Q&A CDI WEEK

Changing role of CDI specialists

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As part of the second annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. ***Heidi Hillstrom, MS, MBA, RN, CCDS,*** *clinical documentation management professional at St. Luke's Hospital in Duluth, Minn., and past cochair of the Minnesota ACDIS chapter, answered the following questions regarding the changing role of CDI specialists. Contact her at* HHillstrom@slhduluth.com.

Q ***The most common job description of CDI is clarifying principal and secondary diagnoses. In what ways is this traditional model changing?***

As we progress in the CDI profession, more attention is being made on the CDI specialists' role in ensuring a complete and accurate medical record and on ensuring the consistency of the documentation throughout that record. Not only should we aim to capture documentation of valid diagnoses, but to also capture the documentation of ruled-out diagnoses for a complete and accurate medical record.

We have evolved into being more proactive and less reactive through physician education and physician collaboration. Also, many CDI programs have started partnering with quality and case management to make sure documentation reflects medical necessity, core measures, and other initiatives instead of only looking at how a particular diagnosis affects DRG assignments.

Q ***What should CDI specialists be doing to keep their roles and career relevant and fresh?***

Definitely network and collaborate with other CDI programs and attend as many education sessions as possible that pertain to the profession. Be in tune with all medical record documentation requirements that may pertain to other disciplines such as medical necessity for utilization, quality, ED, outpatient, etc., and seek opportunities for documentation needs outside of DRG assignment, principal diagnosis, and MCC/CC capture rates. One such example is physician E/M documentation. At my facility we are moving forward with reviews of this type. It really opens doors in terms of building a relationship with physicians along with growing and building a CDI program.

CDI specialists, if they come from a nursing background, should look to expand their coding knowledge, too. They need to understand how to assign DRGs but should also build an understanding of CPT/HCPCS codes and APCs. They also need to be in tune to what is going on politically and in terms of ongoing legislation.

Q ***How have recent initiatives (Recovery Auditor, value-based purchasing, present on admission, etc.) impacted the CDI profession?***

CDI specialists are becoming more in tune with denial avoidance over denial management. We have to understand how obtaining [a] complete and accurate medical record helps in that effort. In addition, more and more programs better understand the need to be working very collaboratively with physicians and coding staff, along with ensuring that valid diagnoses are on the discharge summary as well as ensuring the documentation of ruled-out diagnoses.

So much of hospital payment reform is tied to quality initiatives; how can CDI specialists impact quality measures and documentation?

Depending on the program and resources, CDI specialists can work very collaboratively with quality initiatives. It can range from CDI ownership of documentation of the quality initiatives, to being an extra set of eyes for the quality department or assisting with insertion of core measurement queries for the quality department to pursue.

Where do you see the CDI profession 10 years from now? Are there any service lines or facility types that CDI will expand into?

Working with physicians closely on their E/M documentation is one area. I can also see CDI transitioning into the outpatient arena in order to capture accurate diagnoses for denial avoidance. It is also expanding into an appeals line; my program is currently moving in that direction as well. In my opinion, CDI could take ownership of all healthcare documentation, i.e., E/M, outpatient, quality, and medical necessity, and maybe even be viewed as physician documentation consultants.

Keep on the cutting edge of CDI by embracing change

Mel Tully, MSN, CCDS, *senior vice president of clinical services and education for the consulting firm J.A. Thomas & Associates in Atlanta, has been involved in CDI efforts for many years. She understands how the profession has progressed and sees still more opportunities for growth in the years to come. Her comments follow.*

In five or 10 years, I see the CDI role as becoming very, very important to the veracity of the codes that are assigned, and I think there will be exponential growth over the next few years in support of the CDI process. It is not enough to work in a siloed environment anymore looking only to improve the DRG or capture a single CC/MCC.

More than 10 years ago, JA Thomas started introducing severity clarifications in its CDI process—then core measures. It trademarked the phrase "Advanced Practice CDI" and looked to incorporate any documentation aspect that could affect not only reimbursement but public reporting statistics. CDI is, just as its name implies, *clinical documentation improvement*. There really needs to be a loop of connection between what is written in the medical record and the care that was provided to a particular patient. The best part of the profession comes when you understand how that coordination of communication improves patient care. I fully believe that CDI efforts have become more patient-centric over the years.

As government and private payers seek to more closely align reimbursement with quality of care measures, it means additional opportunities for the expansion of the traditional CDI role. For example, this year (October 2012) is the first year facilities will receive payment for the care they documented under the value-based purchasing (VBP) program. As the VBP program goes forward, reimbursement will be more closely aligned to patient outcomes, and other payers will latch on to CMS' severity-adjusted methodology. How will you make sure your outcomes are well documented? You turn to your CDI program. It has a halo effect, and soon CDI efforts are going to be paramount to capturing documentation regarding the delivery of care, and facilities will be pushed to provide good care at a lower cost. That's what VBP is all about.

One of the ways to evolve the clarification process is to query not just for the diagnosis but also the clinical support for that diagnosis. The Recovery Auditors and others are denying claims because the clinical support for those efforts was not documented. It may be an awkward query to place, but it is necessary. If the hospital is denied, then the physician can get denied as well.

Keep on the cutting edge of CDI by embracing change

ICD-10 is another opportunity. The increased granularity that the new code set contains will support healthcare research and take our data to a much more sophisticated level. Of course, ICD-10 represents a tremendous challenge to facilities. If they do not have a CDI program currently, they should implement one. Facilities will not survive in ICD-10 without a robust CDI effort.

There are a number of other opportunities for expansion of the CDI role, including implementation of the electronic medical record, documentation improvement efforts in the emergency and outpatient services, and private payer record reviews.

The profession itself is a tremendous profession. It brings benefit for the patient and the facility and the physicians. Those who have been in the role for 15 years or more know there is something wonderful, meaningful, purposeful in this. But CDI specialists need to be committed to staying ahead and maintaining awareness of all the changes coming down the line. If I had to provide one piece of advice to CDI specialists, I'd tell them to embrace the changes.