

# Q&A



## Career Advancement



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. **Laurie Morelle, RN, MS, CCDS**, manager of clinical documentation at Lifespan Corporate in Providence, Rhode Island, and a member of the 2017 CDI Week Committee, answered these questions on CDI and career advancement. Contact her at [lmorelle@lifespan.org](mailto:lmorelle@lifespan.org)

**Q What, in your mind, does the “typical” CDI specialist role entail?**

**A** A CDI specialist must have in-depth critical thinking skills, be able to analyze the clinical status of a patient along with the treatment plans and history, and be able to find potential gaps in documentation that will result in a more accurate reflection of the patient’s severity of illness and risk of mortality.

A CDI specialist must also be able to effectively communicate with and educate licensed independent practitioners (LIP) through individual sessions, queries, and other means of compliant communication. The CDI specialist must demonstrate expert knowledge of ICD-10 codes and DRG assignments and be able to reconcile differences in the final coding.

**Q As CDI programs advance, they begin to branch out into other review areas. What areas do you think programs should move into first?**

**A** After determining the individual organizational focus and what quality metrics/benchmarking

programs the organization may belong to, a CDI program could first branch out into doing mortality concurrent reviews. This will lead to showing the risk of mortality a patient has and the overall organization’s mortality risk metrics. They could then advance from this into the retrospective mortality reviews on all expired patients.

**Q What is the most important thing a health-care professional should do to further their career as a CDI specialist, either in CDI or elsewhere in healthcare?**

**A** Constant education about medical and surgical diagnoses is of utmost importance. A CDI specialist needs to build close relations with the LIP partners so they can ask questions to better understand clinical criteria.

It is imperative to also collaborate with coding partners to be a conduit between the LIP and the coders—always asking, “What is needed to have the final DRG complete upon final coding?” CDI specialists should become members of their organization, ACDIS, which offers phenomenal education, Q&As, blogs, training, webinars,

radio briefings, on and on. It is important for a CDI specialist to network and dig into the resources available.

**Q Do you think CDI specialists are compensated adequately for the work they do? Why or why not?**

**A** We can always hope for more compensation! I do believe that we have a strong impact on the financials and, as importantly, the quality metrics. I would hope that all CDI professionals are compensated appropriately with those factors in mind.

**Q It seems like the most typical career ladders for CDI fall into two categories: the step category, in which individuals advance based on education, time on the job, and certification; and the expertise category, in which individuals advance based on their demonstrated capabilities and task sets such as CDI physician educator, quality reviewer, or data analyst. Can you talk about some of the pros and cons of these categories? What does your facility have in place?**

**A** In our facility, we have two levels of CDI specialists: the CDI specialist and the senior CDI specialist. In order to become a senior CDI specialist at our facility, you must be certified, have two years of CDI experience, and have well-demonstrated role model performance. You must be a clinical resource and mentor for your peers, orient new hires, develop and deliver education to LIPs consistently, have compliant work, and participate in extra projects such as audits, appeals, etc. It is an incentive to have this ladder as it motivates staff to excel and achieve an advanced role within the department.

**Q How important do you think it is to develop career ladders of some sort to ensure CDI retention?**

**A** It is very important for staff to have the ability to grow within a department. It takes a lot of

resources, education, and time to develop staff into independent, well-trained CDI specialists. The ladder shows staff that the organization values the department's goals and achievements by offering career advancement. Career ladders assist in retention and staff morale and overall sense of value to the organization.

**Q What type of salary structure do you think career ladders might employ (e.g., 5% salary increase per year or bonus structure)?**

**Why?**

**A** In our organization, once a CDI specialist becomes a senior CDI specialist, we do offer a one-time salary increase. This is a way that the organization rewards an individual for advanced skills and commitment to the organization.

**Q How different will CDI look as a profession 10 years from now?**

**A** I have been in the CDI world for eight years, and there has been huge growth. No longer is CDI just MCC/CC focused. The CDI industry has grown and advanced into many quality metric directions to outpatient CDI programs.

Not to mention the huge technology advances—paper to full EHR! I can only imagine what the next 10 years will bring with the many changes in healthcare, but I feel there will always be a strong inpatient CDI focus with major outpatient CDI growth.

Technology will continue to surge ahead with advanced forms of computer-assisted coding. Some may say all will be remote in the future, but I feel that a balance with remote shifts is needed, as the “human factor” is very important for building relationships and education. I still feel the hallmark of a successful CDI program is building relationships with providers, coders, and other peers face-to-face.



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. **Caryn Nowak, RHIT, CDIP**, a clinical documentation integrity specialist at Rady Children's Hospital in San Diego and a member of the 2017 CDI Week Committee, answered these questions on CDI and technology. Contact her at [cnowak@rchsd.org](mailto:cnowak@rchsd.org).

**Q How long have you had electronic health records?**

**A** At Rady Children's Hospital—San Diego (RCHSD), we began our EHR journey with a phased approach. In August of 2009, we began with the emergency department and some outpatient clinics and phased in the remaining ambulatory clinic locations throughout 2011.

In September 2011, inpatient and ambulatory surgery records transitioned to electronic. Currently, we are fully electronic, enterprise wide.

**Q: Have there been any real sticking points with the transition to full electronic systems?**

**A:** We have had great success in transitioning to an electronic system through leveraging interdisciplinary collaboration and governance. The leadership and medical staff have been supportive throughout.

The EHR and revenue cycle steering committee provided excellent governance for the whole process.

Midway through our first five years, there was a brief pause to allow for workflow optimization, particularly for clinicians. For HIM and hospital coding professionals, leveraging technology and system tools such as computer-assisted coding (CAC) allowed for a smooth transition with the EHR as well as ICD-10.

**Q What are the next steps to make sure everything continues to run smoothly?**

**A** The next step to ensure processes run smoothly is being ahead of the game through innovation, integration, and collaboration. The clinical information services team and HIM clinical informaticists are continuously identifying new ways for innovation. The clinical informaticists perform robust testing scenarios and test workflows with each system upgrade. Both teams work together as a collaborative effort with the same end goal in mind.

**Q** RCHSD has leveraged innovation and interoperability between EHR and other systems to ensure smooth and efficient systems.

**A** **Do you have an electronic query system separate from the EHR?**

The RCHSD query to the clinician is generated through an EHR inbox message. The clinicians are then prompted to update the documentation in the actual note as well as the hospital problem list, as the query is not part of the legal medical record.

RCHSD uses the CDI functionality within the CAC application for tracking and reporting query metrics on a monthly basis.

The CDI team receives a weekly productivity report capturing CDI reviews, query response rates, and pending queries.

**Q** **Do you have staff who work remotely now that you are electronic?**

**A** At the start of the program over six years ago, the CDI team worked on the inpatient units, but when the EHR went live in September 2011, they moved into the HIM department. The team has since moved to a hybrid schedule, with two days working on the units, two days remote, and one day in the off-site HIM department.

The day the CDI team is in the HIM office together allows for sharing of ideas and teamwork. The CDI team has a buddy system where a more experienced CDI staff member works with a newer member of the team while on-site at the hospital.

On the hospital days, the CDI team members have the opportunity to meet with each other to discuss case scenarios. The CDI team appreciates the hybrid schedule, which allows for flexibility in their work schedules.

**Q** **How has the partial move to remote staffing affected productivity and physician engagement with the CDI team?**

**A** The CDI team is productive regardless of their location; however, being able to be on-site in the hospital allows for relationship building. It gives them the ability to work face-to-face with clinicians, ask

verbal queries, and attend departmental rounds, which are all integral to building and maintaining relationships with our customers, the clinicians. In my opinion, these opportunities would not be possible if the staff was working 100% remotely.

**Q** **How do you handle team education?**

**A** Every Monday, the CDI staff works in the HIM office and has a weekly huddle. The team brings forth topics they wish to discuss. Examples of challenging case scenarios are presented and discussed as a team until a consensus is reached. Once a month, the inpatient coding staff come on-site for a meeting with the CDI team. This monthly meeting allows for face-to-face time with their peers, relationship building, and team collaboration.

**Q** **Were there challenges related to the CDI team conducting reviews in the EHR or challenges facing physicians following your EHR implementation?**


**A** Originally, the CDI staff were on the floors with a paper chart. If the CDI team had a question, they would walk over to the clinician with the paper chart in hand. The clinician would hover over the chart, and the two would have a discussion. When the EHR was introduced initially, there was a struggle for both the clinician and the CDI team as a new workflow was in place. Change can initially present its own challenges, but in the end, it's beneficial for ease of workflow.

**Q** **Are note bloat and copy/paste a problem at your facility? If so, how are you working to combat it?**

**A** The documentation is validated by CDI staff to ensure the current conditions are documented within the medical record. If the CDI staff notices a discrepancy or needs clarity, a query is placed for clarification with the clinician. The clinical informaticists within HIM assist with ensuring workflows are functional from the clinician perspective and can troubleshoot note template issues. The clinical decision support committee is

supportive with the copy/paste initiative based on hospital policy.

### **How have you leveraged technology to improve CDI efforts?**

 We use reporting in the EHR to ensure the hospital problem list is completed enterprisewide. Reports created by clinical informaticists enable the CDI team to query for any blank hospital problem lists within the medical record without having to review every single inpatient encounter.

Since RCHSD is a pediatric organization, ensuring that the hospital problem list is updated with the current conditions receiving treatment is vital. A complete hospital problem list allows for a more thorough clinical picture of the patient at the time of the encounter.


Any discrepancies or clarifications need to be queried to confirm if the diagnosis was current and actively being treated. The idea is that if the hospital problem list is reviewed for accuracy for each encounter, then the next time the patient presents at RCHSD, any chronic conditions would already be reflected on the problem list.

Although the CDI team has sent queries for blank hospital problem lists since 2013, the team began leveraging reports in November 2016. Since we began utilizing reports within a matter of months the amount of queries decreased by half.

Now, the majority of RCHSD clinicians have completed the hospital problem list before the CDI team performs their first review. The success with the hospital problem list project has allowed the team to begin looking for new

ideas of how to leverage system reports to identify additional opportunities.

### **What advice do you have for people transitioning to EHRs?**

 The best advice is to understand how the system works: understanding the why behind the what.

Collaboration is also essential for success. If CDI is able to help answer a question for a clinician, helping them improve their workflow, a positive relationship can be cultivated. The CDI team is providing enhanced customer service to clinicians, which in the end helps with the overall documentation workflow.

The makeup of our CDI team is unique in that we have a mix of nurses, coding, and HIM professionals with different backgrounds. The team also has a former ICU nurse, who was also a clinical informaticist. Having a former EHR informaticist on the team has helped identify, note, and fix issues with clinician note formatting and templates.

Conversely, one of the HIM clinical informaticists was formerly a CDI team member. They understand the CDI workflow and are a valuable asset when it comes to identifying and correcting workflow issues. Another CDI team member has an information technology background and has received additional EHR training, hence the CDI team is equipped to help clinicians troubleshoot issues when they are working on the units.

The cohesiveness of the different backgrounds has allowed for process improvement, innovation, leveraging system tools, relationship building, and knowledge sharing amongst the team.

**Jonathan Elion, MD, is the founder of ChartWise Medical Systems, Inc., in Providence, Rhode Island. He is a practicing board-certified cardiologist and an associate professor of medicine at Brown University. He has served on the finance committee and board of trustees of several Brown-affiliated hospitals and is well versed in hospital finances. Here Elion discusses the role of CDI in quality measures. Contact him at [jelion@chartwisemed.com](mailto:jelion@chartwisemed.com).**

The use of technology has become a requirement for most modern Clinical Documentation Improvement programs. The right software can bring consistency and efficiency. But not all software is created equal. You should look for tools that, at a minimum, provide the following features and functionality.

### Accurate Patient Census

This information is usually obtained from the HL7 “Admission-Discharge-Transfer” (ADT) messages in a Hospital Information System (HIS). The ADT messages also contain valuable information about payers which should be tracked to provide accurate reimbursement metrics.

### Worklist Management

Cases for review should be automatically assigned to documentation specialists and physician advisors based on assignment rules that can be managed by the CDI manager. The ability to handle scheduled and unscheduled absences, as well as hand-off between staff members, is especially important.

### Expertise to Enhance User Knowledge

True Artificial Intelligence (AI) provides answers to problems, eliminating the need to consult a human expert. When AI is applied to a CDI program in a built-in Expert System, it can analyze and interpret information from the patient’s chart.

For example, an expert system could look at a patient’s list of medications and laboratory results and suggest additional relevant diagnoses. It can notice that despite the use of an antibiotic, no bacterial infection code has been noted. It can help to find potential relationships and linkages among diagnoses and make inferences about things not yet fully documented.

While an expert system cannot be expected to be better than the human expert, it can automate and process large amounts of information, effectively cloning the expertise of the human expert. This becomes extremely helpful in improving efficiencies and in training new staff in the subtleties of CDI.

### Increased Efficiency

Rather than attempting to prioritize charts to see which ones should be reviewed, a good tool helps to increase efficiency so that all targeted charts can be reviewed. As we move into the world of risk adjustment, using prioritization to cherry-pick reviews will be less and less effective.

If you pick your most “acute” patients based on admission codes, patients with chronic conditions are likely to be overlooked. A DRG with a high weight does not necessarily equate to a high-level Risk Adjustment Factor (RAF) score. Remember, it’s the chronic conditions that make a major contribution to the RAF score.

### AHIMA/ACDIS-Compliant Query Library

A complete library of query templates ensures consistency and compliance across all CDI staff, helps to avoid leading queries, demonstrates a broad coverage of topics (not just those that lead to higher reimbursement), and provides an auditable query process.

Information from physician responses should directly populate metrics and code lists to help improve accuracy and efficiency.

### Minimal IT footprint

Hospital Information Technology (IT) departments are quite busy these days, making a web-based application an attractive proposition. The IT department has no hardware or software to install, configure or maintain, as

the software vendor takes care of all of that for you, and the time to install is greatly reduced.

### **Timely and Meaningful Reports**

There are situations where immediate access to up-to-the-minute information is important. For example, resolving documentation of possible Hospital-Acquired Conditions (HACs) and Patient Safety Indicators (PSIs), making sure the CDI specialist and the coder agree before the bill is sent, and resolving open queries before billing all require immediate access to the relevant data and reports.

Look for reports that are available at any time “on demand,” and able to be sent on a scheduled basis. For hospital systems, it is important that reports and data be available on a division- or enterprise-wide basis, without

requiring any work by staff to collect and aggregate the numbers from each hospital.

### **Promotes Collaboration**

In addition to the obvious collaborations among CDI staff, coders, and clinicians, it is important to make data and communications available to other departments as well, such as Case Management, Utilization Review, and Quality Management. Facilitating internal notes and notifications goes a long way to breaking down barriers between departments.

The right technology tools can improve the quality, compliance and consistency of your CDI program, while making it more efficient and impactful. And at the end of the day, that should be the goal of everyone involved.



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**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.

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

 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.

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

 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?**

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.



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**Q How does clinical validation differ from DRG validation?**

**A** Clinical and DRG validation involve two different skill sets. Coding professionals use their expertise with coding conventions and guidelines to select the correct codes for sequencing of the principal diagnosis and any secondary diagnoses. Coders know how to apply rules and exclusion criteria to documentation that may be viewed differently through the clinician's lens. The level of care and utilization of resources brings the views together.

The DRG and clinical processes are different, and communication with coders is vital for successful reviews. Clinical validation requires expertise with pathophysiology and treatment. Experience caring for patients facilitates the process by providing the clinical documentation specialist a wealth of references for the human response to illness and treatment.

When a question arises during a chart review, the CDI specialist asks for documentation of what the provider saw in that response to illness and treatment. The diagnosis belongs to the provider.

**Q What does your clinical validation process look like? Can you describe it? (e.g., is it part of the CDI staff's ongoing concurrent review process? Do you have a pre-bill/post-discharge second look process?)**

**A** Clinical validation built into concurrent review provides as near to real-time clarification as possible. The physician has a clear recollection, and the documentation can support why a particular course of treatment was prescribed at that time. Changes in condition are more easily compared, especially for off-shift covering providers. Clinical validation supports the accuracy and integrity of the record as a communication tool.

**Q What is the most difficult part of clinical validation reviews? (e.g., crafting a compliant non-leading query, establishing a comprehensive process for reviews, working with physicians to develop facility or system wide clinical criteria for frequently targeted diagnoses)**

**A** Clinicians often see things the same way: "Oh, I know what the note is saying." It helps to look at a note from different angles so that interpretation by

any possible reader isn't necessary. The note must be clear because the diagnosis is what the doctor says it is, as they're the one caring for the patient.

Asking for clarification of criteria can be difficult. Some clinical indicators must seem obvious or redundant to the provider writing the notes, but they do add up to a clearer picture of what is going on with the patient.

Recommending evidence-based criteria from sources such as the National Kidney Foundation or ASPEN can assist, but the choice is ultimately up to the provider to include the criteria that informed their decision.

**Q Why are clinical validation reviews more important now than they may have been previously? (e.g., the 2017 Official Guidelines 1.a.19 and the Fourth Quarter 2016 Coding Clinic, or the prevalence of claims denials based on lack of supportive clinical indicators)**

**A** Clinical validation is not simply to see if the patient has the disease documented. It is to clarify with the provider if the condition is resolved, excluded, ruled out, or improving. Patients are complex, and therapies for one illness may not be indicated for another condition; congestive heart failure and renal failure are classic examples.

Presenting symptoms can be vague and reflect many different illnesses. A chief complaint of weakness can turn out to be a serious problem. Clarifying promotes a clear, consistent record that keeps ruled-out or excluded conditions from getting into the coding while the providers and specialist consultants are able to communicate in the chart.

The ACDIS white paper "Clinical validation and the role of the CDI professional" is a good resource to use as it pulls sourced information together and includes query design options for best practice.

**Q What portions of the medical record are the most helpful when conducting clinical validation reviews?**

**A** The physical exams in the emergency department and history and physical set the stage for the principal diagnosis and present on admission

conditions. Baseline lab values give definitions for comparing the patient's usual state of health to the current diagnoses. Nursing, nutrition, physical, or respiratory therapy documentation adds description, and many providers will reference reports from these clinicians as they collaborate in caring for the patient.

**Q Can you describe your escalation process, if you have one?**

**A** Building relationships with the providers helps avoid escalation and improves the overall process. Clinical documentation leaders and key physician leaders communicate, and peer-to-peer dialogue provides respectful and effective resolution. Sometimes it's just a need for information, such as when processes or formats change. Why escalate when you can relate and communicate?

**Q How do you assess the success of your clinical validation efforts?**

**A** Query opportunities decrease, and the inclusion of specific criteria such as baseline labs, key terminology for specificity, and highly descriptive exam notes increase.

**Q How do you provide general education regarding clinical validation to the medical staff?**

**A** We do formal presentations with slides, mini presentations on selected topics at meetings, and one-on-one conversations in the clinical areas or over the telephone. A strong relationship with the medical staff where CDI specialists are seen as a resource is key. The CDI specialists must be up to date and able to answer questions. The doctors can look things up and have tools and applications at the ready.

The clinical documentation team has to offer more. We must be trusted to provide information and recommendations that are in line with regulatory guidelines and evidence-based practice. Having someone with a unique skill set, ethics, and expertise to explain why and how things work or are needed in the chart provides value.

Q&A

CDI  
WEEK 

Physician  
Engagement



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. **Kristie Perry, RN, MHSA, CCDS, CCS**, a CDI specialist at Erlanger Health System in Chattanooga, Tennessee, and a member of the 2017 CDI Week Committee, answered these questions on CDI physician engagement. Contact her at [Kristie.Perry@erlanger.org](mailto:Kristie.Perry@erlanger.org).

**Q Can you describe the engagement and collaboration of the medical staff in CDI?**

**A** You've come a long way, baby!" That's how I would start to describe the journey with CDI and the physicians.

I've been doing CDI at my facility for 10 years, and I'm one of the original nurses that started CDI at our hospital. I was assigned to the trauma service/surgical critical care service/general surgery service. Initially, the relationship was nonexistent.

I would write queries, often without any response, and finally, after I built up my nerve, I would do a verbal query when the residents/attendings were rounding. Needless to say, there were a few charts slammed, eyes rolled, calls to my manager, and raised voices.

Just like you have to stay focused when disciplining your children, however, that's how I approached my doctors. I remained calm and was a constant presence. They know now that I have their interests and the hospital's interests at heart.

**Q Why do you think so many CDI programs have such trouble engaging the medical staff?**

**A** I strongly believe that the physicians want to do the right thing. After all, they've racked up enormous debt from schooling in order to help others. Just like a stay-at-home mom with multiple children, though, the doctors are being pulled in numerous directions and have numerous responsibilities.

**Q What has been your most successful approach for obtaining physician buy-in?**

**A** I hate to keep referencing children, but with my physicians I have become that constant motherly support/force. They have come to accept that I'm not going away. I simply try to be kind, give a pat on the back for great documentation, and always say thank you! Using good manners never goes out of style. Or, you could say that I kill them with kindness.

Also, I really try to limit the focus on money and through the years have reported to the individual physicians how their words affect severity of illness (SOI) and risk of mortality (ROM); I even expand that into education about

Patient Safety Indicators (PSI) and the impact to their profile.

**Q Do you have uncooperative/unresponsive physicians, and how do you handle them?**

**A** Within the group of six that I spend the majority of my time with, I have one physician who can be a bit hard-headed. I have learned to just step back and assess his mood for the day and decide if I want to interact verbally or via written word. I must admit though, early on in my CDI efforts, I verbal queried him at the bedside one day and received a response with a not-so-nice expletive—one that I responded right back to him with and walked away.

Now, that is not my standard practice at all, but it completely changed the dynamic of our working relationship. In general, I just try to be polite and professional, and eventually they come around.

**Q Do you provide formal education to your physicians, one-on-one/informal coaching, or both?**

**A** The education role within CDI is one that I thrive in. There's nothing that I enjoy more than being out on the floors or in the units when the teams are rounding. In my mind, you cannot build that relationship unless you are visible and providing real-time education.

The education that I provide has grown over the years to include the daily education on rounds, but at least once a year I provide education to our new surgery residents

as well as the returning/senior residents in a more formal classroom setting. I provide actual charts from our facility and show how their words affect reimbursement, length of stay, SOI, and ROM.

**Q Could you tell us about an experience you had winning over a physician to CDI?**

**A** The hard-headed physician that I referenced earlier recently told me, "The major reason I cooperate with you is because you work so closely with us and try so hard." That did not happen overnight. That has come from blood, sweat, and some tears for sure! Persistence will pay off!

**Q How has the changing reimbursement landscape affected the way you interact with physicians?**

**A** In the infancy of our CDI program, I tended to focus on the dollar impact. Over the 10 years, though, that has changed drastically, and the focus is almost always on the quality aspect, such as value-based purchasing or PSI-specific information. I am an original member of the PSI committee, which has given me the opportunity to provide very specific education to the doctors and focus it on their physician profiles.

Some of the doctors couldn't care less about their profile, but most are eager to learn and often seek me out if there is a known PSI issue or question.

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### **Achieving the Quadruple Aim with Computer-Assisted Physician Documentation (CAPD)**

Providers who use EHRs and computerized physician order entry report lower levels of job satisfaction and higher rates of burnout compared to their counterparts who still use paper, according to a 2016 Mayo Clinic Proceedings study. Documentation workflow templates and cut and paste features in EHRs are supposed to improve patient care and ease physician burden, but if they're pulling physician focus away from the patient, that's not the case.

Hospitals and providers have finally recognized that helping physicians in real time when they are dictating, and enabling them to get all the critical information very quickly into the medical record without these clicks, is going to improve their satisfaction and decrease the risk that documentation doesn't comply with regulations and patient care.

And, computer-assisted physician documentation (CAPD) not only improves physician engagement, but also improves population health, increases patient satisfaction, and reduces healthcare spending.

### **Improving physician documentation at the point of care**

Nuance developed the concept of CAPD in 2011 with the idea that just-in-time guidance provided in-workflow and in line with the physician's clinical thought processes would result in a better experience for the physician, and better quality documentation earlier in the process. That innovation was driven by the realities of modern practices, and hospitals, and ever-increasing regulations, demanding that physicians document patient care in the EHR with as much detail as possible to support financial and quality reporting requirements.

Physicians want the advantage of real-time clinical guidance presented while they are entering their notes, with relevant history that comes forward on that patient, to be able to add sufficient detail to capture the full and complete story for each patient during their visit. They have a kind of remote memory – it becomes more remote the minute they step out the door of the patient's room. And so even documentation improvement efforts that are concurrent, which are much better than after discharge, are still not real time.

### **Nuance CAPD and the Quadruple Aim**

Beyond traditional CDI, which addresses gaps in documentation after the patient has entered the system with concurrent and retrospective record reviews and physician queries, CAPD spans a variety of applications and clinical content designed to bring the right information forward at the right time to the right care provider at the point of decision-making.

As a result, physicians are engaged in creating clinical documentation that contains the most appropriate information to drive the most critical aspects of the healthcare process, improving communication between caregivers, reflecting the accurate quality of care delivered, informing proper coding and reimbursement, impacting proper risk-adjustment for the population of patients served, and driving more value from EHR investments.

Regardless of where the physician sees the patient, speech recognition and real-time clinical documentation guidance is available to help the physician capture the details necessary for reimbursement, quality measures and compliance while telling an accurate patient story. This improves clinician overall satisfaction, and ultimately achieving the Quadruple Aim.



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. **Angie Curry, RN, BSN, CCDS**, the CDI director at Conifer Health in Frisco, Texas, a member of the ACDIS Advisor Board, and the 2017 CDI Week advisor, answered these questions on CDI and quality. Contact her at [angie.curry@coniferhealth.com](mailto:angie.curry@coniferhealth.com).

**Q Has reviewing for quality measures hindered CDI department's "traditional" CDI chart reviews or overall productivity?**

**A** CDI programs involved in assisting with quality measures have seen a decrease in how many cases can be reviewed, according to traditional CDI staffing recommendations. Reviews have become much more than the original CDI goal of establishing a working DRG, and MCC/CC capture.

CDI programs are crucial in addressing potential quality issues while the patient is still being treated—whether as an outpatient or an inpatient.

Many programs have needed to decrease the expected number of reviews related to the increased time being spent looking for potential quality issues.

**Q What were your initial focus items, and how have they grown or changed?**

**A** Initially, CDI programs were minimally involved with quality initiatives other than establishing present on admission (POA) status. The industry soon realized if we could positively affect complications by

establishing that conditions were actually present when patient entered the facility (and not caused by the facility) maybe CDI could assist with other aspects, such as core measures.

From there, we've seen interest in other quality measures such as severity of illness (SOI) and risk of mortality (ROM) scoring.

At this point, the evolution into quality has become part of the CDI review—including queries that may not move the DRG, but do provide an increase in SOI/ROM.

**Q Have ongoing changes in CMS and other payer reimbursement models pushed CDI program involvement with quality forward?**

**A** Yes, absolutely! Bundled payment initiatives, a CMS program, brought CDI to the table to discuss the accuracy of code assignment. These initiatives depend upon getting the primary diagnosis correct for the patient to show the true volume of inpatients that fall into either a voluntary or mandatory bundled payment. Thus making accurate DRG assignment more important than ever.



Pay-for-performance measures are another initiative where CDI has been very successful. Assisting providers in accurately capturing their patient's true SOI by capturing all comorbid conditions being monitored, evaluated, or treated in their documentation.

**Q What first steps do you think CDI program managers and/or staff members can take to expand into quality?**

**A** The advent of quality measures is a great initiative to pull together an interdisciplinary team to look at the quality issues at your facility.

Many facilities have workgroups including quality, coding, and CDI teams to do second-level reviews to assist with physician education, providing guidance for quality teams, as well as education for CDI and coding teams.

**Q How do you see quality in the greater health-care industry evolving, and what can CDI do to prepare?**

**A** Quality in the outpatient arena has become the next horizon for CDI programs throughout the United States.

Hierarchical Condition Category (HCC) capture is an integral part of outpatient care. CDI teams are learning how to review for HCCs as well as assisting not only providers but educating the hospital administration on how accuracy is integral in both inpatient as well as the outpatient medical record.

Accuracy in the outpatient record has the potential to increase the accuracy of the inpatient record, too. By getting things right in the outpatient record, those comorbid conditions can more easily be identified with an inpatient admission, and will once again assist in accurate reporting of SOI/ROM.

Facilities are experiencing decreased reimbursement for care provided. Therefore, medical record accuracy is more important than ever.

CDI programs have the potential to decrease denials, also decreasing the amount of time and staff used by facilities on the back end arguing for payment for services rendered.

I believe the future of CDI is accuracy, and at the end of the day we can all be proud of the work we do.

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Changes within the healthcare industry are driving the need for clinical documentation improvement (CDI) programs to become more actively involved in addressing quality of care metrics and outcomes reporting for their facilities. With government incentive programs, such as value-based purchasing and its various components, hospitals face financial penalties for underperforming on specific quality measures.

Furthermore, private reporting agencies pick up federal coded healthcare data and employ it on consumer advocacy sites and reports. Drive down any highway in America to visualize the effect of this reporting on the marketing of our community hospitals. Billboards lining the highways tout X Hospital as the number one provider of cardiac services in the region or Y Hospital as having earning accolades from U.S. News and World Reports for its care.

All this information is not only driven by the quality of the care provided but the quality of the documentation captured and the accuracy of the codes assigned related to that care. CDI programs may have originated to help with CC/MCC capture and drive MS-DRG assignments as a way to accurately capture reimbursement but now those efforts are also driving the narrative regarding the quality of care a facility provides.

### **Collaboration leads to quality improvement**

The secret to success may not be a well-kept, nor very complicated, one. Simply, put CDI programs need to reach out and collaborate with their facilities' coding and quality teams. If these three departments are not on the same page, it could put the program and the facility at real risk. They need to align their medical record review efforts so that the picture of that patient's care can be as accurate as possible.

Quality departments can provide the team with the current baseline data and explain the various documentation and coding components to their focus areas. As a team, the

three departments can examine their process workflows and identify areas of overlap and potentially mutually beneficial points of interest. Patient Safety Indicator 90 and hospital acquired condition documentation represent low-hanging fruit targets to start with. Programs should analyze their data to evaluate the current status of these items and lead the way to target improvement opportunities.

The CDI industry needs to move back to the original intent of the ICD coding system—as a method to capture data about healthcare trends—and really focus on capturing those chronic conditions that not only affect reimbursement but affect quality and risk adjustment as well. The healthcare industry seemingly moved away from that with the implementation of MS-DRGs but we need to go beyond those reviews now and capture everything that's going on with the patient during his or her treatments.

### **Systemic collaboration**

As departments evaluate their workflows, they need to consider employing technology that holds all these initiatives in mind. Having everyone work within the same system allows the entire team to see beneath the covers, to understand when the physician was queried and why, to demonstrate the various ways each department staff member interacts with the medical documentation and effect on the final code assignment.

Oftentimes, quality, CDI, and coding employ different playbooks. Effective artificial intelligence (AI) in form of a system-wide solutions can bring these playbooks, these different documentation rules, seamlessly together. The technology should help you run all the rules of the game. AI at the point of care helps the healthcare team act rapidly when a quality of care concern may be suspected so the CDI team can ensure the most accurate documentation possible. It can be a real game changer in this ever-challenging healthcare game.

