Clinical Documentation Improvement Week

2015

Industry Overview Survey

Association of Clinical Documentation Improvement Specialists | www.acdis.org

INDUSTRY OVERVIEW SURVEY

It's hard to think about healthcare without thinking about change. This year alone, the healthcare industry has seen a number of transitions and improvements, such as the long-awaited shift to ICD-10-CM/PCS, employing electronic health records, and boosting quality and performance-based efforts.

According to the 2015 CDI Week Industry Overview Survey, CDI is no exception. The CDI profession is growing rapidly, testing new waters in the inpatient setting, and branching out into new arenas, from outpatient to pediatrics. In fact, 62% of survey respondents have already expanded, or are planning to expand, their CDI efforts beyond the traditional inpatient, acute care hospital setting.

"With all the changes in healthcare, and the differences in payment structures, the focus is on quality documentation which affects not only the inpatient setting but outpatient as well," says CDI Week survey advisor ***Judy Schade RN, MSN, CCM, CCDS,*** *CDI specialist at the Mayo Clinic Hospital in Arizona, and an ACDIS Advisory Board member. "Expanding CDI into different areas represents efforts to have a more global view of patient populations and complete and accurate documentation of the clinical picture."*

The survey also revealed a number of other developments. CDI departments have made significant progress with ICD-10 preparation, and feel adequately prepared for implementation. They generally feel their CDI efforts have garnered more support from medical staff and have noticed improvements in physician engagement and query response rate. Respondents indicate productivity improvements due to implementation of electronic health records (EHR) and typically believe the outlook for CDI growth and advancement is high, though many feel the opportunities are limited within their own facilities.

Following is a recap of the survey's results beginning on page 9 and Schade's commentary.

About the CDI Week survey advisor

Judy Schade, RN, MSN, CCM, CCDS, is a CDI specialist at Mayo Clinic Hospital in Arizona. A nurse with more than 30 years' experience, Schade has experience in a variety of clinical areas, including acute and home health nursing, discharge planning, case management, utilization and denial management, medical auditing, and bill review specialist. Her CDI experience spans more than 12 years and includes establishing the CDI program for Mayo Clinic.

An ACDIS member since 2008, she was recently elected as co-leader of the Arizona ACDIS Chapter. In 2013, received the CDI Professional Achievement award from ACDIS. She was elected to the ACDIS Advisory Board in 2015.

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CDI growth

Survey results indicate that most respondents (62%) have or are planning to expand CDI efforts beyond the traditional inpatient, acute care hospital setting into the following top areas. 25.5% will expand into hospital outpatient services. 29.7% will expand into physician practice or primary care physician documentation. 19.2% will expand into pediatrics. Other areas of expansion include critical access or rural health (10.5%) and residency (15%).

At Mayo Clinic, CDI has been reviewing all payers and patients, except for obstetrics and pediatrics, for the past nine years. Merging in to the outpatient arena especially, said Schade, seems like a natural progression for CDI, as many providers incorporate the outpatient visit documentation in the inpatient record. The documentation issues are the same across patient populations and payers, she says.

"You need to focus on the complete and accurate clinical picture to support medical necessity, severity of illness, and risk of mortality," says Schade. "If you limit reviews then you may be missing opportunities and have denials down the road."

Respondents say their CDI programs are expanding reviews to other payer types, with 23.4% having expanded reviews to include all payers for the adult population, and 30.6% review all patients/all payers. More than half indicated they're expanding their focus in line with healthcare reforms and initiatives, a pleasant surprise, Schade says.

"What we're seeing now is a real push towards quality care," says Schade. "When you're on the front lines, you have to pay attention to what Medicare and other entities are auditing. CDI specialists are in a key position to identify documentation concerns."

As for expanding CDI efforts to departments and patient populations within their own facility, respondents seem to feel opportunities are more limited with 32.1% of respondents indicating they have no plans to expand concurrent review efforts, and 23.2% indicating they weren't sure what their program's plans were. A large number, 40% of the respondents, say they are not planning to expand CDI reviews outside of the concurrent cadence, and 29.11% said they did not know.

"Some CDI programs may not have the resources or the staff to review records for all service lines [or] payers," says Schade. "Each CDI program should conduct record audits and use available data to identify documentation and coding opportunities, and to understand where to focus CDI efforts. While all areas are important, when you have to choose, you need a logical approach based on resources and outcome data."

The ongoing changes in healthcare, Schade says, impact CDI efforts. "CDI departments should expand and consider specific target retrospective DRG audits and a reconciliation process, where another review is done after coding prior to billing."

As CDI efforts continue to expand, the role of the CDI specialist has evolved as well. Most of the respondents agree that their role has changed significantly, with less than 5% saying it has had little to no changes. Not surprisingly, nearly half (47.2%) of the respondents said ICD-10-CM/PCS has had the biggest effect on the CDI profession, closely followed by electronic health record implementation (36.71%).

Schade wasn't surprised, as more and more people are looking in the record and realizing how important documentation is. Without complete and accurate documentation, she said, the complexity of patient care is not reflected.

"As much as we don't want to put all of our eggs in one basket, we really have to focus on documentation as being the key that unlocks a lot of doors for quality," she says. "You could have the best doctors and care in the world. However, if the medical necessity, severity of illness, and risk of mortality is not well documented, no one is going to know that you gave excellent quality care to very complex patients."

"There is a lot of buzz in the healthcare industry regarding the growth and expansion opportunities for hospital CDI programs. The survey demonstrates varying interests in regard to growing a CDI program. Where some indicate expansion of payer focus or new patient types, many are looking to broaden their programs to include things such as outpatient CDI and quality metrics. The key to successful program growth is identifying the staffing, tools, workflow, and performance metrics needed to empower the CDI program of the future. Prioritization of reviews, cross team collaboration, and quantifiable metrics will help to sustain the success of current CDI programs, while positioning for greater success in the future. -Lorri Sides, RN, Senior Director of Product Management for Optum360

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CDI and quality

When it comes to quality, more than half of the respondents review severity of illness/risk of mortality (SOI/ROM) concurrently (61.43%) or retrospectively (41.43%). Over half (55.5%) are also reviewing hospital acquired conditions (HACs), and 41.8% are reviewing patient safety indicators (PSIs). Quality reviews tend to go hand in hand with standard CDI reviews, and Schade was glad to see more CDI programs focusing on quality measures.

"You capture the complete picture," she says. "Whenever any diagnosis is documented, we need to identify the clinical validity, and support the medical necessity and resources used to care for the patient. Quality initiatives encourage CDI to go more in-depth."

An almost equal split among respondents indicate that reviewing quality measures either has (38%) or has not (39.2%) hindered their CDI chart review productivity. Schade empathizes with CDI specialists on "scope creep," or the burden of additional chart-related duties to CDI simply because they're already reviewing the chart.

At Mayo Clinic, CDI and quality work as a team to tackle the often time-consuming quality reviews: quality performs the initial review and if they find a complication or diagnosis that needs to be clarified, they work with the CDI specialists to make sure the documentation supports exactly what happened so it can be accurately coded.

"Quality reviews are complex and the focus is to understand the events of the case and the result," says Schade. "The reality is there are going to be HACs and PSIs. However, the challenge is to make sure the documentation and coding accurately reflects the circumstances and the outcomes. Both CDI specialists and quality reviewers have specific expertise, so the best model is a partnership."

Another pleasant survey affirmation came from the 75.4% of respondents who indicated they'd query the physician or provider, even if it has no effect on reimbursement but could affect a quality measure.

"The goal of CDI is a complete and accurate clinical picture, no matter what, and I was thrilled to see these results," says Schade.

"There are so many initiatives out there, some of which may be risk adjustments in the future. We do not always know the methodologies of how the data is sliced and diced, and what conditions might count on which public reporting models. Being proactive and having all the secondary diagnoses documented and coded is important because the coding summary reflects the clinical picture and lists the conditions being addressed and procedures performed."

Overall, Schade says quality is a necessary component for CDI program success. "When we see the outcomes of quality, it all goes back to documentation," says Schade. "I can't stress this enough: complete and accurate documentation leads to complete and accurate coding. If we don't get that right, our outcomes are not going to reflect our patient population."

"The CDI field has seen a gradual change from reviews and queries done only after discharge to where they are now done concurrently during the hospital stay. Quality measures are also poised to make a similar transition, as we strive to know not only how we were doing six months ago, but how we were doing six minutes ago. This will, in turn, allow a hospital to focus on improving the quality of care while the patient is still in the hospital, resulting in better outcomes." — Jonathan Elion, MD, founder of ChartWise Medical Systems, Inc.

ICD-10 preparedness

The October 1, 2015 ICD-10 implementation date has been confirmed, and many CDI departments are feeling the pressure. However, the majority of the respondents (41.2%) feel they're about where they should be in terms of preparation. Still, a handful (32.8%) say they are not prepared or they are only somewhat prepared. In open responses, one individual indicated that coding is prepared, but the CDI team is not; another said they are very prepared, but understaffed; and another said CDI isn't part of the facility's ICD-10 preparation team.

It can be difficult for a facility to pinpoint exactly how prepared they will be for the transition because, as it stands, even with dual coding, no one knows exactly what the situation will be like to work in a post-implementation environment, according to Schade.

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"Realistically, how prepared can you be," she says. "The transition to ICD-10 will be a process, and there is definitely going to be a large learning curve. CDI will continue to trend opportunities and identify provider educational strategies to improve documentation and coding in ICD-10. This will involve a team effort and a strong partnership between CDI and coding."

When asked how prepared they were for specific preparation items, procedure (PCS) codes and physician education ranked the lowest. The majority of respondents agreed (58%) that physicians were only somewhat prepared.

"We can't base preparation simply on giving physicians education," Schade says. "What it's really going to boil down to is using queries and clarifications to educate and identify what particular verbiage the providers are struggling with, so we can educate effectively."

At Mayo Clinic, the CDI team uses a number of different preparation methods. They've employed basic ICD-10 PowerPoint presentations, documentation tip sheets, and in-person meetings with individual departments and service lines to identify top concerns for specific groups. Among survey respondents, pocket cards and tip sheets (60.9%), online/e-learning (55%), and PowerPoint presentations (55%) were found to be most effective.

"The issue is that educational and learning environments can be different for everyone," says Schade. "What one provider might like, another might not like. Offering a variety of learning methods is the key to successful education."

The largest number of respondents (40%) they have not asked to hire new staff in anticipation of ICD-10; although 27.64% did successfully hire new staff, and 12.73% were denied their request for additional staffing. Although ICD-10-CM/PCS implementation represents a huge endeavor, facilities do not have the firm outcomes or statistics to prove that adding more staff would increase productivity, or make up for productivity losses, because ICD-10 implementation hasn't happened yet, says Schade. Administrators need that hard data to identify the return on investment in new hires. To support the need for additional staff, managers will need to closely monitor outcomes and denials in the days, weeks, and months following implementation to ensure complete and accurate documentation and coding, along with timely claim submission. Where the need for queries increases, or adjustments in case mix index occurs, managers can track that data and show administrators the need for additional staff.

"Educating and preparing coders, CDI professionals, and healthcare providers up to and beyond the October 1, 2015 deadline will require continued monitoring of healthcare data to pinpoint knowledge and skill gaps to ensure that patients are provided quality care at affordable rates. From a provider's standpoint, it is important to ensure that viability of the organization is maintained, with strategic plans developed on the back of accurate and complete data." —Deborah Neville, RHIA, CCS-P, Director of Revenue Cycle, Coding, and Compliance for Elsevier Clinical Solutions

Elsevier
Clinical Solutions

Physician engagement

The survey results show that most programs (64%) have a physician advisor to CDI, although 51% are employed in a part-time capacity and only 13% work on CDI fulltime.

Schade was glad to see that 35.4% of respondents said their physician advisor was effective, but wasn't surprised to see that 29% found their physician advisor was only somewhat effective, while 12.6% said they were not effective at all. "Most CDI physician advisors have additional clinical/staffing duties and responsibilities, which limit the time available for CDI" she says. "In addition, some physician advisors have had no formal training in the role and expectations. Physician advisors need strong leadership skills and administrative backing to be able to support CDI efforts, challenges, and build strong peer relationships."

Most survey respondents indicated that their medical staff was "mostly engaged" in CDI and motivated to document well, with some exceptions (43.2%). Only a small percentage (6.4%) said they felt their staff was highly engaged and motivated, while 36.8% answered "somewhat engaged" and 13.5% answered "mostly disengaged and unmotivated." Schade says physician involvement continues to be a challenge in the profession, even more so with the rapid changes in the healthcare industry.

Physicians face so many competing initiatives, from profiling, outcomes, readmission rates, medical necessity issues, and quality measures. It's easy to see how they simply get overwhelmed,"

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says Schade. "I try to be cognizant of the provider's time and limit [queries] to the most important diagnoses. By combining clarifications with education, the focus is to have the correct diagnosis documented so the severity of illness and risk of mortality can be coded accurately."

Regarding query responses, 26.6% require their physicians to answer within two days, and 9.5% require them to answer within three days. However, the highest number of respondents has no time frame for query response (27.7%). At Mayo, Schade say the query response time frame is usually 24-48 hours.

"You really need to have a query policy that outlines the specific guidelines and query expectations," says Schade. "It is important to educate the providers regarding their responsibilities and any specific time frame requirements."

Nearly half of respondents say that their physician query response rate within their facility's timeline is above 81%. The majority report a slightly lower physician query agree rate—28.4% indicated that it was within the 81-90% range, and 16.4% indicated it was within the 91-100% range.

"Query response rate might not be an accurate measure of success," says Schade.

If a facility only submits five queries a week and getting an 80-90% response rate and another is doing 100 queries a week and having an 80-90% response, the results of each program are totally different; the second program clearly has more physician engagement in CDI efforts than the first program, she says. Specific data regarding the queries is necessary to identify provider trends and subject matter. In addition, there should be audits to identify if any documentation opportunities were missed. Any unanswered queries could represent an educational opportunity for either the physician or the CDI specialist team. CDI staff should regularly audit their query efforts and use statistics on what queries go unanswered to develop an education plan.

Most respondents (43.3%) do not have an escalation policy, although those who do have such a policy come in a close second at nearly 40%. As a teaching hospital, many of Mayo's queries get sent to PA's, NP's, residents, or fellows who author progress notes and discharge summaries. If she doesn't receive a response within 24-48 hours, Schade will resend the query and include the attending physician. If she still doesn't receive a response, she escalates the query to the chair of the department. She rarely needs to include the attending physician on the queries and has included the department chair maybe once or twice a year because she makes query response expectations known up front.

"Set your expectations; make sure the providers understand what is expected of them and the consequences, so there will be no surprises when the chair of the department asks why a particular query was not addressed," says Schade.

"Most physicians understand that documenting to better capture medical necessity, SOI and ROM on every admission will positively impact reimbursement, clinical care, and quality metrics. The key is to educate them about the benefits of getting pre-discharge documentation feedback. Nearly all physicians will value any effort to minimize post-discharge queries, which is disruptive to their workflow. They also need to understand that, when tied into real-world clinical workflow, the documentation process allows more collaboration, helps identify patients at risk of potential complications, and helps them implement preventative measures sooner." —Victor Freeman, MD, MPP is a CDI consultant and Regional Medical Director for Nuance.

NUANCE

Electronic health records

One of the greatest challenges facing healthcare professionals today has been the implementation of the EHR. A combined 62.6% of our respondents have either a complete EHR after discharge, with some paper records scanned, or a completely digitalized EHR. That's an increase from the 2014 CDI Week survey, which indicated a combined 56%.

The EHR has brought forward a number of opportunities for CDI, automating review processes, alerting providers to queries, and tracking physician responses. Having an EHR is a huge advantage, Schade says, allowing CDI to have all of the information at their fingertips when reviewing a record. EHRs, she says, also solve misinformation from illegible handwriting. However, there are some disadvantages with cut-and-paste and note bloat, which many facilities still struggle with.

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Overall, the highest percentage of respondents are "mostly satisfied" with their vendor software (37.4%), though 35.4% are only somewhat satisfied.

Commonly used EHR vendors include Epic (32.7%) and Meditech (15.5%). Mayo Clinic, like a high number of respondents (21%) uses Cerner, which has electronic queries through its EHR. Nearly 50% of respondents indicated that their EHR system handles queries also. Physicians at Mayo however became overwhelmed by the number of different messages and requests sent through the EHR, so they requested queries be sent via e-mail.

"CDI should look for the best methods for querying and communicating with physicians and incorporate provider feedback to identify any documentation education opportunities," Schade says. "Talk to physicians and see what would help them. You might have prompts that aren't working. The goal is to make the EHR process user friendly, we don't want to lead the physician with prompts and set us up for potential audits and denials."

Most of the survey participants say electronic querying has improved CDI efficiency (53.33%). Nearly 35% say they are more productive, and 31.5% say it has improved query response rate.

"If the providers like electronic queries, use them," says Schade. "We have to keep statistics on what is working and what is not, and if we have to make any changes, seek provider input."

Although EHRs have also allowed for more and more CDI specialists (23.3%) to work remotely, or at least have a work-from-home option a few days per week the majority (73.6%) do not have a work-from-home option. Schade currently works remotely, though she worked in CDI onsite for 10 years, and was the only CDI specialist at Mayo Clinic for six. She says building trust and respect with physicians is critical to working remotely. Before CDI specialists work remotely, it is important to establish standards, outcomes, and define expectations and goals.

"If you have a good rapport with physicians, working remotely is a win-win," said Schade. "But I do think it's important to have onsite opportunities. I try to be onsite three to four times a year, doing face-to-face with my departments, and doing whatever I need to do to let them know that I'm available even when I'm offsite."

Working remotely does have disadvantages, including the social and team aspect of working in the facility, she says. However, Schade feels that productivity is the same, or better, without the distractions of working in a hospital environment. She still collaborates and networks daily with her colleagues, many whom also work remotely, especially coders.

Those who do have a remote option say productivity is the same onsite versus offsite for query rate (78.3%) and query response rate (79.7%). Overall productivity while working remotely is actually better than onsite, according to 50.9% of respondents.

"I do think productivity and reviews should be monitored and audited for all staff to make sure CDI specialists are meeting expectations," says Schade. "There should be a productivity balance competing with other activities. The goal should be quality. Flexibility in the work place is very important and I think we will see more and more remote CDI positions to attract the best employees."

Career advancement

More than half of this year's survey respondents say their employer does not have a career ladder for CDI, and that raises are minimal. CDI departments should develop standard professional development opportunities for their staff as well as competency expectations for the different levels on that ladder.

"We're not doing anybody justice if we don't have possibilities for growth and development, and rewards for education, experience, and proven outcomes," says Schade. "If there are no incentives and no opportunities for advancement, a CDI specialist might not stay in that position."

In terms of potential career advancement in the broader CDI industry, respondent's perspectives seem to be more positive with 33.7% indicating their impression of opportunities to advance looks "good," while 28.3% said "moderate," and 14% said "excellent." Only 12.8% say there or very little or no chances to move up in the CDI field.

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"I think there are a lot of opportunities to build a career ladder in CDI similar to nursing career ladders," says Schade. "I am not talking about just management opportunities, but also advancing on the front lines. You need CDI staff with strong clinical skills performing reviews. I think there needs to be more awareness of the opportunities for advancement in CDI within facilities and beyond."

Respondents were split on whether or not they feel adequately compensated for their work: 58% said yes, while 42% said no. The majority received a raise in the past year (38.4%), and a combined 34.1% received one within the last three to six months. 20.2% have gone more than a year without a raise.

"CDI specialists working overtime aren't usually compensated when they're doing extra hours if they are salaried employees, and that's frustrating because it is on their own time," says Schade. "On the other side, I think those who say they are fairly compensated could be coming from a nursing background where the compensation seems better because they aren't working holidays and/or weekends. There's more work-life balance and flexibility in the CDI positions and when you factor in these variances that might explain the differences in response rates."

An overwhelming 82.4% said their raise was not based on incentive, but rather due to overall job performance and productivity. Schade would rather raises be based on performance.

"Whenever you have incentives, like asking someone to do a certain amount of reviews or queries per week sometimes you get incomplete reviews and/or queries that are unnecessary," she says. "Basing raises on performance tells a different story. There are a number of factors that focus on complete and accurate reviews and it is important to have specific data and outcomes to reflect the whole picture. Making sure the CDI staff know the performance expectations and have the right resources and tools to accomplish these goals is essential. The focus should be on quality reviews and clarifications."

Overall, only a small percentage (1.2%) of respondents say the future of CDI is poor. Some (27.4%) have mixed feelings, and say CDI growth depends on location, facility, and such. However, the majority of respondents think the growth outlook of CDI looks very good, with a high number of opportunities due to ongoing changes, new regulations, and an increasing need for CDI programs (71.4%). Schade agrees with the majority, saying the opportunities for CDI are innumerable.

"CDI is a very challenging career in a rapidly changing healthcare environment," said Schade. "You are constantly bombarded with new regulations and potential targets, which necessitates shifting your focus and your goals. Provider documentation has to support medical necessity, severity of illness, risk of mortality, length of stay, resource consumption, and high value care. There will always be a need for complete and accurate documentation as this is the only way to prove the excellent and highest quality care we give our patients."

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2015 CDI INDUSTRY OVERVIEW SURVEY
Branching Out Into Healthcare

1. Please enter the number of beds in your facility:

Answer Options	Percent	Count
100 or less	12.6%	46
101-200	19.5%	71
201-300	15.7%	57
301-400	11.8%	43
401-500	10.2%	37
501-600	7.7%	28
601-700	4.9%	18
701-800	4.9%	18
801-900	2.2%	8
901-1000	1.1%	4
More than 1000	6.6%	24
N/A	2.7%	10
Total		
364		

2. How many CDI specialists do you have on staff? (Please count each part time CDI as a .05 FTE):

Answer Options	Percent	Count
Less than one	3.6%	13
One	14.3%	52
Two-Three	27.8%	101
Four-Five	16.8%	61
Six-Seven	12.9%	47
Eight-Nine	7.7%	28
10-12	6.6%	24
13-15	4.4%	16
More than 15	5.8%	21
Total:		
363		

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3. Which payer types do your CDI specialists currently review?

Answer Options	Percent	Count
All patients/all payers	49.0%	178
Medicare only	16.3%	59
DRG payers only	16.3%	59
Don't know	0.8%	3
Other (please specify)	17.6%	64
Total:		
363		

Other (please specify):

- Medicare and Medicaid
- Medicare and DRG payers
- Mostly Medicare, but can move to other payers if census is low
- Medicare, will start Public Aid and Medicaid next month
- HMO Medicare
- Medicare and Blue Cross AQC
- Medicare and some commercial
- All patients and payers
- BCBS
- United Healthcare, Tri-Care, Cigna
- All payers except self-pay/workers comp

4. Which of the following areas does your facility currently review for documentation improvement opportunities or have plans to expand into:

Answer Options	Percent	Count
Hospital outpatient services	25.5%	73
Physician practice/primary care physician documentation	29.7%	85
Pediatrics	19.2%	55
Critical Access/Rural Health	10.5%	30
Residency	15.0%	43
Don't know	19.6%	56
Other (please specify)	26.6%	7
Total:		
286		

Other (please specify):

- Hospital inpatient only
- Somewhat rural
- Emergency room/department
- We are a small community hospital
- Medical/surgical
- L&D and newborn
- NICU and OB
- Inpatient rehab
- We're waiting to expand until after ICD-10
- None of these

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5. Are you looking to expand reviews to other payer types beside Medicare? Check all that apply.

Answer Options	Percent	Count
Yes, all payers for a dult population only	23.4%	68
Yes, all patients/all payers	30.6%	89
Yes, APR-DRG payers	10.7%	31
Yes, Medicaid	6.2%	18
Yes, Medicare Advantage / Hierarchical Condition Categories (HCCs)	4.8%	14
No	9.6%	28
Don't know	8.6%	25
Other (please specify)	21.0%	61

Total:

291

Other (please specify):

- Currently Medicare, then selected insurances as able
- We review all payers
- We review all payers except Medicaid
- We plan to expand, but are not sure which ones yet
- Yes—Blue Cross
- Looking at all IP and OBS now
- APR-DRG, Medicare, and Medicaid
- We will eventually review all payers
- We already review all payers excluding psych, OB, and NB
- Commercial Insurers
- Not applicable

6. Are you planning to expand your CDI program's concurrent review focus to include any of the following healthcare reforms/initiatives? Check all that apply

Answer Options	Percent	Count
Hospital Value Based Purchasing (HVBP)	26.7%	78
Hospital Readmissions Reduction Program (HRRP)	20.5%	60
Present on Admission (POA)	42.1%	123
Hospital-Acquired Conditions (HAC)	44.9%	131
Patient Safety Indicators (PSI)	42.8%	125
Core measures	20.2%	59
Medical necessity	15.4%	45
No	7.5%	22
Don't know	20.2%	59
Other (please specify)	14.0%	41

Total:

292

Other (please specify):

- We already review all of these
- Length of stay
- SOI/ROM (mortality index)
- Bundle payments—working DRG

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7. Are you planning to expand your CDI program's concurrent review to additional hospital departments/patient populations?

Answer Options	Percent	Count
Pediatrics	14.3%	42
Obstetrics	15.7%	46
Psychiatry	5.1%	15
Rehab or other post-acute care	5.5%	16
Emergency department	17.4%	51
Hospital outpatient services and procedures	18.4%	54
No	32.1%	94
Don't know	23.2%	68
Other (please specify)	5.1%	15
Total:		***293***

Other (please specify):

- Contracted outpatient physician's offices
- No plans as of now
- Depends on budgeting for FTE's
- Physician offices
- Acute inpatient rehab
- Currently reviewing all inpatient populations
- Only adult inpatient population

8. Are you planning to expand your CDI program reviews outside of the concurrent cadence?

Answer Options	Percent	Count
Retrospective/post-bill	3.4%	10
Retrospective/pre-bill	7.9%	23
Retrospective for denials management	9.6%	28
No	40.1%	117
Don't now	29.1%	85
Other (please specify)	9.9%	29
Total:		***292***

Other (please specify):

- Already do retrospective reviews
- We only review concurrently
- Retrospective pre-bill reviews only for mortality, PSIs, and HACs
- We already do this

9. How much has your role as a CDI specialist evolved since you first started?

Answer Options	Percent	Count
Hugely; my role has evolved into something entirely different	17.0%	50
It has had significant changes	40.1%	118
It has changed to some degree	23.8%	70
It has had minimal changes	13.3%	39
It has had no changes at all	3.1%	9
Don't know	1.0%	3
Other (please specify)	1.7%	5
Total:		***294***

Other (please specify):

- I just started in CDI
- We are a new CDI program, and are still developing
- I am not currently in CDI

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10. Which of the following reforms/programs/initiatives has most affected the CDI profession, in your opinion? Please rank in order of significance (1 being most important):

Answer Options	1	2	3	4	5	6	7	8	9	Average	Count
ICD-10-CM/PCS	135	85	42	14	5	2	1	1	1	1.92	286
Electronic health record (EHR) implementation	105	111	33	14	7	2	5	5	4	2.24	286
Bundled payments	7	19	99	71	38	24	11	10	7	4.13	286
New ACDIS/AHIMA physician query practice brief	10	35	51	94	44	26	11	13	2	4.14	286
HVBP/quality reforms	20	13	27	36	131	40	14	1	4	4.57	286
Physician Value Based Payment Modifier	5	5	17	28	29	148	39	13	2	5.62	286
HHRP	0	2	5	7	13	31	176	45	7	6.83	286
Growth of Medicare Advantage	1	12	10	21	17	9	24	188	4	6.94	286
Other	3	4	2	1	2	4	5	10	255	8.62	286
Total											***286***

11. Do you think there is a danger inherent in too much CDI growth?

Answer Options	Percent	Count
Yes, the CDI role should stay focused on acute care inpatient reviews/DRGs	7.8%	23
Somewhat/proceed with caution	36.9%	109
No, the sky is the limit for this profession	47.5%	140
Not sure	7.8%	23
Total:		
295		

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12. Which of the following quality measures and/or quality related items does your CDI program review on a concurrent basis? Check all that apply. If you answered "we don't review quality measures/metrics", please proceed to question 16.

Answer Options	Percent	Count
CMS Inpatient Quality Measures, i.e., "core measures" (not specific to HVBP)	31.1%	87
HACs	55.4%	155
HVBP	12.1%	34
PSI only (not specific to HVBP)	41.8%	117
Severity of illness/risk of mortality (APR-DRG methodology) concurrent to stay	61.4%	172
Severity of illness/risk of mortality (APR-DRG methodology) retrospective mortality reviews	41.4%	116
Surgical Care Improvement Project (i.e., SCIP) or other quality specialty database	15.0%	42
We don't review quality measures/metrics	18.2%	51
Other (please specify)	3.2%	9
Total:		
280		

Other (please specify):

- SOI/ROM for AMI, PNA, CHF, and CABG patients
- POA and readmissions
- UHC mortality, retrospectively and concurrently
- We do retro reviews for PSI/HACs found by coders
- We have tried these programs, have not sustained

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13. If you answered yes to reviewing for PSI in question 12, which of the following PSIs do you review? Check all that apply.

Answer Options	Percent	Count
Pressure Ulcer (PSI 03 & element of PSI 90)	83.2%	129
Iatrogenic Pneumothorax (PSI 06 & element of PSI 90)	58.1%	90
Central Venous Catheter-Related Blood Stream Infection (PSI 07 & element of PSI 90)	70.3%	109
Post Op Hip Fracture (PSI 08 & element of PSI 90)	47.1%	73
Post Op Hemorrhage/Hematoma (PSI 09 & element of PSI 90)	59.4%	92
Post Op Physiologic and Metabolic Derangement (PSI 10 & element of PSI 90)	36.1%	56
Post Op Respiratory Failure (PSI 11 & element of PSI 90)	67.1%	104
Post Op Pulmonary Embolism or Deep vein thrombosis (DVT) (PSI 12 & element of PSI 90)	57.4%	89
Post Op Sepsis (PSI 13 & element of PSI 90)	62.6%	97
Post Op Wound Dehiscence (PSI 14 & element of PSI 90)	49.0%	76
Accidental Puncture or Laceration (PSI 15 & element of PSI 90)	71.6%	111
Other (please specify)	7.7%	12
Total		**155**

Other (please specify):

- Not applicable
- PSI-4
- UTI, sepsis, pneumonia, and DVT
- We do the initial review, and then refer to our quality department

14. Has reviewing for quality measures hindered your traditional CDI chart review productivity?

Answer Options	Percent	Count
Yes	38.0%	90
No	39.2%	93
We don't track productivity	10.5%	25
Not sure	12.2%	29

Total:

237

15. Does your CDI department query a physician and/or other provider when the query only impacts a quality measure, not reimbursement?

Answer Options	Percent	Count
Yes	75.4%	187
No, only if it impacts reimbursement	9.3%	23
Don't know	4.8%	12
Other (please specify)	10.5%	26

Total:

248

Other (please specify):

- We do both
- We don't review quality measures
- We query regardless of impact
- We query for the greatest specificity to accurately reflect care delivered
- If it increases SOI/ROM as well as the DRG
- We query to keep the chart honest
- We perform a quality review and query whenever it is needed, period.

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16. How prepared is your facility for ICD-10-CM/PCS implementation on Oct. 1, 2015?

Answer Options	Percent	Count
Extremely prepared	4.0%	11
Very well prepared	18.6%	51
About where we should be	41.2%	113
Somewhat prepared	27.0%	74
Not prepared	5.8%	16
Don't know	1.8%	5
Other (please specify)	1.5%	4
Total:		
274		

Other (please specify):

- Coding is prepared, CDI is not
- We are very well-prepared, but understaffed
- Not sure: unfortunately, CDI is not part of ICD-10 preparation

17. How prepared are you on the following specific ICD-10-CM/PCS related items?

Answer Options	Not prepared	Somewhat prepared	About where we should be	Very well prepared	Extremely prepared	Rating Average	Response Count
Coding conventions and guidelines	18	83	114	45	11	2.81	271
Clinical modification (CM)/diagnosis documentation specificity	14	81	116	50	11	2.86	272
Procedural Coding System (PCS) documentation specificity	32	97	107	33	3	2.55	272
Updating query forms/templates	31	66	99	49	24	2.88	269
Physician education	44	97	85	39	5	2.50	270
EHRs/electronic query systems	47	54	99	46	19	2.76	265
Other	5	6	14	5	3	2.85	33
Total							**272**

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18. Describe the level of ICD-10 preparedness of your physician staff/providers:

Answer Options	Percent	Count
Fully prepared	0.4%	1
Well prepared	12.9%	35
Somewhat prepared	58.1%	158
Not prepared	22.4%	61
Don't know	5.1%	14
Other (please specify)	1.1%	3
Total:		
272		

Other (please specify):

- Initiated physician training in late July
- Some are prepared, some not at all

19. What training methods have you used to educate your physician staff/providers for ICD-10 implementation? Check all that apply:

Answer Options	Percent	Count
One on one training with a CDI, physician advisor, or HIM/coding specialist	50.9%	138
Webcasts	20.3%	55
Live training (conferences, boot camps, etc.)	32.8%	89
Online training/e-learning program	55.0%	149
PowerPoint presentations and/or group meetings	55.0%	149
Pocket cards or tip sheets	60.9%	165
Newsletters	36.5%	99
Other (please specify)	12.2%	33
Total:		
271		

Other (please specify):

- Posters
- We have not begun training
- HCPro boot camps
- Coding is responsible for arranging training
- Monthly e-mails and a ticker board in the doctor's lounge
- Updated admission templates
- Consultants
- Self-study modules by company
- We don't educate our physicians
- Not sure what administration has planned
- Seminars
- Preparedness testing for physicians
- Overview at staff meetings

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20. Has your CDI department asked leadership to add CDI staff in anticipation of ICD-10 implementation?

Answer Options	Percent	Count
Yes, and it was approved	27.6%	76
Yes, and it was denied	12.7%	35
No, have not asked	39.6%	109
Don't know	13.1%	36
Other (please specify)	6.9%	19
Total:		
275		

Other (please specify):

- We were told we would not need extra staff
- Transitions in leadership occurring
- Yes, still pending approval
- We have asked, but have not heard anything
- Contracted employees for three months
- We are adding staff, but not related to ICD-10
- Pending to add one more, but worried about budget constraints

21. Please rate the engagement and collaboration of your medical staff in CDI:

Answer Options	Percent	Count
Highly engaged and motivated	6.4%	17
Mostly engaged and motivated, with some exceptions	43.2%	115
Somewhat engaged and motivated	36.8%	98
Mostly disengaged and unmotivated	13.5%	36
Total:		
266		

22. How supportive is your organization's administrative team to the success of CDI efforts?

Answer Options	Percent	Count
Strong support	37.7%	101
Moderately supportive	28.7%	77
Somewhat supportive	25.4%	68
No apparent support	6.7%	18
Other (please specify)	1.5%	4
Total:		
268		

Other (please specify):

- Information does not filter down
- They are in it for the money
- We never see them or interact with them

23. Do you have a physician advisor to CDI?

Answer Options	Percent	Count
Yes, in a full-time capacity	13.0%	35
Yes, in a part-time capacity	50.9%	137
No, but we have plans to add one	14.1%	38
No, and we have no plans to add one	21.2%	57
Don't know	0.7%	2
Total:		
269		

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24. If you answered yes to question 23, how is your physician advisor paid?

Answer Options	Percent	Count
Not paid/volunteer	10.0%	18
Part-time/paid hourly or as percentage of time	31.7%	57
Full-time/salaried	15.0%	27
Don't know	38.3%	69
Other (please specify)	5.0%	9
Total:		
180		

Other (please specify):

- Contracted with a small payment
- Part time UM, part time CDI
- Don't know/leadership handles
- Our advisor is a hospitalist and is compensated for that
- He is the CMO and physician advisor is part of his duties
- Salaried, but holds other roles

25. If you answered yes to question 23, please rate the effectiveness of your physician advisor:

Answer Options	Percent	Count
Very effective (i.e., greatly improved query response rates, handles escalated problems very well, provides successful educational sessions, etc.)	22.9%	40
Reasonably effective	35.4%	62
Somewhat effective	29.1%	51
Ineffective	12.6%	22
Total:		
175		

26. How many days do physicians have to respond to a query in your facility (i.e., the required time frame in which they are supposed to answer)?

Answer Options	Percent	Count
One day	6.8%	18
Two days	26.6%	70
Three days	9.5%	25
Four days	1.9%	5
Five days	1.5%	4
Six days	0.4%	1
Seven days	3.8%	10
Seven-14 days	5.7%	15
Within 30 days	7.6%	20
We don't have a time frame for query response	27.4%	72
Don't know	3.4%	9
Other (please specify)	5.3%	14
Total:		
263		

Other (please specify):

- Varies with physician practice group
- We ask for 24 hours
- Six hours
- 48 hours concurrently, 72 hours retrospectively
- If not answered in 24 hours, escalated to physician reviewer
- Three hours
- Ideally three days, but we chase until we get an answer
- Prior to discharge
- We escalate after 24 hours
- 15 days until suspension

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27. What is your physician query response rate (i.e., % of queries meaningfully acknowledged by the physician) within your facility's required time frame?

Answer Options	Percent	Count
0-10%	0.4%	1
11-20%	1.5%	4
21-30%	1.1%	3
31-40%	0.7%	2
41-50%	2.6%	7
51-60%	3.4%	9
61-70%	4.5%	12
71-80%	13.8%	37
81-90%	28.7%	77
91-100%	28.4%	76
Don't know	9.7%	26
We don't track this metric	5.2%	14
Total:		
268		

28. What is your physician query agree rate (i.e., written response on a query form or in the record that results in a new or more specific ICD-9/ICD-10 code)?

Answer Options	Percent	Count
0-10%	0.0%	0
11-20%	2.2%	6
21-30%	1.9%	5
31-40%	1.1%	3
41-50%	0.7%	2
51-60%	2.2%	6
61-70%	6.0%	16
71-80%	19.8%	53
81-90%	28.4%	76
91-100%	16.4%	44
Don't know	14.6%	39
We don't track this metric	6.7%	18
Total:		
268		

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29. Does your Medical Executive Committee have an escalation policy or other policy requiring physicians to respond to queries/CDI clarifications?

Answer Options	Percent	Count
Yes	39.9%	107
No	43.3%	116
Don't know	11.2%	30
Other (please specify)	5.6%	15

Total:

268

Other (please specify):

- Yes, but it is not enforced
- Currently developing this process
- They do not follow through with this policy
- We have this policy with our hospitalist group
- HIM policy, not medical executive
- CDI has a policy, not with the medical executive team
- It is on paper, not all of the necessary parts are not fully in place

30. Where does your facility stand regarding implementation of an EHR? If you answered "all paper" or "not applicable" to this question, please proceed to question 35.

Answer Options	Percent	Count
Currently completely digitalized with EHR	42.5%	110
Completely digital EHR after discharge, but some records are scanned	20.1%	52
Currently hybrid medical record (electronic and paper) with plans to be totally electronic by 2016 or sooner	20.8%	54
Currently hybrid medical record (electronic and paper) with no immediate plans to be fully electronic	13.1%	34
All paper medical record, but with a defined plan/process to be totally electronic by 2016 or sooner	0.4%	1
All paper medical record with no immediate plans to implement an EHR	0.0%	0
Not applicable/I don't work in a facility or hospital	0.8%	2
Other (please specify)	2.3%	6

Total:

259

Other (please specify):

- Hybrid record, want to go electronic but unsure when
- Currently hybrid, fully electronic in 2017
- Total EHR by July 1, 2015

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31. Who is your EHR vendor?

Answer Options	Percent	Count
EPIC	32.7%	84
Cerner	21.0%	54
McKesson	7.4%	19
Meditech	15.6%	40
Allscripts	6.2%	16
Athenahealth, Inc.	0.4%	1
eClinicalWorks	0.0%	0
NextGen Healthcare	0.0%	0
GE Healthcare	1.9%	5
Greenway Medical Technologies, Inc.	0	
Abraxas Medical Solutions	0.4%	1
Siemens	4.3%	11
Quadramed	0.4%	1
Don't know	3.5%	9
Other (please specify)	6.2%	16
Total:		
257		

Other (please specify):

- Not applicable
- Paragon
- Evident/CPSI
- Switching to Epic by 2018
- Medsphere
- 3M
- Edco Solcom
- Medhost
- Nuance/DSS
- Sunrise
- Upgrading Meditech in 2016
- Comination of systems
- Varies

32. Please rate your level of satisfaction with your EHR vendor's software:

Answer Options	Percent	Count
Very satisfied	9.8%	25
Mostly satisfied	37.4%	95
Somewhat satisfied	35.4%	90
Not satisfied	14.2%	36
Not satisfied and looking for a new vendor/product	3.1%	8
Total:		
254		

33. Does your EHR allow for electronic queries/ prompts to the physician?

Answer Options	Percent	Count
Yes, it's built into our EHR vendor software and we use it	47.5%	121
Yes, we have this capability but choose not to use it	6.3%	16
No, we don't have this capability	27.8%	71
No, but we use a supplemental electronic query program	4.3%	11
Other (please specify)	14.1%	36
Total:		
255		

Other (please specify):

- Not applicable
- We have it, but it doesn't work well
- We use e-mail for queries
- We use the sticky note feature (in Epic) to leave queries
- In the process of building it
- Coders use written queries, CDI use verbal queries
- We use both HER and e-mail generated queries
- We use it sometimes
- We will start using is later on, in the process of implementing

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34. If you answered yes to question 33, has electronic querying been beneficial for your CDI specialists? Check all that apply.

Answer Options	Percent	Count
Yes, it has improved our efficiency	53.3%	88
Yes, we are more productive	34.5%	57
Yes, it has improved our query response rate	31.5%	52
Yes, we are now able to work off-site	23.0%	38
Yes	5.5%	9
No	7.9%	13
Not sure yet	13.9%	23
Other (please specify)		20
Total:		
165		

Other (please specify):

- It's easier for our physicians
- The response rate is not greater
- Our response rate is dropping
- Could be better
- Physician satisfaction has declined
- It has not improved efficiency, we still have to chase physicians down
- Depends on the provider—verbal queries are sometimes better
- New CDI program/just started with a new EHR

35. Do your CDI specialists work remotely?

Answer Options	Percent	Count
No/our facility does not allow or have capacity for this option	73.5%	189
Yes, about 10% work remotely	12.1%	31
Yes, about 25%	3.5%	9
Yes, about 50%	5.4%	14
Yes, about 75%	4.3%	11
Yes, 100% work remotely	1.2%	3
Total:		
257		

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36. If you answered yes to question 35, please compare the effectiveness of your CDI specialists working offsite vs. those onsite:

Answer Options	Better than onsite	Same	Worse than onsite	Rating Average	Response Count
Query rate	11	47	2	1.85	60
Query response rate	9	47	3	1.90	59
Productivity	30	25	4	1.56	59
N/A	3	6	1	1.80	10
Don't know	5	11	1	1.76	17
Other	2	4	2	2.00	8
If other, please specify					9
Total					**75**

Other (please specify):

- We do work remotely if bad weather only
- Each CDI works one day per week remotely

37. Does your facility provide career ladders within your CDI department?

Answer Options	Percent	Count
Yes, we have steps based on experience, educational level, and certification	3.1%	8
Yes, we have advancement levels and job description variations (i.e., CDI Specialists, CDI Educator, CDI Team Leader, Advanced CDI Practitioner, etc.)	6.2%	16
No, but we have salary steps instead	19.8%	51
No, and we have minimal raises	58.5%	151
Don't know	6.2%	16
Other (please specify)	6.2%	16
Total:		
258		

Other (please specify):

- Unionized
- Salary steps and possible raises with annual evaluation
- One minimal raise in five years
- No, but we have an incentive bonus
- No, we have merit raises
- Retention bonus program
- Exploring the possibility
- No specific structure for raises
- Clinical ladders and certification get paid, but not through CDI

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

Answer Options	Percent	Count
None/very little	12.8%	33
Moderate	28.3%	73
Good	33.7%	87
Excellent	14.0%	36
Don't know	11.2%	29
Total:		
258		

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

Answer Options	Percent	Count
Yes	58.1%	150
No	41.9%	108
Total:		
258		

40. When was your last salary increase?

Answer Options	Percent	Count
Within the last 3 months	19.8%	51
Within the last 6 months	14.3%	37
Within the past year	38.4%	99
More than a year ago	20.2%	52
Other (please specify)	7.4%	19
Total:		
258		

Other (please specify):

- I am newly employed
- We receive salary increases tied to annual reviews only, not CDI
- Quarterly incentive bonus
- Our CDI program is still too new
- I am the top of my salary range for my position, so I receive an annual payout based on my performance
- I received a raise last annual review, but several years for any market match

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41. If your raise was based on incentive, how was your adjustment based?

Answer Options	Percent	Count
Query rate	5.9%	6
SOI/ROM	3.9%	4
Case mix index (CMI)	4.9%	5
Query response rate	2.9%	3
Other (please specify)	82.4%	84
Total:		
102		

Other (please specify):

- Not based on incentive
- Workload, which increased due to transient leadership
- Wasn't based on CDI work
- Percentage of salary
- Peer review
- Standard 2% across the department, unless you are maxed out
- Productivity measures and contributions to system mission and core values
- Higher CMI and reduction in HACs
- Promotion
- Yearly
- I didn't receive a raise

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

Answer Options	Percent	Count
Very good/high growth industry (due to changes/new regulations/need for CDI programs)	71.4%	185
Mixed—depends on state/location, etc.	27.4%	71
Poor—restrictive regulations and other changes have diminished growth potential	0.4%	1
Other (please specify)	0.8%	2
Total:		
259		

Other (please specify):

- Good short-term growth
- CACDI enhancements will limit growth in the next 5-7 years

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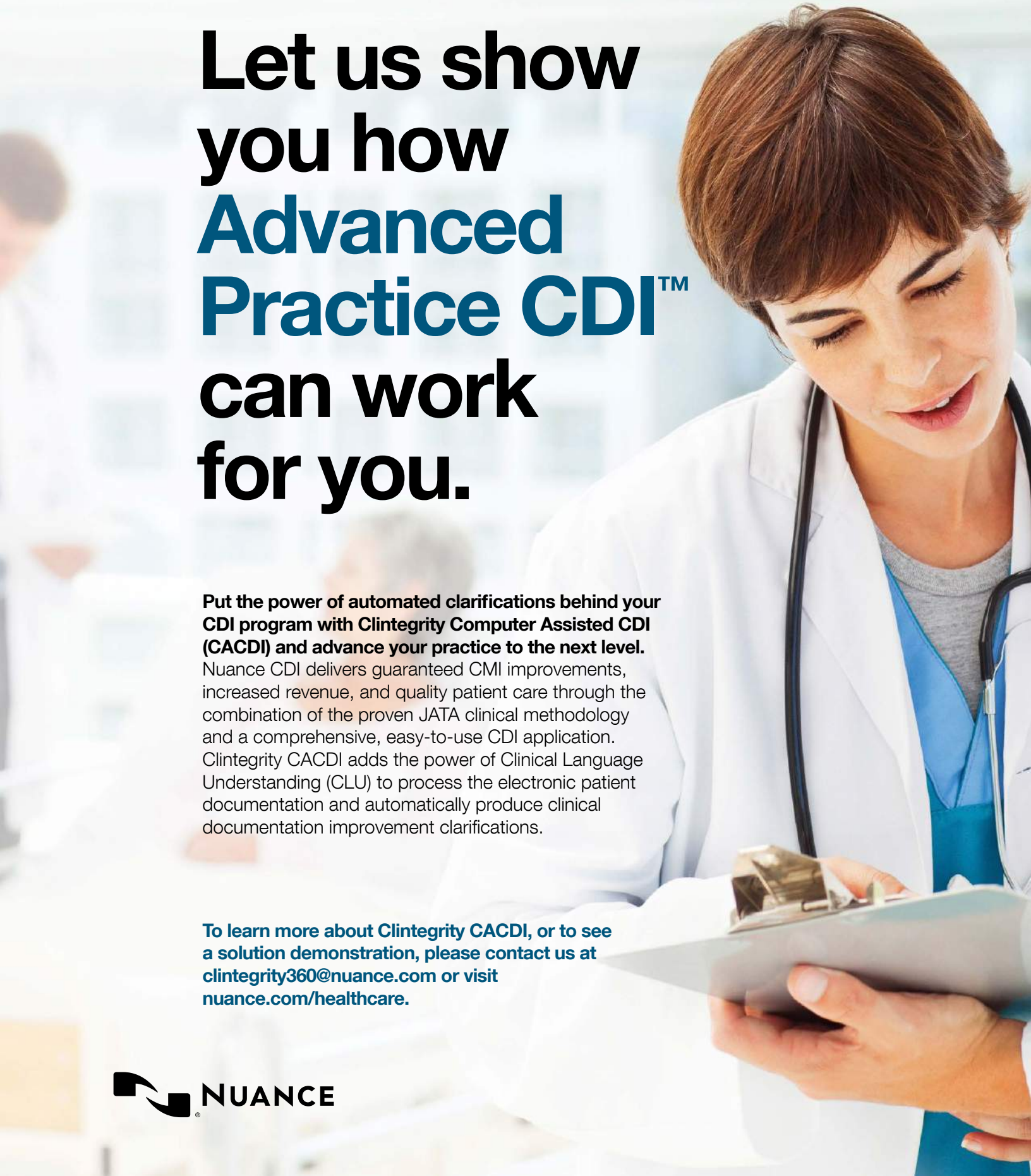

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