along with that round's outcome (error rate). If the error rate remains high, the provider will continue on to another round.

- The provider has 45 days to internally educate or make necessary changes before the next round of reviews begins. After the third round, if the error rate is still high, CMS decides the next course of action.

With only 45 days between rounds to make changes, how much can facilities accomplish? The answer is "more than you might thing," especailly if they've got their inpatient and outpatient CDI staff mobilized and ready to assist when these reviews arise.

Considering that CDI teams are already in the charts, this could be another opportunity for them to increase their impact and show their diverse value to a facility.

Working on the defense of denials can be another great way to share our unique and valuable expertise should it be called upon.

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GUEST COLUMN

Collaborate across silos to succeed in quality-focused CDI efforts

By Cheryl Manchenton, RN, BSN

From a bird's–eye view, your CDI program may be a well-oiled machine. CDI specialists pose queries, physicians respond, and coders assign the most accurate and specific codes.

But, what happens as your organization continues its journey from volume- to value-based reimbursement? How do you know whether you have the right team in place to improve documentation for quality outcomes on which reimbursement and quality profiles will be based?

To achieve accurate quality rankings and value-based payments, your efforts must extend far beyond coding and CDI to include clinical providers, quality specialists, and other healthcare professionals—and everyone must collaborate to achieve positive results.

Why is collaboration important? Collaborative CDI not only enhances documentation and coding, but it may also improve patient care and clinical outcomes. These outcomes equate to increasingly transparent data on which financial incentives, penalties, and even hospitals' reputations are based.

It's important to "get it right"—that is, to ensure that documentation reflects

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the high quality of the clinical care provided. An incentive payment today could be a liability tomorrow. Payers may eventually audit organizations that receive incentives based on exceptionally high-quality care to determine whether documentation and coding justify these additional payments. Look no further than meaningful use audits for examples of this, and remember it's not out of the realm of possibility that we will see it with value-based incentive payments as well.

Collaboration is also important because there are so many quality measures, and they are constantly in flux. No single individual or department can manage it all on their own. Finally, collaboration eliminates duplication of efforts and increases efficiency. It also sends a unified message that quality care is a priority for the organization.

Step one: Build your collaborative CDI team

Collaborative CDI requires a team of individuals representing multiple departments and perspectives. When thinking about collaboration, include representation from the following departments:

- **CDI:** CDI specialists pose the queries that ultimately affect quality outcomes (positively or negatively).
- **HIM:** HIM professionals understand coding guidelines and can identify the documentation of diagnoses that can—and cannot—be coded. A number of quality outcomes are largely based on coded data.
- **Quality:** Quality professionals drive the type of clinical process improvement that's necessary to achieve positive quality outcomes.
- **Physicians:** Physicians provide the clinical care, and documentation, on which quality outcomes are based. Without their buy-in and opinions, quality-driven CDI efforts could suffer.

Expand the team past the four areas above, as necessary, to gain additional input. For example, the infection control department can identify whether the volume of catheter-associated urinary tract infections that the organization reports to the Centers for Disease Control and Prevention National Health Safety Network correlates with the coded data reported for billing purposes. Likewise, case managers can provide valuable input when addressing readmissions.

> **[D]on't overlook the importance of identifying an executive sponsor—someone who can reiterate the purpose of CDI (i.e., to ensure that the organization receives accurate reimbursement and accurate quality scores based on the care provided)**

Also, don't overlook the importance of identifying an executive sponsor—someone who can reiterate the purpose of CDI (i.e., to ensure that the organization receives accurate reimbursement and accurate quality scores based on the care provided). Purposely altering documentation to increase reimbursement or improve outcomes is not the goal.

When selecting individuals to serve on the team, look for those who possess strong subject matter expertise and passion for quality improvement. These individuals must be self-motivated, lifelong learners who are less concerned with always being right and more concerned with the team's overall vision. Effective communication skills are a requirement, as individuals must be able to converse respectfully with others who have different opinions.

Step two: Define your vision, and create a mission statement

Your team's vision statement captures the overarching goal of the initiative and how it fits in with the organization's larger objectives. Consider this example: "To be recognized as a premier organization whose documentation reflects our quality of care."

The mission statement takes a deeper dive by providing directives you'll follow to accomplish this vision. Consider the following examples:

- Ensure accurate reporting of coded data
- Clarify provider documentation that's ambiguous, conflicting, or represents an unintended meaning
- Align the organization's clinical and coding definitions

Reevaluate your vision and mission statements at least annually as organizational priorities change. Has your mission changed or evolved? If so, how can you alter your statements accordingly?

Step Three: Develop objectives and goals

Having a clear sense of the team's objectives and goals keeps everyone focused and on track. Gather the team together to brainstorm ideas. What ideas are most applicable to your organization? Are some too narrow or too broad? Collaborative goals, for example, might pertain to ensuring accuracy related to the following:

- Value-based purchasing scores
- Readmission rates
- Reimbursement for care rendered
- MS-DRG and APR-DRG assignments
- Quality rankings (e.g., Healthgrades, Hospital Compare)

Be specific when setting goals. Rather than setting a goal to "improve patient safety indicator (PSI) 3 rankings," for instance, consider "move into the 10th percentile for PSI 3." Or instead of "improve PSI 90," set a goal to "reduce incidences of PSI 13 by 15%." This makes goal achievement—or lack thereof—more objective.

Goals must also be measurable, meaning you must have a way to track progress. "Achieving good PSI scores" is not measurable. "Receiving a five-star CMS ranking," on the other hand, is. Also, consider whether can you run a specific report regularly to view your progress toward achieving the goal.

Goals should be attainable. A small rural hospital shouldn't set a goal of being the top-ranking hospital in the country. This clearly isn't a realistic goal, and it sets everyone up for disappointment. Instead, set a reasonable goal, such as being in the top ranks of small hospitals in the country.

When evaluating whether a goal is attainable, consider measuring the gap between your organization's current state and the best practice you hope to achieve. How wide is the gap, and would a staged or incremental goal be more appropriate instead? "Improve overall central line–associated blood stream infection rate by 5% by the end of first quarter 2018," is an example of a staged goal toward a 20% reduction in the next two years.

Finally, goals must be timely. Avoid setting a six-month goal, for example, when 12 months or more must elapse before you are able to collect the data necessary to evaluate progress.

Also, understand the data used as a benchmark for progress. For instance, CMS' Hospital Readmission Reduction Program uses three years of discharge data to calculate a hospital's excess readmission ratio for each applicable condition. It may be more appropriate to set a readmission reduction goal that doesn't incorporate years prior to the initiation of your collaboration efforts.

Reevaluate your goals quarterly. Do any goals require attention? Can you refine any of them based on new information? When one metric shows improvement, it may be more appropriate to prioritize a different metric and place the original one in "monitor" status.

Step four: Create an efficient workflow

Successful collaborative CDI workflows have these traits in common:

- Developed collaboratively by HIM, CDI, providers, and quality
- Documented in a detailed fashion
- Include checks and balances as well as an arbitration and escalation process

Ensure that the workflow also has an associated timeline. Without one, the discharged-not-final-billed days could increase significantly. A possible timeline could include requiring physicians to review and respond to cases flagged for a potential quality concern (i.e., those that require clarification or amended documentation) within three days. This means the entire process—from flagging the case to securing a resolution—must be accomplished within three days.

Many organizations also use technology to increase efficiency and review all cases rather than a select few that may or may not affect quality outcomes. This technology automates case selection based on the working or final code set, allowing providers to act in real time to improve clinical care, documentation, or both.

Some solutions also provide inclusion and exclusion criteria so staff members can easily determine why a case is flagged as having a potential quality issue, reducing false positives and false negatives. Finally, technology may allow users to share their findings and opinions, providing a single source data repository and documentation trail that explains the collaborative process without having to retrace steps or sift through emails.

Step five: Convene regularly

A collaborative CDI team is effective only when it meets frequently to track progress and hold everyone accountable. As the team starts to form, daily meetings are a reasonable expectation.

Once the team finds its rhythm, consider holding weekly or monthly meetings to address one or more of the following four questions:

1. Are we on track to meet our goals? Encourage members to share their achievements as well as their barriers to success. How can the team overcome these barriers, and what additional support might be required? Have the goals changed or evolved, and if so, what new work groups are required to achieve the revised goals?
2. What clinical cases require additional discussion? Identify cases for which there is a quality concern prior to the meeting, and request that all attendees review documentation in advance. During the meeting, everyone shares their opinions and makes a joint decision without using precious meeting time to process the information.
3. Do we have any blind spots? Without clinical insight, for example, it may be difficult to improve documentation identifying postoperative complications versus expected outcomes that are integral to a procedure. When this is the case, invite a surgeon to the meeting to explain the procedure in detail. Look for other ways in which the organization can capitalize on internal resources to improve quality.

   In some cases, bringing in an external consultant may be beneficial. Consultants can help organizations define and build workflows that ensure accurate quality outcomes. They can also help organizations expand CDI programs into the quality realm, provide targeted quality education, and identify the root causes of quality deficiencies, as the consultant has no institutional bias.
4. Have we been as transparent as possible? This includes sharing feedback (and suggestions for improvement) with physicians. Do feedback mechanisms exist that correlate physician documentation improvements with outcomes data? Is quality data also transparent to other employees and the public via the organization's own website?

Also consider these additional tips for successful meetings:

- **Stay focused.** As the meeting begins, identify your objective—then stick to it.
- **Summarize the meeting.** Upon conclusion, summarize your accomplishments. Do you need to delegate any additional tasks? If so, when do you expect individuals to accomplish these tasks and report back to the group?
- **Make decisions.** When possible, make firm decisions so you don't need to schedule another meeting.
- **Limit the number of meetings.** The more time you spend in meetings, the less time there is to do the actual work.

Step six: Ensure sustainable CDI

As organizations forge ahead into value-based care, they need to identify CDI strategies that will yield a long-term return on investment. What's the best approach?

Collaboration. Collaboration lays the foundation for high-quality care that ultimately yields accurate reimbursement. Collaborative CDI requires a multidisciplinary team that's truly invested in clinical care improvement. When this happens, the organization wins financially and earns higher quality rankings. More importantly, patients receive better care.

Editor's note: Manchenton is the senior inpatient consultant, project manager and quality services lead at 3M Health Information Systems. She specializes in workflow design, program management, quality metrics, and performance. Contact her at *cmanchenton@mmm.com*. Manchenton's comments and opinions do not necessarily reflect those of ACDIS, its Advisory Board, or 3M Health Information Systems.