

Q&A

CDI
WEEK 

Technology

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As part of the sixth annual Clinical Documentation Improvement Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. **Colleen Stukenberg, RN, MSN, CMSRN, CCDS**, the director of resource management at FHN in Freeport, Illinois, and a past ACDIS Advisory Board member, answered these questions on electronic health records and using technology in CDI efforts. Contact her at CStukenberg@fhn.org.

Q How long have you had electronic health records?

A We have had computers since the early 1990s, but we used them mostly for nursing documentation. The physicians did not do documentation or ordering on them. Then we went with a newer version, but it was still principally nursing-based.

Eventually we went to computerized physician order entry so at least we had the orders in the electronic system and they could look up laboratory test results and diagnostics. At the time, we tried to explain to the physicians the value of computerized systems, and that they could access the documentation from their offices rather than from the nursing station in the hospital.

Today, we are on an entirely different platform. Once you start in with the electronic systems, it is a never-ending process of continual improvements and upgrades. It is like getting a car. Sure, it is shiny with new technology, but once you drive it off the lot it starts to depreciate in value, and there is always some fix that needs to be made or maintenance that needs to get done—new tires, oil changes. Technology moves faster than you can keep up with it.

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

A While technology may always be changing, at the same time, it does not always do the things you want it to do: One screen may not “talk” to the next or certain fields of information may not transmit to another section of the chart. It is a process and not just a flipping of the switch to make EHR systems work.

For the IT developer, it is important to have the end user involved in the creation of the system. Without their involvement, it will be difficult to get a product that works effectively. That is not being an idealist—that is being realistic. The earlier you get that involvement, the smoother the transition will be.

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

A Next is tweaking the template as changes are needed. Facilities should have a process for improvement recommendations and a process for change in place. Do not do it in a knee-jerk fashion.

For example, if there is a concern about the EHR which relates to the safety of the patient, that change receives priority. If there is a concern brought forward from one specialty, such as cardiology, go back to the team of cardiologists to make sure that everyone in that group is on board with the change that needs to be made and its effectiveness for everyone involved. You cannot have solution A for physician A and solution B for physician B, or the entire system will be a mess.

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

A The CDI program started on paper queries. Within the EHR, they were able to build queries into the system, and CDI staff send the physicians a message to alert them. The physician responds to the query and documents any changes in the medical record electronically. The CDI team saves the correspondences, but they are not included in the clinical record. Query disagreements are fine—the physician does not need to agree with the premise of the CDI staff member’s query—but the physician is expected to answer in some form.

The team does use query templates and tweaks the templates with the clinical information related to each case. This helps us from having to reinvent the wheel every time we have to ask a query for heart failure or malnutrition.

Q Do you have staff who work remotely now that you’re electronic?

A CDI staff members are on-site even though the computer-based system could allow for remote activities. As a resource for the physicians, having them on-site enables casual conversations and encounters, which can really assist the physicians.

Q Were there challenges related to the CDI conducting reviews in the EHR or challenges facing physicians?

A Actual record reviews in the EHR setting have not been that difficult. The same challenges that occurred in the paper chart may be in the electronic one. A chart, be it electronic or paper, is only as good as what is documented. Electronic records moved those challenges over. With a hybrid record, CDI specialists had to review the information in the computer and then go to the nursing units to review the paper chart. In a way, you are still trying to find the necessary information, but hopefully it is easier now.

Copy-and-paste concerns really go back to how well your system was built, how much input the various users had, and what the regulations are. For example, do the lab results get pulled into the medical record automatically? If not, physicians will need to pull it into their note if they want the results in their documentation. There has been a lot of information and expressed worry out there about this issue, but you have to have a happy medium. It is up to physicians to pull in the pertinent information and pay attention to what they are doing. If you purposely copy and paste the culture count for a patient with MRSA to describe the infection, that is an appropriate use of computer technology. However, as with any documentation, the physician will need to add a corresponding diagnosis and not just say the culture is the diagnosis.

While CDI specialists need to watch for these types of documentation aberrations, it is just another aspect of their typical role. They are not policing EHR use by physicians; they are a resource and help physicians get the best information into the record to support the conditions being treated.

Q What advice do you have for people transitioning to EHRs?

A Most facilities have electronic health records at this point. Some may still be hybrid, but the sooner they make the leap to one electronic record, the better it will be. You need to have someone on the staff who can help the physicians as they transition (and continue with ongoing upgrades within the EHR). There will be little things that the physicians might forget how to do, or remember a piece of but forget one step. That is where CDI professionals can really shine. If the CDI staff know how the physician's documentation is designed, they can help them navigate and answer questions. If it is not CDI staff, it needs to be someone designated for the physicians to help them.

Q With all the natural disasters occurring around the country now—fires in California, flooding in Louisiana, hurricanes Sandy and Katrina, and so on—how do facilities respond to criticism regarding what happens when the power goes out?

A You have to have a backup plan. Downtime within an electronic system can be anything from a two-hour upgrade, to a failed server, to a flood. You need to have a procedure to follow.

First, make sure the institution identifies an individual to be responsible for what constitutes downtime and to communicate that message to the entire hospital staff. Does downtime consist of a couple of hours, a day, or longer? Do staff simply take paper notes while the system is down, and then add the information back into the EHR once it is back up?

Unless you have lived through a disaster, you would not know all of the effects it can have. Fortunately, I have not had to live through a major disaster. However, when a disaster or crisis does strike, all staff attention returns to taking care of the patients. At that point, everyone involved refocuses their efforts in that regard. Payment and record development occur later. It is not like some other professions—when the power goes out in healthcare, people's lives are on the line.

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It is highly visible how technology has affected the business community and our personal lives over the past 10 years. The healthcare industry, not immune to these advances, is now equipped with faster communication conduits. These significant advances have allowed us to almost instantaneously exchange healthcare information, support a virtual patient assessment from a remote region, and bring a never-ending spring of medical information right to our fingertips.

Yet despite these evolutionary strides, the CDI industry still struggles to define new CDI productivity metrics. As a result, some programs faithfully adhere to old-school benchmark expectations. The healthcare industry is experiencing technological advances, so why would CDI neglect to define how technology improves workflow and productivity?

There are obvious productivity wins, such as less “waste” of valuable CDI time. Remember when the standard workflow was to print the admit list, travel to the nursing unit, and systematically pull each chart for review? Fast forward to the present: Now, technology identifies medical records with vague or inconsistent documentation and prioritizes them for review on a CDI work list. Consequently, productivity gains are reallocated to formatting a compliant, non-leading query and conducting the follow-up required after sending it to the physician. In other words, the CDI team may “lose” productivity for the number of total reviews, but see an overall increase in the number of queries.

The scope of CDI reviews has changed with the advent of technology. Historically, CDI programs centered around MS-DRG reimbursement methodology, with a foundation of physician documentation within a paper medical record. Now, the industry expectation is that most healthcare facilities support some facet of an EHR—in fact, the majority of facilities are well on their way to being 100% electronic. Technology is producing data to support outcomes that push organizations to whole new levels of accountability. The CDI landscape has shifted its focus to “quality” documentation, not only to support billing, but also to address quality measures and the identification of hospital-acquired injuries and infections. CDI reviews can take longer when reviewing information from differing perspectives.

Ideal technology will facilitate physician queries straight into the physician’s workflow. The result will be an increase in physician responses—and less need for CDI staff to stalk a physician for a response. Additionally, interfaces available in some technologies provide real-time alerts to the CDI specialist when the physician answers. This virtually eliminates the need to log into a patient account multiple times throughout the day to see if the physician has answered.

Despite some hospital best efforts to implement technology, the result has been several disparate software programs that do not interface with one another. Commonly, there are several separate IT systems to collect information, beginning at the first patient encounter and extending to the final billing of services. Therefore, despite the availability of an electronic medical record, there may be more than one system that a CDI specialist must log on to when reviewing important aspects of a patient’s medical information. This certainly negates some of those quick wins discussed above.

Sometimes even the savviest of software can fail to produce substantial increases in CDI productivity. Frequently, this is because the staff refuse to embrace new workflows to effectively capitalize on gains in efficiency. Some just find comfort in continuing to work the process that they have followed from the beginning.

How does one redefine the CDI best practice productivity benchmark? The recommendation is, it depends. Productivity is affected by differing constraints of technology—the still-evolving scope of additional review responsibilities outside of the MS-DRG world, the nuances of disparate IT systems, and the level of required physician education.

Remain cautious of consulting firms that provide staffing metrics without understanding those additional CDI responsibilities unique to your organization. Regarding productivity, any time a CDI specialist is able to interact with a physician to add clarity to vague documentation, that specialist’s time has been productive. The CDI world has advanced (much like technology) from reviews that support reimbursement to documentation that supports organizational accountability, both for proper reimbursement and patient outcomes.