as being compliant," Dewees says. "Those two issues do go hand-in-hand, and then when we start talking about HCC captures and appropriate risk adjustment [...] it does, in some ways, come down to protecting the organization from a financial standpoint, as well as protecting the organization from a compliance standpoint."

In addition to these review focuses making logical sense, they have typically been the starting place for many outpatient programs. For Viviano, the emphasis

Figure 2: Review focuses



on HCC capture in particular has long been a part of outpatient CDI conversations. "Historically, we've seen a lot of HCC review, and that's kind of been where it's been expanding from our side," she says. "We have customers using HCC reviews who expand into the outpatient CDI space that way, by adding inquiry concepts on those outpatient things."

Viviano also explains that many of the payment structures in the outpatient space drive the focus on HCC capture. Recently, more and more payers have switched to value-based payments, which focus explicitly on the health status and the risk score of the patient. Hence, many organizations are homing in on recent E/M changes and ensuring that HCCs are being coded correctly.

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—Mary Alice Dewees, BSN, RN, CCDS, CRC
CDI Director, Hartford HealthCare

As such, for those currently determining their area of focus in the outpatient space, it is important to assess what leadership is looking for (i.e., where the health system's biggest opportunity for ROI is) and then analyze the areas of risk in the patient population. Pursuing an area of focus that fulfills these conditions will allow systems to ensure quality outcomes for the patient and positive financial outcomes for themselves.

Nevertheless, it is important to ensure that all the resources are available to undertake such a project. "I always want to look at bandwidth, technology, and sustainability because I don't want to make promises that I don't have the staffing, ability, or technology to really follow through on," Dewees says.

Technology and consultant use

Most CDI programs do not have technology specifically for outpatient efforts, according to the survey. In fact, many programs share technology between their inpatient and outpatient reviews: 20.86% said they have electronic groupers, 16.89% said they have electronic querying, 16.23% said they have internally developed EHR modifications, and 15.23% reported they have computer-assisted coding (CAC) on both sides of the house. (See Figure 3.)

Though computer-assisted physician documentation (CAPD) is becoming more common on the inpatient side (20.86% of respondents reported they have that technology for their inpatient reviews), still less than 2% total have access to the technology on the outpatient side.

The paucity of outpatient technology can largely be explained by the relatively recent emergence of outpatient CDI. Since outpatient hasn't been around as long as inpatient, it would make sense that much of the preexisting technology would be geared toward the inpatient setting, infrastructure, and requirements.

"Inpatient has just been around for so much longer, leaving much more time for solutions to be built, then also for necessary performance and tweaks to allow for new and different processes. The technology for outpatient CDI is still very new and emerging, which is challenging because solutions might have kinks that need to be worked out," Viviano says.

As for why the inpatient technology cannot simply be applied to the outpatient setting, it's a question of capturing the right nuances: The outpatient technology needs to be able to report on what matters most in the outpatient setting. In both settings, for instance, RAF scores, HCCs, denials, and clinical validation will be important; however, inpatient technology doesn't necessarily include tools for assessing things like E/M, CPT codes, and provider patterns, which are all critical for understanding the dynamics of the outpatient setting.

Sometimes, customizing tools can be an option, but it is vital to determine a set of clear requirements ahead of time so that workflows can be kept smooth post-implementation. For example, according to Viviano, if a CDI department wanted to build out a dashboard or summary view, it would need to maintain a balance between providing access to the full spectrum of data and over-encumbering the user.

"What you need to see, how you want to see it—really scope it out ahead of time, and then you can go into those meetings with the IT department or your vendor and have those conversations around, 'This is what I need, can you do it?' " she says.

Unfortunately, in many cases, the requirements of an outpatient technology will exceed that which inpatient can provide. Modifications of preexisting technology can sometimes work, but only if the right tools are available in a health system's electronic medical record (EMR): "It's difficult to take an existing technology that has been built for one thing and morph it into something that's looking at something close but not exactly the same. It depends on your EMR and your tools that you currently have, and what it's already set up to do," Lambert explains.

Figure 3: Technology and consultant use

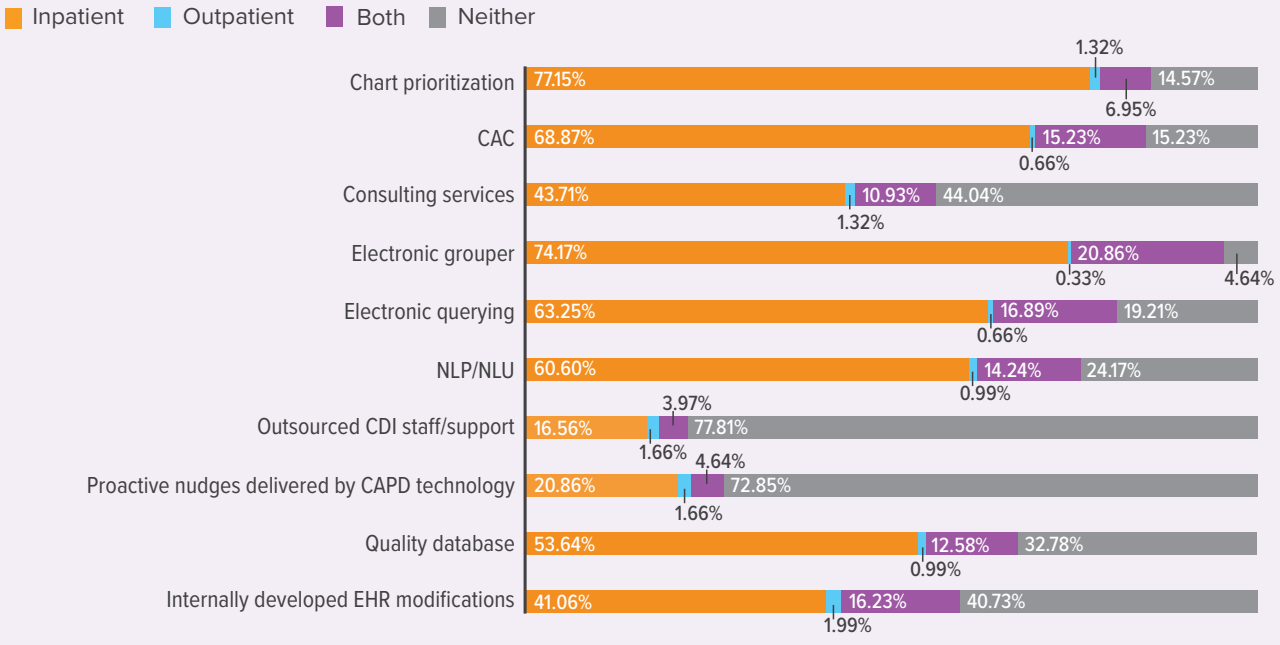
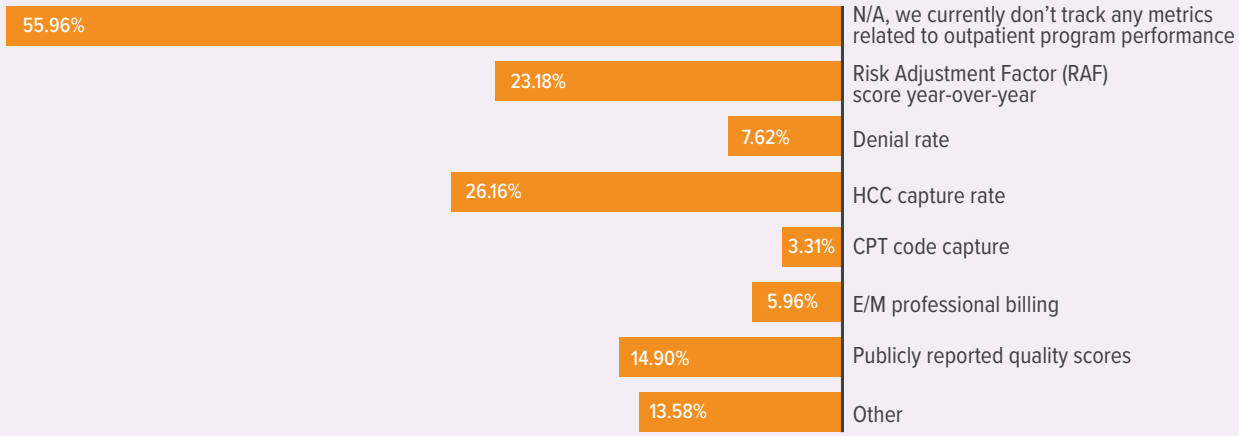


Figure 4: Metrics for outpatient ROI



Selected "other" responses:

- Vizient mortality scores and ranking improvements
- Unsure
- Currently creating program
- Case-mix index (CMI) and CMI plus length of stay
- CC/MCC capture
- Financial impact

Nevertheless, one "semi-success" has occurred at Hartford HealthCare, where Dewees' team has been able to leverage inpatient technology to identify patients for review, develop a work list, and create compliant query tools. "There are some things you can look at and make modifications with what you have," she says. "You just have to really work with your vendor to see if they can help you." When in doubt, Dewees adds, it's never a bad idea to solicit best practices from other organizations across the country with like features.

Metrics for outpatient ROI

More than 26% of survey respondents said they use HCC capture rate and 23.18% said they use their RAF score year-over-year to show their outpatient ROI. Additionally, only 5.96% and 3.31% use E/M professional billing and CPT code capture, respectively, to show their impact. (See Figure 4.)

In an ideal world, CDI departments would receive all the material and personnel necessary to support their work; however, as Dewees notes, this is not an ideal world.

"From an organizational perspective, it's about ROI, and in challenging times—which we have been in challenging economic times for almost 15 years now—preventing revenue leakage and understanding regulatory requirements become a really big piece that organizations want to know about," Dewees says.

Though determining which metrics to track can be a challenge because of how many metrics there are, it is important to communicate with leadership to understand which aspects they want to see over time and what will give the best picture of a CDI department's financial development.

However, some metrics have a time scale that make them difficult to simultaneously track over time, connect to ROI, and showcase to leadership. For example, RAF score is typically measured and reported over a long period of time. Therefore, it is critical to be in constant communication with leadership about expectations and to provide year-end data and month-to-month data to demonstrate local and global progress.

"I think we focus a lot on what the year-end data is—so if it is the second month of the year, it's hard to show what to project where we'll be at the year end. So you look at the past couple of years to show the increase of that, and then the progression from month to month in order to say, 'Here's where we are in this month, as opposed to where we were this month of last year,' " Lambert says.

Tracking outpatient impact

As noted previously, many health systems do not have access to outpatient tracking technology. According to the survey, the largest percentage (just over 15%) said they manually track their impact using a spreadsheet,

8.61% said they rely on feedback from payers and their accountable care organization (ACO), and 5.63% said they use an internally developed tool from their IT department. (See Figure 5.)

A large portion still said they do not have a way to track their outpatient impact, though many of the free-text comments mentioned that their tracking is combined with their inpatient CDI efforts or that they simply don't review outpatient records.

For those who find themselves in that category, Lambert recommends asking the health system for resources that may assist in the process of manual tracking.

"It takes a lot of time to be able to run these reports and put all these things on a spreadsheet. Possibly make a dashboard on an Excel® spreadsheet and report from your EMR. A lot of those EMRs have those [reports] embedded in," Lambert says. "So, find that support from those resources, pull the right data elements that you need, and utilize someone who will be able to put that into a centralized place."

Creating templates to limit options in Excel can also be helpful, according to Viviano: "If you do have to use Excel, limit the variety of responses through templates. It sounds like a really small thing and really nitpicky, but having to consolidate from a capital 'Y' to a lowercase 'y,' to a capitalized 'Yes,' to a lowercase 'yes'—that's four different values, all meaning the same thing. It can be really time consuming," she says. "I think having templates can really help with that."

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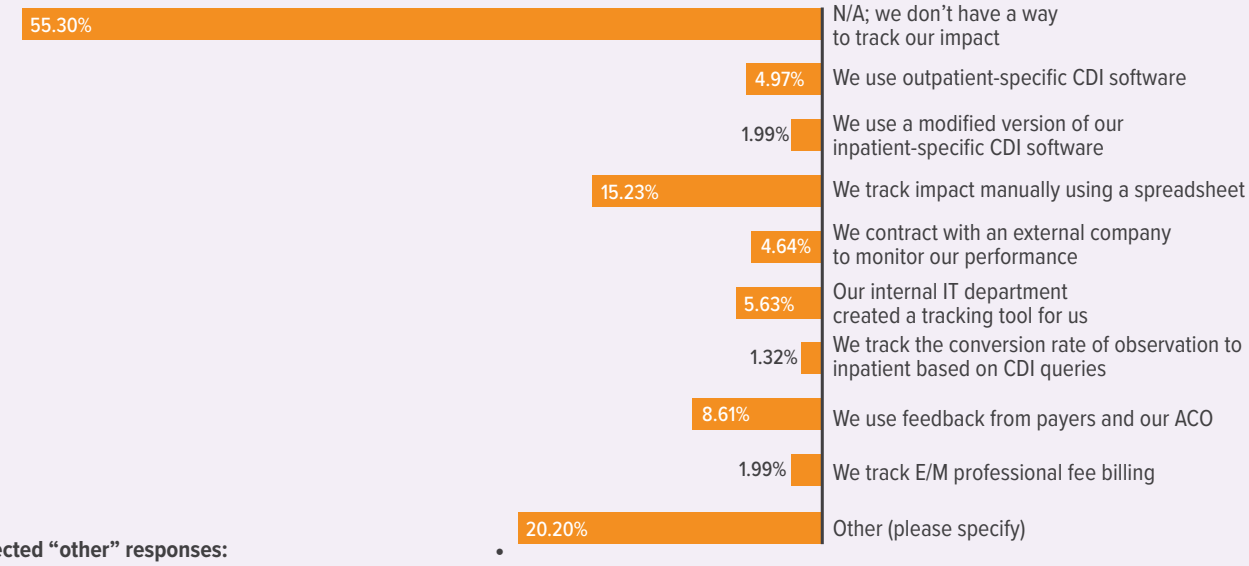
CDI Manager, WVU Medicine

After choosing the means and methods for tracking and reporting, it is critical to institutionalize them and to share them throughout the organization, Dewees suggests.

"Once you have something that's working for you, coach and mentor a small group of people on your team to do it as well as they possibly can and become the subject matter experts," she says. "It makes it a lot easier if you can go to that small group of people that really understand the data, the process, and who can also put out reliable reporting." ■

Figure 5: Tracking outpatient impact



Selected "other" responses:

- No outpatient program
- EHR database
- Tableau reports