# Q&A CDI WEEK

## CDI Expansion

*As part of the seventh annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics.* ***Leigh Wolff, RN, BSN, CCDS****, a clinical documentation specialist at Elkhart General Hospital in Elkhart, Indiana, and a member of the 2017 CDI Week Committee, answered these questions on CDI expansion. Contact her at lwolff@beaconhealthsystems.org.*

**Q When did you first get involved in CDI, and what was your CDI program's focus?**

A I started with CDI in December of 2000. It all started when I attended a seminar to learn about legal documentation for nurses. The seminar interested me, and I began to read more about nursing documentation.

A few months later, I saw a posting at my hospital for a new position for clinical documentation improvement; I thought it would be a great fit. I applied and received one of the two positions available.

We had a few focus areas:

1. To ensure that clinical indicators, medications, and treatments had coordinating medical diagnoses (because coders "cannot assume and are not mind readers," as my very wise consultant told me).
2. We looked for alternative principal diagnoses that could potentially capture greater revenue.
3. We looked for CCs, which helped to drive the payment higher.

Basically, our focus was to increase our revenue by asking the physicians to accurately document their care with the correct verbiage, correct abbreviations, and specific diagnoses. We accomplished our revenue goal in less than a year and received a framed certificate for our efforts.

**Q How has the focus of your CDI program changed over the years?**

A I have seen many changes in the CDI field. We were trained with the coders at our hospital, and this made for a good team since we both could learn from each other.

We only reviewed Medicare charts at the beginning—and paper charts at that! Our worksheets were also on paper.

At the time, there were only a few CDI consulting firms, and no CDI networking organizations. It was on-the-job experience without much help or influence from others.

Also, remember that in 2000 it was the DRG system with only CCs, no MCCs. And CCs were easy to get—dehydration, atrial fibrillation, and hypokalemia were actually

CCs back then. We didn't worry about present on admission (POA) status, Patient Safety Indicators, hospital-acquired conditions (HACs), Recovery Audit Contractors, Medicare Audit Contractors, or any auditors for that matter, because they were not present at this time.

Next, they introduced us to the MS-DRGs with CCs and MCCs. This increased the number of codes and MS-DRGs.

Also introduced during this time were quality control for facilities, core measures, POA, and HACs. We started to hear about quality auditors with all those different abbreviations coming to take the hospital's revenue.

It was a scary time. Our hospital formed an audit committee in which the CDI department participated. We then focused on getting the most accurate and complete documentation in our health records for quality of care and improving our quality measures.

Then, the government said that we needed to go to an EHR, and CDI consultants came up with new CDI computer software programs. This was very helpful with obtaining data and reports. It was an exciting time to have new tools and resources.

Next, CDI associations became available with networking, education, and creating processes and procedures. ACDIS created a certification for CDI professionals—the CCDS certification.

The government started aligning the payment with quality advances. ICD-10-CM/PCS codes, along with CMS quality initiatives (e.g., Hospital Value-Based Purchasing Program, Hospital Readmissions Reduction Program, HAC Reduction Program), can cause penalties or rewards based on the hospital's performance. There are medical necessity issues, clinical validation issues, and inpatient versus outpatient/observation issues that are now part of the CDI practice.

CDI has become a necessary part of the revenue cycle and is expanding into many different areas and roles. It is an exciting time to be in CDI.

**Q How has your CDI program kept up with changes in the larger industry?**

A Our hospital has been fortunate in having committed medical directors and managers involved with the CDI program. Our first manager contracted with a professional CDI consulting firm, which proved to the administration that a CDI program was needed. She used the consulting firm to educate the medical staff, coders, and CDI.

She retained them for collecting data, analyzing it, and reporting to the administration the worth of the program. This produced additional resources for moving into other DRG-based payers, computer software, and additional CDI staff.

The hospital continues to search outside sources for education for the CDI program. The hospital pays for the CDI specialists to join ACDIS and sent a CDI specialist to the first national ACDIS Conference. The hospital continues to send at least one CDI team member to every ACDIS Conference, knowing the importance of the education.

All CDI specialists at our hospital have joined our local state ACDIS chapter for education and networking purposes. All of our experienced CDI specialists have the CCDS certification, and the hospital paid for these.

Our new hires are trained by the ACDIS CDI Boot Camp Online and oriented to CDI by experienced CDI specialists.

We search out and watch informational webinars on CDI, case management, coding, and quality issues as much as possible. We have signed up for many free newsletters from many different organizations in the CDI realm to keep abreast of the many new changes. We purchase educational books on many of the topics in CDI, such as the CDI Pocket Guide.

**Q What do you think is the most important thing for a CDI specialist/manager to do to stay informed about industry trends?**

A I believe that networking with others, by reaching out to other facilities and joining a professional organization or two, are the most important things CDI specialists should do. Seeing what others are learning or struggling with can be very beneficial.

Also, working with other departments in your own facility, especially coding, case management, and quality can expand your scope in CDI.

CDI professionals should also search the internet for CDI websites and sign up for free newsletters and webinars.

**Q What do you think CDI programs/staff should track in terms of data to show program effectiveness and opportunities for expansion?**

A Metrics for our CDI program include the:

- Individual CDI specialists' review rates to show our productivity
- Department query rate
- Top 10 physicians with the most queries for education
- Query topics for these physicians to see if there is a pattern and if we need to do education on these topics
- Response rate to our queries to see if our process is working

The case-mix index for the hospital, which is done by the revenue cycle committee, is also followed very closely. I personally do not favor the monthly CDI comparison as there are too many variables.

**Q Where do you think the greatest opportunities for CDI program growth lie in 2017/2018?**

A The outpatient/observation setting seems to be a hot topic for CDI expansion. There are many different areas in outpatient that could benefit from CDI efforts. It seems to be getting difficult to place patients into inpatient stays due to medical necessity.

Because of this trouble, we are searching for ways to expand CDI into the now more populated area of outpatient and observation.

Quality is another area that CDI is expanding in; with the quality initiatives penalizing the hospitals for HACs, readmissions, etc., hospitals have to create processes to help protect their revenue.

**Q When CDI programs identify target areas, what are some of the typical obstacles they face in obtaining administrative support for program expansion?**

A At first, it was hard for the administration to see that there is a need for CDI expansion because there's limited information on the effect CDI can have. Administrators want proven data and methods, and since CDI expansion is fairly new, obtaining data is difficult—so this lack of data makes it difficult to support the cause of CDI expansion. As we began to see lower revenue, it's now that we are beginning to research expanding CDI efforts.

And, I suspect, the famous words of "not in the budget" can be a very big obstacle in most facilities.