CDI Week

Industry Overview Survey

CDI specialists are in general optimistic about the growth of the profession, but not necessarily within their own departments; aren't involved all that much in RAC defense; use CMI as their primary metric for success; and have found electronic queries beneficial, even though their hospitals are slow to adopt the new technology.

Most of the results were as predicted for Clinical Documentation Improvement Week survey advisor ***Elizabeth Kennedy, RN, BS, CCS, CCDS,*** *associate director for the documentation improvement program at Montefiore Medical Center in Bronx, NY. But others came as a surprise. Following is an overview of the survey results and Kennedy's commentary.*

Survey of emerging CDI topics reaffirms expectations, offers a few surprises

Career advancement

Seventy eight percent of survey respondents described career advancement opportunity in their CDI department as small or minimal. A typical CDI specialist either reviews charts or manages the department, and there's not much room for growth or variation, Kennedy explains. "Unless you're in a big hospital, it sounds like a dead-end position for a CDI staff member," Kennedy says. "I think it would be a great idea for ACDIS to identify some opportunities in or outside their hospitals."

But Kennedy says the job can potentially expand into new and exciting directions. For example, her facility is large enough to allow time for specialized research and presentations. A wound care doctor and a neurologist recently approached her for advice on how to appropriately document debridement and grow their stroke program, respectively.

"I put together these elaborate presentations and researched what we could do, and wrote letters to the providers. We have a different type of job here and a lot of support," she says. Sixty eight percent of respondents agree, stating that CDI has a high growth potential due to the emergence of new regulations and hospitals' increasing demands for staff.

Even routine record review can expand into quality measures, utilization review, and more, Kennedy says. "There is opportunity, even if it's not the perception." Also encouraging: Most respondents (75%) indicated that they are marketable outside their facility. And most respondents (54%) felt adequately compensated for their work.

Data mining

Most CDI programs have access to data, with 94% of respondents indicating that they can access it themselves, have it run for them by other departments, or receive it from a consultant. "In our hospital we don't run our own data reports, IT does," Kennedy says. "We're looking at revamping the whole thing so that we do have access."

Most respondents (72%) state that CMI increase is the best metric for showing the impact of a CDI program, but Kennedy disagrees. "If you're only looking at CMI, you're looking at a case mix which is impacted by change in service lines, a change in inpatient to outpatient status, or doctors being on vacation for two weeks or moving to another facility," she says. "CMI is not a good indicator."

Montefiore uses CC and MCC capture rates as a base metric. They compare these rates to themselves, not other facilities, and report out their results on a monthly basis. Kennedy notes that CC/MCC capture is not an ideal metric, as it does not reflect procedures or principal diagnoses that are changed through queries.

Most respondents report their data to administration on a monthly basis (59%). As far as what they look for in vendor software, most respondents (84%) said a mechanism to view physician response rate was a must, followed by coding references (78%) and a DRG grouper (77%).

Electronic queries

How will electronic queries impact the CDI profession? Most respondents don't know yet, as nearly two thirds (64%) lack this capability. Kennedy says that the current landscape of hybrid records has slowed the incorporation of fully electronic query systems.

Electronic queries don't replace the need for hands-on, face to face communication. It's high touch supported by high-tech. They can take some of the mundane discussions away, and leave time for the high-quality discussions.

—Jon Elion, MD, FACC,
President and CEO of ChartWise Medical Systems, Inc., in Wakefield, RI

ChartWise CDI

"We have a hybrid record, and half-paper, half-electronic makes it difficult," she says."We're still using printed queries and we're about to stop printing progress notes and putting them in the physical chart, so how will physicians see our queries? It's a big issue."

But for those who do use electronic prompts to the provider, 53% reported that electronic queries have made their life easier, as opposed to 19% who stated that they've made matters worse. "Although you would think it would be more than 53%," Kennedy says.

Most respondents state that physicians are no more or less likely to answer electronic queries than other types of clarifications, and 57% state that they neither enhance nor hamper physician education. So it appears that any lingering worries that electronic queries will replace jobs are misplaced. "You're still going to have the same response issues, and the need to provide education. Sending a doctor a question isn't going to replace explaining the rationale of why you're asking it," says Kennedy.

CDI role in RAC defense

Despite the seeming relationship between deficient or non-specific clinical documentation and RAC recoupments, most CDI specialists are not involved in RAC defense. Sixty-seven percent of respondents either are not a part of their RAC team, or their facility lacks a RAC response team altogether. Fifty nine percent are not involved in writing RAC appeals.

Kennedy says the non-involvement o f CDI in RAC is reflected in the results of survey questions 16-17—the largest majority of respondents don't know their biggest problems with the RAC programs (34%) and say that life has gone on as usual (60%) even after national rollout of the RAC program.

Montefiore has its own RAC team and denials management process, but CDI is not involved.

CDI and quality

Although most CDI programs stick to traditional CDI duties (review of records for correct capture of diagnoses and procedures to reflect severity of illness), some 35% of respondents say that they review charts with an eye on quality. This includes POA/HACs, as well as ensuring documentation of core measures.

The majority of respondents who do review records for quality state that it does not hinder their chart review productivity (45%).

Kennedy was not surprised to hear that most physicians fail to document decubitus ulcers or catheter associated UTIs as POA. "I notice there were a lot of 'other' conditions (6%) indicated, but these are our issues too—whether or not sepsis was POA, or whether conditions were acute or chronic on admission," she says.

Montefiore educates its physicians in hour-long sessions, and HACs are part of that training. "We stress the importance of good documentation of skin assessments, or whether the patient had fever on admission or in the ED and it could be a presumed catheter related infection or UTI."

Expansion of CDI into outpatient

These days most CDI departments continue to perform traditional review duties, with an overwhelming focus on inpatient charts. Only 10% of respondents dedicate time and resources to reviewing outpatient services and procedures. That number may climb however as 37% believe that the time has come for expansion.

"There are different types of reimbursement issues [in the outpatient realm]. Our UM team looks at medical necessity, we've educated our ED physicians who manage patients in the emergency room. But we can't even cover all our inpatient beds so outpatient is not a priority for us," Kennedy says.

Those programs that do review outpatient charts say that emergency department procedures and services (60%) and surgical procedures (54%) offer the most room for improvement.

ICD-10 preparation

The majority of respondents (61%) have begun some degree of ICD-10 training, though only 15% have provided any formal education. The vast majority of respondents (78%) believe that ICD-10 represents a major industry change.

Montefiore has an ICD-10 documentation and coding subcommittee that meets monthly with all its department heads. It also used a consultant to perform an analysis of each department affected by ICD-10 and to evaluate what systems and training would have to be put in place by the Oct. 1, 2013 implementation date. Kennedy and several of her staff are also planning to attend the AHIMA "train the trainer" ICD-10 sessions.

"We have many freestanding facilities throughout the Bronx, and many departments, so it's going to be huge," she says. "I haven't found that ICD-10 [diagnosis coding] is too complicated, but the procedure codes are more sophisticated."

> *ICD-10 is the most important change to healthcare in almost 30 years. Codes are so ingrained in everything we do, from research and billing to quality. Changing them will have a significant impact on what we're doing, not only in CDI and in HIM but in healthcare in general.*
>
> —Barbara Hinkle-Azzara, RHIA, *vice president of operations with Meta Health Technology in New York, NY*

Most survey respondents believe that physician training should begin immediately (48%) as they also indicate that physician apathy/lack of response and interest (28%) is their biggest obstacle.

"We're going to start physician training by picking one body system at a time, like pulmonary, which has a lot of changes. It's going to be difficult, but we'll adapt," she says. "It's still too far away for detailed training."

About the Clinical Documentation Improvement Week survey advisor

Elizabeth Kennedy, RN, BS, CCS, CCDS, *is the associate director for the documentation improvement program at Montefiore Medical Center in Bronx, NY. She has 30 years of extensive experience in healthcare reimbursement, CDI, ICD-9 coding, and DRG validation. She has oversight of the program's operations across multiple sites, including providing education for providers and CDI specialists. Kennedy was the recipient of the ACDIS 2009 CDI Professional of the Year award based on the successful clinical and financial outcomes of the program.*

Industry overview survey: Emerging Topics in CDI

Career advancement

1. Please describe the opportunities for career advancement within your CDI department:

None/minimal (Small salary increases, and/or no promotion opportunities)	516	78%
Moderate (Moderate salary increases, and/or opportunity for promotion to CDI manager)	138	21%
Very good (Large salary increases, and/or multiple levels of promotion opportunities in CDI)	6	1%
Total	**660**	**100%**

2. With your experience as a CDI specialist, do you have opportunity for career advancement in your facility outside your department?

Yes	147	22%
No	277	42%
Not sure	233	35%
Total	**657**	**100%**

3. Please describe your impression of career advancement opportunities in the broader CDI industry (e.g., with other hospitals, consulting/other vendors, etc.):

None/very little	170	26%
Moderate	327	50%
Very good	163	25%
Total	**660**	**100%**

4. Do you think that you are compensated adequately for your work?

Yes	352	54%
No	305	46%
Total	**657**	**100%**

5. What is your opinion on the growth outlook of the CDI industry?

Very good/high growth industry due to changes/new regulations/need for CDI programs	450	68%
Mixed—depends on state/location, etc.	191	29%
Poor—restrictive regulations and other changes have diminished growth potential	17	3%
Total	**658**	**100%**

6. How do you obtain your CDI data?

Our CDI department has access to the data	385	59%
Another department in our hospital (i.e., finance, revenue cycle, etc.) generates it for us	88	13%
A consultant/external vendor provides this data	145	22%
We don't measure CDI data	37	6%
Total	***655***	***100%***

7. How often do you report your CDI data to administration?

Bi-monthly or more frequently	59	9%
Monthly	392	59%
Quarterly	126	19%
Semi-annually	15	2%
Annually	6	1%
We don't report our data to administration	61	9%
Total	***659***	***100%***

8. What are the best metrics for showing the impact of your CDI program? Check all that apply.

Query rate	329	50%
Query response rate	439	66%
Query agreement rate	298	45%
CC/MCC capture rate	451	68%
CMI increase	478	72%
Decreased RAC denials	172	26%
Improved severity /mortality data	411	62%
Don't know	21	3%
Other, please specify	59	9%

9. What are the "must have elements" in any vendor software? Check all that apply.

Electronic query system	465	71%
Coding references	511	78%
DRG grouper (embedded in the product)	509	77%
CDI specialist productivity tracking	456	69%
Interface with patient census	468	71%
Physician response tracking	549	84%
Financial impact assessment	496	75%
Electronic CDI worksheet (used to track clinical information and documentation noted in the record)	498	76%
Data storage	427	65%
The ability to create work lists	452	69%
The ability to create custom reports	507	77%
Other, please specify	33	5%

Electronic queries

10. Does your hospital use electronic queries/ prompts to the physician?

Yes	198	30%
No, we don't have this capability	419	64%
No, we have this capability but choose not to use it	37	6%
Total	**654**	**100%**

11. If you answered yes to question 10, has electronic querying made life easier for CDI specialists?

Yes	122	53%
No	43	19%
Not sure yet	67	29%
Total	**232**	**100%**

12. Do you find physicians more likely to answer an electronic query, or less so?

More likely	102	39%
Less likely	34	13%
About the same as other types of queries	126	48%
Total	**262**	**100%**

13. Do electronic query systems enhance or hamper physician education efforts?

Enhance	76	29%
Hamper	38	14%
Neutral	152	57%
Total	**266**	**100%**

14. Are CDI specialists a part of your RAC defense/response team?

Yes, we're a part of the team	216	33%
No, we have a team but we're not a part	354	54%
We don't have a RAC defense/response team	87	13%
Total	**657**	**100%**

15. Is your CDI staff or managers involved in writing RAC appeals?

Yes	210	32%
No	388	59%
Don't know	64	10%
Total	**662**	**100%**

16. What has been your biggest challenge with the RAC program?

Denied/downcoded MS-DRGs	67	10%
Denied inpatient admissions/lack of medical necessity	123	19%
Fear/overcaution in reporting certain diagnoses by physicians	17	3%
Fear/overcaution in reporting certain diagnoses by coding staff	61	9%
CDI not being involved or overlooked in RAC defense/denials	120	18%
Don't know	216	34%
Other, please specify	44	7%
Total	**651**	**100%**

17. Has the permanent RAC program changed the way your CDI department operates?

No, it's business as usual	386	60%
Yes, we're more cautious about physician queries as a result	166	26%
Yes, it has increased our workload as a result	84	13%
Yes, we've had to add additional CDI staff members	9	1%
Total	**645**	**100%**

18. Do you track revenue losses caused by RAC denials/down coding?

Yes	255	39%
No	118	18%
Don't know	282	43%
Total	**655**	**100%**

CDI and quality

19. Do you review for quality measures (core measures, HACs, Surgical Care Improvement Project (SCIP, etc.,) in addition to traditional CDI duties?

Yes	228	35%
No	410	62%
Not sure	20	3%
Total	**658**	**100%**

20. If you answered yes to question 20, has reviewing for quality measures hindered your chart review productivity?

Yes	87	32%
No	123	45%
We don't track productivity	30	11%
Not sure	34	12%
Total	**274**	**100%**

21. What are the some of the most common HACs that physicians fail to document as present on admission (POA)?

Catheter-associated UTI (CAUTI)	262	44%
Venous catheter-associated infections/complications	36	6%
DVT (following certain orthopedic procedures)	16	3%
Traumatic fractures	4	1%
Decubitus ulcer	247	41%
Other, please specify	35	6%
Total	**601**	**100%**

Expansion of CDI into outpatient

22. Has the time come for the expansion of the CDI programs into outpatient services (i.e., day surgery, ED, weekend coverage etc.)?

Yes	240	37%
No, too early	285	44%
No, no opportunity	121	19%
Total	**646**	**100%**

23. Does your hospital dedicate time/resources to outpatient record review?

Yes	66	10%
No	520	80%
No, but we are planning to do so	64	10%
Total	**650**	**100%**

24. If you answered yes to question 23, which outpatient services /records have shown benefit from your documentation improvement efforts? Check all that apply.

Surgical procedures	43	54%
Emergency department procedures/services	48	60%
Injections/infusions services	19	24%
Radiology services	14	18%
Laboratory services	8	10%
Other, please specify	11	14%

25. Have you begun ICD-10 preparation/training?

Yes, we've begun formal training	101	15%
Yes, but informally/at a superficial level	301	46%
No, but we have a plan in place	159	24%
No, and we have no plans in place	94	14%
Total	**655**	**100%**

26. What's your overall take on ICD-10: Major industry change, or merely a little additional specificity needed in the record?

It's a major change for everyone	504	78%
It's a major change, but primarily for CDI/documentation	13	2%
It's a major change, but primarily for HIM/coding	92	14%
It's a moderate change	39	6%
It's a minor change	2	0%
Total	**650**	**100%**

27. When should physician education efforts start?

Immediately	317	48%
By the end of 2011	102	16%
By 2012	134	20%
By the start of 2013	81	12%
Just prior to go-live date of October 1, 2013	11	2%
After go-live date of October 1, 2013	0	0%
Other, please specify	9	1%
Total	**654**	**100%**

28. Which of the following is the biggest obstacle to ICD-10 implementation in your facility?

Physician apathy/lack of response and interest	182	28%
Foreign appearance of codes and new coding rules	36	6%
IT/technical issues	22	3%
Inadequate plan/support for physician education	82	13%
Inadequate budget to prepare staff	59	9%
Inadequate time to prepare staff	21	3%
Lack of internal knowledge on ICD-10	76	12%
Don't know	144	22%
Other, please specify	30	5%
Total	**652**	**100%**

Open-ended responses

Following are some representative open-ended responses from survey takers.

Question: What are the best metrics for showing the impact of your CDI program?

- Monitoring for HACs, assessing for possible present on admission
- Query rate may not be accurate as one can query without need, creating a falsely elevated rate of query
- We no longer measure, report, or have meetings regarding CDI metrics
- Core Measures and Patient Safety Indicators (PSIs)
- Decrease in PSIs, increase in V66.7 coding
- Be careful....documentation shouldn't always be "about the money," so if you are measuring success/failure by CMI, CC/MCC, even agreement with, it puts the CDSs in a very precarious situation for obtaining goals/objectives as well as outcomes
- Decrease in post discharge DRG changes
- Improved quality and continuity of healthcare on a very broad scale. Detailed documentation helps prevent duplicate or unnecessary testing and gives each provider a comprehensive picture of the patient.
- Capturing national quality measures data
- Percentage of cases covered
- CDS productivity rates, match rates with coders
- Review rate/number of new reviews performed

Question: What are the "must have" elements in any vendor software?

- DRG grouper as a standalone tool, not necessarily embedded in a product
- ICD-9 / ICD-10 coding references
- Ability to print out queries for paper & mixed charts
- SOI/ROM impact tracking
- InterQual and/or Milliman criteria
- UR issues discovered
- Coder interaction; physician interaction via email
- Wishlist: Physicians could not further access EMR until the query is answered!

Question: What has been your biggest challenge with the RAC program?

- They are usually correct and we have no defense
- Inappropriate application of coding rules by RAC. RAC does no employ seasoned, qualified coders
- Not being given information about RAC audits
- This information is "secret" and/or not shared overtly between RAC and CDI here as per how the process was set up
- Coding errors
- Unreasonable auditors misinterpreting information

Question: What are the some of the most common HACs that physicians fail to document as present on admission (POA)?

- Sepsis/PNA
- Pneumonia
- Sepsis, respiratory failure, aspiration pneumonia, UTI
- Non catheter assoc UTI's, wounds of any kind
- Diabetic ulcers/neuropathies
- Abnormal labs such as hypernatremia
- the above plus acuity, acute vs. chronic
- Respiratory failure, systolic and/or diastolic CHF
- Decubitous ulcers

Question: When should ICD-10 physician education efforts start?

- CDS should already be querying for specificity
- Six months ago
- They should have already started
- If we start too soon and take "the sky is falling" approach the physicians will balk at our efforts
- Yesterday
- It should be asap, but we are in the process of changing to all computerized charting at this time

Question: Which of the following is the biggest obstacle to ICD-10 implementation in your facility?

- IT changeover expense
- End user overload since we are in Phase 2 of 3 phases of a 10 year EMR implementation project
- Inadequate time to spend on ICD-10 prep work for physician education
- Lack of willingness to hire additional coding staff ahead of the need
- Administrative apathy
- Lack of leadership
- The fact that CDI is taking a back seat to coding education efforts thus far
- New computer system starting up
- Lack of urgency from all
- It is just overwhelming to get your hands around all the education that will be needed
- Inadequate plan for CDI staff plus physicians

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