Clinical Documentation Improvement: Measures, Models, and Multi-facilities

Tuesday, June 4, 2:30 pm

Participants in this session will learn how to maximize the value of a Clinical Documentation Improvement (CDI) program with reporting in Midas+, how to reliably measure staff productivity, and how to monitor program return on investment. This session will also explore various CDI program models and learn how a multi-facility organization utilizing a single Midas+ database can produce meaningful data, even with differing CDI models designed to meet the needs of the individual facilities.

CEU: NAHQ

Presented By:

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Wexner Medical Center
Clinical Documentation Improvement

Measures, Models, and Multi-facilities

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Business Analyst
The Ohio State University
Wexner Medical Center

Objectives

• Compare and contrast Clinical Documentation Improvement (CDI) program goals, reporting structures, staffing models and Midas+ support of the CDI process.

• Define a report to measure productivity for the Clinical Documentation Specialist (CDS) and monitor Return on Investment (ROI) specific to a CDI program.

• Review the challenges of a multi-facility site that incorporates different reporting structures and staffing models; discover how they were able to retain CDI documentation in Midas+ and how they demonstrate the program’s value.
History of the Medicare Inpatient Prospective Payment System (IPPS)

1983 Medicare inpatient claims paid based on CMS-DRGs
- appropriate reimbursement for services rendered
- accurate reflection of expected cost of treatment

2007 Medicare Severity DRGs (MS-DRG)
- considers severity of illness and resource consumption

2008 Present on Admission (POA)
- distinguishes conditions that are present on admission vs. those that were acquired while in the hospital

IPPS Proposed Rule (FY 2014)

- Hospitals will see a net increase of 0.8% in payments. Some MS-DRG weights increased, while others decreased. Review the relative-weight change tables included in the proposed rule.

- Facilities still face a negative 0.8% recoupment adjustment under the Documentation and Coding Adjustment, and CMS expects to make similar adjustments in FY 2015, 2016, and 2017 in order to recover the full $11 billion mandated in the American Taxpayer Relief Act of 2012.

  - “Any ‘improvement’ in a facility’s case mix index with clinical documentation and coding integrity is a truer reflection of their patient’s actual resource intensity in contrast to the ‘under-documentation’ that occurred prior to MS-DRGs.”

  - “Even so, I believe that hospitals and physicians, as well as the entire healthcare delivery system, benefits in their partnership to consistently define, diagnose, and document conditions and treatments as to deploy clinically congruent ICD-9-CM codes essential to MS-DRGs and in their preparation for ICD-10-CM’s impact as well.”

James S. Kennedy, MD, CCS, CDIP, managing director of FTI Healthcare
4/26/13
Why hospitals implement CDI

- Revenue enhancement
- MS-DRGs
- Performance on public health measures (HealthGrades, HospitalCompare, The LeapFrog Group, state report card, etc.)
- The Recovery Audit Contractor program
- Other

Source: HCPro’s January 2011 Clinical Documentation Improvement program survey

Structure for Success

CDI Program Success

- Strong Administrative Support
- Consistent Provider Participation
- Defined Program Processes
- Concurrent Analysis & Clarification
- Retrospective Analysis & Clarification
5 Attributes of a Formal CDI Program

1. Staffed appropriately
2. Primary focus on accurate DRG capture
3. Focus chart reviews on all prospective payers
4. Develop robust tracking capability to insure accuracy and accountability
5. Bolster query compliance with physician education with clear goals and expectations

Egan, M (2011)

CDI Program Objectives

• Identify and clarify missing, conflicting, or nonspecific physician documentation related to diagnoses and procedures
• Support accurate diagnostic and procedural coding, DRG assignment, severity of illness, and expected risk of mortality, leading to appropriate reimbursement
• Promote health record completion during the patient's course of care
• Facilitate communication between physicians and other members of the healthcare team
• Provide education
• Improve documentation to reflect quality and outcome scores
• Improve coders’ clinical knowledge
CDI Impact – Direct & Indirect

- Compliance with patient safety initiatives
- Profession (e.g., physician) reimbursement
- ICD-9 & ICD-10 diagnosis & procedure code assignment
- DRG assignment
- Severity of illness & risk of mortality scores
- CMS quality measures (core measures) reporting accuracy
- Facility efficiencies, value, & quality outcomes in the delivery of healthcare
- Medical necessity of appropriate level of care (e.g. OBS or IP)
- Physician & hospital profiles of publically reported data
- Claims data used in CMS initiatives: readmission reduction & VBP program

CDI Program Priorities

- CC/MCC capture & DRG optimization
- Focused reviews (e.g. Service lines; Target DRGs)
- Overall Case Mix Index (CMI) improvement
- Severity of Illness (SOI) / Risk of Mortality (ROM) improvement
- Quality measures collection
Set Reasonable Goals

- All DRG payers
- 80% of Major Disease populations
- 30-35 charts reviewed per reviewer per day
  - 25% with queries, and
  - 85-90% with Physician response
- Improve CMI by .15
- Improve documentation to reflect quality & outcome scores
- Start small…..

CDI Staffing Models

**Staff**
- Case Managers
- Coders
- Quality Data Abstractors
- Clinical Documentation Specialists
- Advanced Practice Nurses
- Physicians

**Departments**
- Health Information Management
- Case Management
- Quality
- Compliance
CDI Staffing

Determine staffing needs (basic):

\[
\text{# of hrs worked / year / CDS} \\
\text{time to perform average review}
\]

Formula to determine Full-Time Equivalents (FTE):

\[
\text{# reviewable pts admitted in fiscal yr} \times \text{X # of hrs to perform average review} \\
\text{total number of CDI work hours}
\]

Use of time studies

ACDIS – CDI Roadmap

CDI Case Selection

Payers
- Medicare
- Medicaid
- All payers

Service Line
- Cardiology
- Oncology
- Surgery

Diagnoses/Procedures
- Cardiac Interventions
- Excisional Debridement
- Heart Failure
- Renal Failure
- UTI / Sepsis
- COPD

Physician

Unit Based

…and others
Measuring Productivity

**Recommendation:**
Individualize and base these measures on your department’s structure and goals

**Variables affecting productivity:**

- Experience level of staff - (specialization vs. rotate)
- Additional staff responsibilities - (PI, CM)
- Type of Medical Record – (Electronic, Paper, Hybrid)
- Available Software – (Encoder, CDI system)
- Query process – (Paper, integrated with EMR)
- Provider relationships

CDI Collaboration

**Health Information Management / Coding**

- Ensure record provides complete & accurate clinical picture for coding
- Analyze audit data
- Work in collaboration with ICD-10 implementation
- Participate in joint education: IPPS / Coding Clinic

**Case Management / UR**

- Provide working DRG, GMLOS, anticipated discharge date
- Assist with establishment of medical necessity

**Compliance/Denials/RAC**

- Assist with internal reviews of RAC findings
- Monitoring process for MS-DRGs that are high risk for payment errors
CDI Collaboration (continued)

Providers

- Educate importance of documentation
- Educate ICD-9 vs CPT procedure codes & impact on core measures
- Round to help translate clinical findings
- Educate impact of documentation related to hospital & physician quality scorecards

Quality / Patient Safety / Nursing

- Assist with requirements of VBP
- Capture accurate expected mortality and/or acuity
- Alert healthcare team to quality of care issues
- Ensure correct assignment of POA indicators
- Assist accurate reporting of AHRQ Patient Safety Indicators (PSI)

Documentation Criteria

<table>
<thead>
<tr>
<th>Criteria for High Quality Clinical Documentation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legibility</td>
<td>Required by all government and regulatory agencies</td>
</tr>
<tr>
<td>Completeness</td>
<td>Abnormal test results without documentation for clinical significance (Joint Commission requirement)</td>
</tr>
<tr>
<td>Clarity</td>
<td>Vague or ambiguous documentation, especially in the case of a symptom principal diagnosis (e.g. Chest pain vs. GERD; Syncope vs. Dehydration)</td>
</tr>
<tr>
<td>Consistency</td>
<td>Disagreement between two or more treating physicians without obvious resolution of the conflicting documentation upon discharge</td>
</tr>
<tr>
<td>Precision</td>
<td>Nonspecific diagnosis documented, more specific diagnosis appears to be supported (e.g. anemia vs. acute or chronic blood loss anemia)</td>
</tr>
<tr>
<td>Reliability</td>
<td>Treatment provided without documentation of condition being treated (e.g. Lasix given but no CHF documented; KCL administered but no hypokalemia documented)</td>
</tr>
</tbody>
</table>

Russo, R (2010) CDI Achieving Excellence
The Documentation Difference

**Initial Documentation**
- Abdominal hysterectomy
- Age 72
- Weight 92 lbs
- Anorexic
- MS-DRG 743
  - Uterine & Adnexa Proc for Non-Malignancy w/o CC GMLOS 1.8
- RW 0.9079 = $4393

**Final Documentation**
- Abdominal hysterectomy
- Age 72
- Weight 92 lbs
- *Body Mass Index less than 19*
- MS-DRG 742
  - Uterine & Adnexa Proc for Non-Malignancy w/ CC/MCC GMLOS 3.2
- RW 1.3883 = $7219

CDI Program & Revenue Cycle

- Case Mix Index (CMI)
- Management of Recovery Audit Contractors (RAC)
- Quality Standards & Readmissions
- ICD-10
**CDI & RAC**

**Figure 3: RAC preparation focus areas**

- Inpatient medical necessity and one-day stays: 41%
- DRG validation: 16%
- Outpatient coding: 13%
- Appeals process: 11%
- Observation: 9%
- Three-day rule: 8%
- Other: 2%

*Source: HCPro’s RAC Preparedness Benchmarking Report, December 2010.*

**CDI & ICD-10**

**Figure 10: What is your biggest worry about ICD-10? (check all that apply)**

- Need for increased knowledge of medicine/pharmacology: 85%
- Unfamiliarity with new codes: 80%
- Different procedural coding rules: 45%
- Lack of physician documentation to support ICD-10 code assignment: 60%
- Other: 10%

ACDIS CDI Prep for ICD-10 Survey
CDI & ICD-10 (continued)

- Providers have limited understanding of how ICD-10s will affect them
- Impact will vary by specialty
  - ↑ for Orthopedics & Emergency Department
  - ↓ for Family Practice & Radiology
- Bottom Line - one size does not fit all for ICD-10 implementation
- Focus efforts on documentation improvement according to the needs of your organization
- Midas+ is ready! – install in your Test environment now!
- See Clients Only Website for current strategy

Ensuring Continued Success

- Involve the CDI team in medical necessity reviews
- Develop a CDI / Case Management collaborative process
- Expand CDI efforts into the outpatient setting
- Ensure CDI reviews of discharged weekend short-stay records
- Invest in continuing education
Midas+ and CDI

Using Midas+ Care Management

Efficient Computerized Workflow

- Automated Case Assignments
  - Complex rules-based logic
- Electronic Worklists
- Query Tracking
- ROI Data Capture
- Data Analysis & Reporting
CDI Site Parameters

- HCM CDI – Days Prior to Ignore
- HCM CDI – Days to Initial Review
- HCM CDI – Delete Discharge Reviews
- HCM CDI – Move up Future Pending Reviews on Discharge
- HCM CDI – Pending Review Assignment Permanent
- HCM CDI – Retain Future Review Date after Transfer
- HCM CDI – Retain Pending 1st Review on Discharge

Worklist Build

**Step 1:**
Define the CDI staff work assignment rules
- HCM-STAFF ASSIGNMENT RULES Dictionary # 172
Worklist Build (continued)

**Step 2:**
Assign, prioritize and activate rules per facility in CDI Staff Work Assignment Definition

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Worklist Build (continued)

**Step 3:**
Assign Rules to staff in CDI Staff Work Assignment
CDI Worklist – Display Options

- CDI-Goal DRG
- CDI-Init DRG
- CDI-Query Resp
- CDI-Query Subject
- CDI-Query Type
- CDI-Work DRG

<table>
<thead>
<tr>
<th>Patient</th>
<th>Status</th>
<th>Next Review</th>
<th>Admit Date</th>
<th>Location</th>
<th>CDI Init DRG</th>
<th>CDI Work DRG</th>
<th>CDI Goal DRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Riggs,Rebecca</td>
<td>Discharged</td>
<td>2/1/2011</td>
<td>3700 East</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MC/CD/Res/HC</td>
<td>COMPLETE</td>
<td>1/4/2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peacock,Robb</td>
<td>Discharged</td>
<td>1/27/2011</td>
<td>3100 East</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MC/CD/Res/HC</td>
<td>COMPLETE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>292 HEART FAIL</td>
</tr>
</tbody>
</table>

Working: Based on review of all information available in the MR at time of review, including lab results and other documentation that must be interpreted by the physician to be considered for coding.

Goal: Anticipated Final DRG based on clinical expertise and outstanding queries agreement.

Diagnosis: Principle and secondary diagnoses are entered to document the assessment and critical thinking that led to the capture of the initial, working and goal DRGs.

Procedure: Capture procedures confirmed in the chart and procedures with outstanding queries.
Generate Queries & Document Query Responses

Document Overall Outcomes

Weight Delta calculates difference between Initial, Working and Goal DRG assignments compared to Final DRG.
Reporting

ROI Metrics

- Overall CC Capture Rate
  - Medical & Surgical
- Query Volume
  - Response Rate
  - Agreement Rate
- Denial Rate
- Case Mix Index
- Review Volume
- Review Frequency
- DRG Match Rate
- Days in Accounts Receivable (AR)
Quantifying ROI

To compute the dollars gained as a result of CDI interventions, one practice is to multiply the difference between the initial DRG and the coded DRG Relative Weights by the hospital reimbursement rate.

To do this in Midas+, build a computed field at the CDI Series User Field level. The Weight should be the hospital’s Medicare Base Rate – this example uses $5000.

SmarTrack Indicator Profiles

<table>
<thead>
<tr>
<th>CDI REVIEWS BY REVIEW LOCATION</th>
<th>27800</th>
<th>31920</th>
<th>59720</th>
</tr>
</thead>
<tbody>
<tr>
<td>3100 East</td>
<td>11120</td>
<td>12768</td>
<td>23888</td>
</tr>
<tr>
<td>3100 West</td>
<td>8340</td>
<td>9576</td>
<td>17916</td>
</tr>
<tr>
<td>3300 East</td>
<td>8340</td>
<td>9576</td>
<td>17916</td>
</tr>
</tbody>
</table>

| TOTAL ENCOUNTERS WITH QUERIES | 20400 | 24320 | 44720 |
| TOTAL NUMBER OF QUERIES       | 31250 | 33450 | 64700 |
| RATE OF QUERY RESPONSES       | 95.0% | 85.0% | 89.8% |
| TOTAL NUMBER OF QUERIES IN AGREEMENT AND DOCUMENTED | 11875 | 14049 | 25924 |
| TOTAL NUMBER OF QUERIES DISAGREED | 1335 | 2002 | 3337 |
| RATE OF QUERY AGREEMENT       | 40.0% | 42.1% | 41.6% |
| CDI REVIEWS OUTCOMES - FINAL DRG MATCHED GOAL DRG | 9730 | 23940 | 33670 |
| CASE MIX INDEX (CPMS/DV)      | 1.55  | 1.68  | 1.81  |
| DAYS IN AR (Manual)           | 57    | 42    | 50    |
| TOTAL NUMBER OF DENIALS       | 125   | 152   | 277   |
SmarTrack Indicator Profiles (continued)

<table>
<thead>
<tr>
<th>CDI REVIEWS OUTCOMES - ADDTL COMORBID RETROSPECTIVELY</th>
<th>1390</th>
<th>1277</th>
<th>2667</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDI REVIEWS OUTCOMES - DISCREP IN POA ID BY CODER</td>
<td>556</td>
<td>638</td>
<td>1194</td>
</tr>
<tr>
<td>CDI REVIEWS OUTCOMES - POSITIVE FINANCIAL IMPACT</td>
<td>11120</td>
<td>17556</td>
<td>28676</td>
</tr>
<tr>
<td>CDI REVIEWS OUTCOMES - QUESTIONABLE QUERY</td>
<td>2780</td>
<td>957</td>
<td>3737</td>
</tr>
<tr>
<td>CDI TOTAL COMORBID CONDITIONS IDENTIFIED BY CDI SPECIALIST</td>
<td>19838</td>
<td>42875</td>
<td>62513</td>
</tr>
<tr>
<td>DISEASES/DISORDERS OF THE CIRCULATORY SYSTEM</td>
<td>5560</td>
<td>6384</td>
<td>9526</td>
</tr>
<tr>
<td>CDI TOTAL DIAGNOSES POA</td>
<td>18904</td>
<td>28728</td>
<td>47632</td>
</tr>
<tr>
<td>DISEASES/DISORDERS OF THE CIRCULATORY SYSTEM</td>
<td>3780</td>
<td>5746</td>
<td>9526</td>
</tr>
</tbody>
</table>

Other indicators...

**Volume**
- Initial reviews
- Follow up reviews

**Statistics**
- Total population
- Physician rates
  - Queries
  - Responses
  - Agreement
  - Disagreement
  - No responses

**Outcome Analysis**
- Count by Outcome Type
  - Coder to reviewer
  - Coding correction
  - Goal DRG met
  - Higher reimbursement
  - Increased severity
  - No change
Quantifying Results

### Case Mix Index Trending

Capturing higher acuity reflected in CMI
DataVision: Coding Analysis

Performance

<table>
<thead>
<tr>
<th>Opportunities for Improvement: Median/E25th percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PCI - % Readmit within 30 Days</td>
</tr>
<tr>
<td>2. PCI - % Readmit within 15 Days</td>
</tr>
<tr>
<td>3. Knee Replacement, Total - % Listed to O.R. (n=2)</td>
</tr>
<tr>
<td>4. SCIP Int Rate, Surgery, patients receiving temperature mgnt Oth Med Surg</td>
</tr>
<tr>
<td>5. Hip Replacement, Total - % Returned to O.R.</td>
</tr>
</tbody>
</table>

Special Cause Signals:

| 1. Emergency Department - % Length of Stay 6 Hours or More |
| 2. Emergency Department - % Discharged to Outside Acute Care |
| 3. Inpatient - Average Mean Length of Stay               |
| 4. Inpatient - Mortality Rate                           |
| 5. Acute Care - Average Mean Length of Stay             |

Area of Exemplary Performance: E25th/E25th percentile

| 1. SCIP Int - Appropriate hair removal (TIC ID 14187) |
| 2. SCIP Int - Duration Antibiotic Selection Overall (TIC ID 14188) |
| 3. SCIP Int - Average length of stay (TIC ID 14189) |
| 4. AMI - Angioplasty at discharge (TIC ID 14120)     |
| 5. AMI - Beta blocker prescribed at discharge (TIC ID 14121) |

Safety

Nare Event Occurrences:

| 1. TURP Surgery - Mortality Rate                       |
| 2. Transfusion Reactions, All Types - Per 1000 ACA    |

Complications of Care:

| 1. Intravenous Pneumothorax with Venous Cath - Per 1000 Inpatients |
| 2. Intravenous Pneumothorax with Venous Cath - Per 1000 ACA        |
| 3. Adult Postop Pneumonolysis (ICD-10)                     |
| 4. Intravenous Pneumothorax - Per 1000 ACA                 |
| 5. Transplanted Organ Complications - Per 1000 ACA          |

MS-DRG Coding Analysis

| 1. MS-DRG 109/100/101/113/114 |
| 2. MS-DRG 106/107/113/114/115 |
| 3. MS-DRG 103/104/113/114/115 |
| 4. MS-DRG 102/103/113/114 |}

Illustration by David Herbaugh

“Doctor, may I suggest you document to a much greater degree of specificity? My coding skill is beginning to atrophy.”
Multi-facility CDI Management

Ohio State University
Wexner Medical Center

Research  Education  Patient Care

College of Medicine & Office of Health Sciences
Clinical Departments
• School of Biomedical Science
• School of Allied Medical Professions
• Centers, Programs, & Institutes

Faculty Group Practice & Specialty Care Network
Departmental LLCs:
• Medical
• Surgical
• Primary Care
• Hospital Based

OSU Health System & Hospitals
University Hospital (619)
James Cancer Hospital (209)
University Hospital East (192)
OSU Harding Hospital (73)
Ross Heart Hospital (150)
Primary Care Network
Specialty Care Network
Every Day is an Opportunity!

- 4,000 Ambulatory Visits
- 300 Emergency Department Visits
- 150 Discharges (200 on Fridays)
- 120 Surgeries

National Recognition

[List of logos and awards]
CDI Program Goals

Focus is an accurate, complete chart from admission to discharge

“It’s not just about the revenue or the DRG, but Severity of Illness and Risk of Mortality for rankings.”

CDI Structure – UH / Ross / East

- **East**
  - Program started 2004
  - Based out of Medical Information Management (MIM)

- **UH/ Ross**
  - Began in the Ross with a focus on Cardiology 2004
  - Full expansion into UH completed in December 2012
  - Much transition with this group
    - Began in MIM
    - Moved to Utilization Management and became a shared role
    - Returned to MIM
CDI Structure – UH/Ross/East (continued)

Reports to Assistant Director, MIM

Accountable to Medication Documentation Steering Committee and an Operational Improvement Team

Assignments are service-based

- 13 staff
  - All but 1 are RNs
- 2 to 7 services per staff

NOTE: Current staffing does not account for coverage of ill or vacation time

CDI Structure – UH/Ross/East (continued)

Initial Proposal (benchmark)

- 1 CDS per 2,500 discharges

ROI was calculated by looking at the Revenue Opportunity in moving CC/MCC capture rate to top quartile performance

- University Health Consortium
- Medicare Only
CDI Structure – The James

Based out of Case Management

Reports to Manager of Case Managers
  • Accountable to Utilization Management Committee

Program began 2010

Assignments are service-based
  • 3 staff
    – All RNs
  • 8 to 10 services
  • Not all patients on all services
    – Surgery-focused
    – Large procedures and co-morbidities
    – Outliers

CDI Structure – The James (continued)

Proposed Staffing Model

Estimated review of 25 – 35 charts per day
  • New admissions should account for 15-20
  • Follow-up reviews every other day

Services that are largest driver of CMI and revenue were included in building the model
Work from Home Program

Eligibility
• Work on-site for minimum 6 months
• Meet all productivity/quality standards, including annual review score
• Not involved corrective action process

Guidelines
• Limited to 1 scheduled day per week
  • May not occur during a week with a Holiday or other Vacation Time
• Must have appropriate internet access at home
  • Laptop and remote access provided by department for use
• Scheduled flex hours may occur during WFH time with prior approval
• Productivity/Quality standards reviewed monthly

Keep the Basics the Same
Midas+ Process

CDI Staff Work assignments

Additional User-defined Worklists
- Pending Queries
- Outliers – The James only
  - All cases that meet outlier criteria are referred via worklist back to CDI to review for potential CC/MCC

Cases are reviewed every other day

Reporting - ReporTrack

User Report Processing
- Detail reports
  - Facility, User, Service

- Used for:
  - Staff Audits
  - Frequency of working DRG changes
  - Specifics on Working/Final DRG match
  - Query subject details
Examples

Detail Report – Working DRG Changes and Query Subject

Review Report – Working/Final DRG match

Reporting - Profiles

Multiple Profiles

- Program Management
  - By Reviewer and Service

- Physician
  - Provider profile for Query Response Rate

- Used for:
  - Counts and Rates
  - Staff Feedback
  - Physician Feedback
  - Unofficial CMI monitoring
Sample CDI Review Profile

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td># Admissions with CDI Review Completed</td>
<td>1326</td>
<td>1379</td>
<td>1873</td>
<td>2018</td>
<td>2041</td>
<td>2039</td>
<td>12160</td>
</tr>
<tr>
<td>% Admissions with CDI Review Completed</td>
<td>4733</td>
<td>53.52</td>
<td>4517</td>
<td>4603</td>
<td>5056</td>
<td>4719</td>
<td>20824</td>
</tr>
<tr>
<td># CDI Reviews Completed</td>
<td>4097</td>
<td>4005</td>
<td>5064</td>
<td>5463</td>
<td>4119</td>
<td>8824</td>
<td>40221</td>
</tr>
<tr>
<td># of CDI Reviews per Adult</td>
<td>3.39</td>
<td>3.62</td>
<td>2.77</td>
<td>2.71</td>
<td>3.63</td>
<td>3.24</td>
<td>3.44</td>
</tr>
<tr>
<td># of Admissions with CDI Questions</td>
<td>401</td>
<td>492</td>
<td>347</td>
<td>385</td>
<td>952</td>
<td>872</td>
<td>5327</td>
</tr>
<tr>
<td>% CDI Query Rate</td>
<td>26.24</td>
<td>22.47</td>
<td>20.48</td>
<td>24.90</td>
<td>31.71</td>
<td>30.72</td>
<td>30.65</td>
</tr>
<tr>
<td># CDI Queries: v1 Response</td>
<td>596</td>
<td>805</td>
<td>561</td>
<td>779</td>
<td>1320</td>
<td>1406</td>
<td>5707</td>
</tr>
<tr>
<td>% of CDI Queries</td>
<td>722</td>
<td>1213</td>
<td>695</td>
<td>888</td>
<td>1777</td>
<td>2094</td>
<td>4979</td>
</tr>
<tr>
<td>% of CDI Provider Query Responses</td>
<td>76.39</td>
<td>95.79</td>
<td>86.25</td>
<td>97.72</td>
<td>80.10</td>
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<td>% CDI Query Pending</td>
<td>3.40</td>
<td>2.76</td>
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<td>140</td>
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<td>59</td>
<td>130</td>
<td>229</td>
<td>103</td>
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<td>18.61</td>
<td>13.95</td>
<td>7.13</td>
<td>11.26</td>
<td>11.36</td>
<td>9.91</td>
<td>12.94</td>
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<td>% CDI Queries In Agreement &amp; Documented</td>
<td>408</td>
<td>503</td>
<td>396</td>
<td>616</td>
<td>1151</td>
<td>1301</td>
<td>4059</td>
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<td>% of CDI Queries In Agreement and Documented</td>
<td>58.51</td>
<td>50.15</td>
<td>62.20</td>
<td>64.57</td>
<td>64.77</td>
<td>65.75</td>
<td>62.27</td>
</tr>
<tr>
<td>% CDI Queries in Agreement but Not Documented</td>
<td>35</td>
<td>67</td>
<td>36</td>
<td>47</td>
<td>79</td>
<td>92</td>
<td>540</td>
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<tr>
<td>% of CDI Queries in Agreement but Not Documented</td>
<td>5.46</td>
<td>5.59</td>
<td>5.96</td>
<td>5.29</td>
<td>6.45</td>
<td>5.47</td>
<td>5.14</td>
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<tr>
<td>% CDI Queries Disagreement</td>
<td>97</td>
<td>169</td>
<td>94</td>
<td>115</td>
<td>237</td>
<td>269</td>
<td>1017</td>
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<tr>
<td>% of CDI Queries Disagreement</td>
<td>13.43</td>
<td>16.48</td>
<td>13.23</td>
<td>12.96</td>
<td>16.15</td>
<td>16.32</td>
<td>15.23</td>
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<tr>
<td>% CDI Queries Noted in Record</td>
<td>61</td>
<td>109</td>
<td>82</td>
<td>49</td>
<td>92</td>
<td>60</td>
<td>573</td>
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<tr>
<td>% of CDI Queries Noted in Record</td>
<td>8.45</td>
<td>15.58</td>
<td>5.31</td>
<td>9.41</td>
<td>10.68</td>
<td>8.49</td>
<td>7.96</td>
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Sample CDI Review Profile (continued)

# of Working = Final DRG-MDC | 1451 | 1668 | 1848 | 1795 | 2242 | 1942 | 9209 |
| % Working DRG-MDC Match | 76.13 | 76.67 | 80.53 | 80.31 | 79.64 | 65.40 | 76.41 |
| # Discharges W CC | 996 | 1085 | 991 | 1029 | 1018 | 952 | 6001 |
| % Discharges for Capture Rate Denominator | 3040 | 3764 | 3706 | 3780 | 3745 | 3468 | 22313 |
| CC Capture Rate | 25.94 | 25.97 | 26.73 | 27.16 | 27.18 | 27.45 | 26.69 |
| # Discharges W MCC | 1004 | 1077 | 1124 | 1160 | 1194 | 1043 | 6605 |
| % Discharges for Capture Rate Denominator | 3040 | 3764 | 3706 | 3780 | 3745 | 3468 | 22313 |
| MCC Capture Rate | 26.15 | 26.61 | 30.31 | 30.70 | 31.08 | 30.67 | 29.60 |
| # Discharges W MCC and CoMCC | 2000 | 2002 | 2115 | 2192 | 2212 | 1996 | 12606 |
| % Discharges for Capture Rate Denominator | 3040 | 3764 | 3706 | 3780 | 3745 | 3468 | 22313 |
| CoMCC Capture Rate | 52.08 | 55.58 | 57.04 | 57.87 | 59.07 | 57.53 | 56.50 |
| # Discharges W MCC or CoMCC | 1040 | 1672 | 1593 | 1596 | 1533 | 1473 | 9707 |

Sum of Final DRG Relative Weights | 7744.679 | 8297.6922 | 6779.5875 | 8990.8893 | 9454.0404 | 7668.7307 | 4894.0192 |
Number of Inpatient Discharges | 4824 | 4904 | 4950 | 5006 | 4997 | 4771 | 29532 |
Average OPE | 1.6053 | 1.4649 | 1.6028 | 1.6700 | 1.6510 | 1.6074 | 1.6573 |
Provider Profile

UH/Ross/East Only

- Request was driven out of an Operational Improvement Team

- Target Response Rate: 93%

- Individual Physician results are provided to
  - Department Chairs
  - Senior Management
  - Finance Administration

Sample CDI Provider Profile

<table>
<thead>
<tr>
<th></th>
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<tbody>
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<td>566</td>
<td>805</td>
<td>779</td>
<td>1530</td>
<td>1496</td>
<td>5707</td>
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<td>888</td>
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<td>1644</td>
<td>6679</td>
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<td>% CDI Provider Query Response</td>
<td>78.39</td>
<td>85.39</td>
<td>88.75</td>
<td>87.73</td>
<td>86.10</td>
<td>85.52</td>
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</table>

Provider: [Redacted]

Default Service: Internal Medicine/Cardiovascular

Default Specialty: Cardiovascular Medicine

<table>
<thead>
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<td>24</td>
<td>11</td>
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<td>10</td>
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<td>11</td>
<td>0</td>
<td>10</td>
<td>15</td>
<td>64</td>
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<tr>
<td>% CDI Provider Query Response</td>
<td>75</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>98.44</td>
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</table>
Challenges

Documentation Standardization
- Difference in use of “Noted in Record” response type
  - Now standard

Patient Location
- Patients from The James bedded in a physical location of UH
  - Unable to use “Assigned To” metrics

Challenges (continued)

Managing Shared Location Patients
- All Surgical ICU patients are in one location
  - Required a Location work assignment
  - Both teams use the shared list to identify patients

- All Medical ICU patients are in one location
  - James MICU patients are not covered at this time
  - UH staff have to delete the initial work assignment review for patients from The James
Keeping CDI in Midas+

- EMR upgrade allowed for CDI Documentation
- Documentation of all functions/reports requested for transition planning
- List would be provided with a demo of functionality

Keeping CDI in Midas+ – The List

- Demo of module and ability to create fields
- Current reporting
  - Ad Hoc Reports
  - CDI Profile
  - Pending Requests
- Moving Working DRG
  - Interface
  - Double Documentation

- Worklists
  - Initial cases for review
  - Pending queries to follow
  - Notification of positive micro cultures
  - Outlier case referrals for review

- Use of Statit
Keeping CDI in Midas+ (continued)

Key Points that made our case:
- Ability to use Worklists to drive workflow & communication
- System flexibility
- Proven comprehensive reporting
- Future plans that could be executed with current version

Future Plans

Coder Access into Midas+
- This was initially provided at go-live but not used
- Currently being piloted
- Much pushback about coders being in two systems and meeting productivity

Clinical Integration
- Utilize Lab interface to worklist positive cultures to CDI

Statit Use
- Move key metrics into a Statit scorecard

Relationship with Case Management
- Continuously developing
- UH/Ross CM leadership meets every other month with CDI leadership
Conclusions

• CDI Programs have increased in numbers since release of MS-DRG

• Formal CDI Programs ensure adequate staff to maintain accuracy and completeness of electronic health record

• Engaging stakeholders and recruiting the right champion and CDI staff are crucial components

• Midas+ CM allows clients to customize according to institutional processes

• Key metrics, data capture, and reporting ensure communication and process advancement

Thank you for attending.

Questions?

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