Clinical Documentation Improvement Week

2017

Industry Overview Survey

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

INDUSTRY OVERVIEW SURVEY

A lot has changed in healthcare broadly and CDI specifically since the initial rollout of ICD-10-CM/PCS in 2015. From the advent of quality initiatives, to CDI's expansion into other settings such as outpatient, to the evolution of clinical validation reviews, it seems that every day offers a new set of challenges and adventures. Much like the Wild West—the theme for this year's CDI Week festivities—the world of CDI is expanding, and the individuals working in this world need to saddle up for the ride.

"If you don't like change, then CDI's probably not the place for you right now," says **Angie Curry, BSN, RN, CCDS, CIP,** CDI director at Conifer Health in Springfield, Missouri, and an ACDIS Advisory Board member. "With all the change, some days really do feel like the Wild West."

Each year, ACDIS asks its members to weigh in on the state of the CDI profession in the CDI Week Industry Overview Survey. This year's survey garnered 410 respondents, slightly less than last year's numbers (612), but up from 2015 (364). The respondents represented a number of different positions and titles:

- CDI specialist (58.79%)
- CDI supervisor/manager/director (27.38%)
- HIM/coding supervisor/manager/director (2.02%)
- HIM/coding professional (1.15%)
- Physician advisor (0.29%)
- Hospital executive (0.29%)
- Consultant (2.02%)
- Other (8.07%)

Additionally, the respondents to this year's survey spanned several experience levels. The best represented group was CDI professionals with between three and five years of experience in their current role. Next were those with six to eight years under their belts (22.83%), those with more than 10 years (20.81%), those with zero to two years (13.29%), and finally those with nine to 10 years (10.98%).

Outside of the demographic trends, the survey also revealed other signs of expansion. Compared to previous years, more and more CDI programs have expanded, or are planning to expand, into areas beyond the traditional inpatient acute care hospital setting. The physician engagement and response rates rose further, the percentage of those who feel strongly supported by their administration improved, and the number of reviewers for quality and clinical validity increased as well.

The CDI field is changing rapidly, requiring quick thinking and an adventurer's spirit.

Although this report will not discuss every survey question in detail, responses to all of this year's questions begin on p. 8.

About the CDI Week survey advisor

Angie Curry, BSN, RN, CCDS, CIP, is the CDI manager at Conifer Health in Springfield, Missouri. Curry's experience in nursing and CDI covers 19 years. Her nursing expertise includes cardiovascular, education, and now CDI. As a manager, she seeks to develop program metrics for reporting, monitoring, and distribution. Also, she is responsible for DRG-based denial management, including case reviews and working with the HIM physician advisor during the appeals process.

A member of the ACDIS Advisory Board since April 2017, Curry has contributed to multiple articles on a variety of CDI topics and has been a featured speaker for various local and national CDI events.

Career advancement

In 2016, more than half the survey respondents reported lacking a career ladder for professional advancement. Unfortunately, the results were similar in 2017, as only 21.49% report having a formal ladder in place. (See Figure 7.)

According to the 2016 ACDIS White Paper, "*Keep your staff growing and engaged with a CDI career ladder*," "a career ladder demonstrates CDI is more than a temporary stop, and it may keep experienced CDI staff engaged and excited about their role and future career within their facility. A career ladder also provides the incentive to explore CDI as a long-term career option for healthcare professionals."

More managers answering this question, however, seemed to indicate they have career ladders and regular salary increases in place. Of those respondents in the manager category, 28.42% say they have a career ladder in place and 38.95% say they have regular salary increases. According to CDI specialists' responses, on the other hand, only 17.15% say they have a career ladder and 33.82% say they have regular salary increases. The numbers seem to indicate a disconnect between CDI program leadership's perspective and that held by CDI specialists reviewing records. This disconnect appeared to be a common theme with this year's survey.

Despite the lack of (or perceived lack of) formalized advancement opportunities, 47.28% of the respondents still believe there's good or excellent growth opportunities in the CDI industry as a whole. (See Figure 8.) Those who answered "other" indicated that opportunities are available only if the individual is willing to independently seek them out.

Consistent with previous years, only 65.9% of respondents believe they're compensated adequately for their work and 34.1% say they receive minimal raises. (See Figure 9.) Despite the expanded duties and responsibilities for CDI (discussed later), the rates of pay have remained stagnant—something also noted in ACDIS' 2016 Salary Survey, *"Salaries flat, but options open for career growth."*

"I think the low numbers honestly go back to the state of healthcare and hospitals right now," says Curry. "There's a lot of uncertainty, so facilities are hesitant to spend money on career advancement. It's unfortunate because CDI is bringing a lot of money in the door. All that should really trickle down to the actual CDI specialists."

Despite the somewhat disappointing stagnation of salaries and career advancement, respondents still report loving their jobs. (See Figure 10.) When asked how they view the CDI profession, they responded:

- "A career I'm passionate about and want to grow in"—60.74%
- "A solid job that I'm thankful for"—34.10%
- "A temporary stepping stone to bigger or different things"—2.29%
- "Other"—2.87%

"The money is not all we're about. It's worthwhile work," says Curry.

CDI expansion

Nevertheless, the survey shows that CDI expansion is still on the rise. In 2016, the areas with the highest percentages of anticipated expansion were the outpatient services—a trend consistent with this year's results.

"When people talk outpatient CDI, they have different ideas of what it means to them," says Curry. For this reason, there were seven outpatient focus areas included on the survey. (See Figure 11.) They were:

- Ambulatory surgery
- Emergency department (ED)
- Medical necessity
- National and local coverage determinations
- Quality measures
- Risk adjustment
- Physician practice/Part B services

The ED often proves the most logical entry point for CDI programs looking to expand into outpatient services, with 35.13% of the respondents saying they

have plans to expand into that area in the near future. As *an ACDIS article in the CDI Journal* says, "Not only does it offer outpatient opportunities, but the documentation from ED encounters directly affects the documentation if (or when) patients move to the inpatient setting."

Next on the list of popular expansion areas was ambulatory surgery, with 34.55% of respondents saying they plan to expand into the area in the near future. "That would be my choice for expansion," Curry says. "It's pretty common to lose money with ambulatory services, so it'd be good to have a CDI reviewing there."

Reviewing payers other than Medicare also presents a common area for CDI expansion. In 2016, 69% of respondents planned to expand to all payers. Only 38.62% report the same this year. (See Figure 12.) However, 45.77% of respondents already review the payers listed as expansion options. Furthermore, those not planning on reviewing other payers besides Medicare declined from 6.3% last year to 5% this year.

"The industry push is really to look at all payers, so it's good to see a lot of people already doing that," Curry says.

Reviewing outside the concurrent cadence (namely, in the retrospective space) is another area for expansion. While 28.31% do not plan to expand to these areas, 36.51% say they've already done so. (See Figure 14.) Of course, the transition can prove difficult, according to Curry. One respondent who answered "other" even specified that their facility was reviewing retrospectively, but that they had to step back into the concurrent space. With any expansion, planning is essential. With retrospective reviews, there are also other groups reliant on the review being completed timely in order to ensure the healthcare bill gets filed as quickly as possible to keep the finances turning, Curry says.

"One thing we've been really concerned about here is that we don't want to hold up final billing on the cases," particularly related to retrospective CDI reviews, she says.

With increased expansion into other patient populations, settings, and even review time frames, it's no wonder that 92.85% of respondents say their role has experienced a substantial degree of change since they started. (See Figure 15.) As seen in last year's industry survey, all this change has increased CDI staff interaction with other departments as well. According to Curry, collaboration proves valuable for all areas of expansion.

"It really is a time of change in this industry," she says. "The issue of silos is huge still, though. I've always worked really closely with the coding team, but now I'm working even more with quality too."

Clinical validation

Clinical validation seems to be one of the hottest topic in CDI right now (next to outpatient, of course). Recent changes within the 2017 *Official Guidelines for Coding and Reporting* and *Coding Clinic for ICD-10-CM/PCS* have disrupted some practices and caused some confusion. For this reason, this year's industry survey included several questions on the topic.

Only 4.63% of respondents say they do not conduct clinical validation reviews/queries. Despite this fact, only 60.97% track the frequency of the queries they issue. (See Figure 16.)

"If I didn't have anything to track that, I wouldn't have any metrics for how we're doing right now," says Curry.

Despite the lack of formal tracking for clinical validation queries, 44.88% say they crafted five or more clinical validation queries in the last month. (See Figure 17.) Many CDI departments don't seem to have specific policies and procedures for conducting clinical validation queries, however, with 41.81% reporting they have policies and 45.48% reporting that they do not. (See Figure 18.)

The lack of specific policies may be due to the existence of an overarching query policy, but Curry still finds those results a little troubling.

"No policies for clinical validation was super surprising to me," says Curry. "What worries me even more, though, was that there was a higher percentage of managers who say they have policies for clinical validation [compared to CDI specialists' responses]. Maybe you have some CDI specialists working on the floor who don't know they have a policy to follow. If that's the case, we have a problem."

"It is best practice for an organization to put policies and procedures in place to address how to construct a clinical validation query, along with delivery methods of written and verbal queries," according to the ACDIS White Paper, "*Clinical validation and the role of the CDI professional*."

The White Paper goes on to say "Organizations need to be transparent regarding the need for strong supporting clinical criteria in the medical record and the clinical validation process." Unfortunately, this transparency was not borne out in the survey results, as little more than half (57.64%) report communicating documentation trends with physicians regarding validation queries. (See Figure 20.)

"I was so disappointed that more people didn't communicate with the physicians about the queries. Sometimes, I've gone to the providers to talk to them and they say, 'How am I supposed to change if I don't know I need to?' " says Curry.

Whether or not the trends are communicated to the physicians themselves, most every CDI specialist conducting validation reviews knows what the major problem diagnoses are. Not surprisingly, sepsis came out on top of the list for clinical validation query frequency, garnering 36.25% of the responses. (See Figure 21.) The remaining diagnoses to choose from were:

- Respiratory failure (31.5%)
- Encephalopathy (3%)
- Malnutrition (7.25%)
- Acute renal failure (5.5%)
- Other (please specify) (16.5%)

Because clinical validation reviews often stem from a desire to combat denials for common target diagnoses, CDI specialists need to know the clinical criteria used by their facility. "Those diagnoses are the big ones," says Curry. "You have to remember, though, that depending on where you work, your definition of things like sepsis can be really different. On top of that, the payers all use different criteria. Wouldn't it be nice if they all could all agree on the clinical definitions?"

The ACDIS White Paper on the topic encourages collaboration to create "organizationally established guidelines and clinical indicators for problematic or high-risk diagnoses" to "help support CDI professionals and coders in the clinical validation process."

CDI and quality

Oftentimes, quality, CDI, and coding work from different playbooks. Effective artificial intelligence (A.I.) technology (i.e. natural language processing) in the form of a key component for a robust documentation surveillance solution at the point of care. Implementing technology that supports a concurrent, multidisciplinary review of documentation brings these playbooks together. A.I. enables concurrent identification and review of potential quality of care concerns, arming CDI, coding and quality teams with tools to ensure the clinical documentation accurately represents the patient care story. A.I. and computer-assisted code suggestion is a game changer in this ever-challenging healthcare industry because it brings a centralized view of record to identify documentation gaps. Many organizations purchased computer-assisted coding solutions (CAC) to prepare for the ICD-10 transition. Combining CAC technology with artificial intelligence documentation surveillance continues to tout the importance these tools provide to the CDI, coding and quality world.

Anne Robertucci, MS, RHIA, Strategic Product Manager, Enterprise CAC and CDI 3D, Optum360

When CMS and other payers began implementing quality measures and value-based purchasing, many CDI teams saw a corresponding shift. That trend remained prominent in this year's industry survey as well. Overall, the percentage of respondents *not* reviewing quality measures at all decreased (from 20.79% in 2016 to 15.86% in 2017). The distribution between the various measures, however, remained nearly the same with severity of illness/risk of mortality gaining the top slot with 65.05%. (See Figure 22.)

Though the percentage of those reviewing quality measures increased, there are those (36%) who feel the additional focus has hindered CDI productivity. (See Figure 24.) That's a large portion, says Curry, but it's not necessarily surprising.

"One of the hard things about these quality measures is that it affects the number of chart reviews you can do each day. The productivity numbers were decided on before we did all this quality stuff, so now it looks like we're less productive," she says.

Staffing is another issue likely contributing to the lower productivity associated with quality reviews, says Curry. Only 25% increased staffing associated with increased responsibilities—57.45% did not. (See Figure

25.) Likely most CDI professionals are familiar with this problem, often known as "mission creep."

"We've taken on additional initiative because it's what's best for the hospitals, but our staffing hasn't increased, so that can be a problem," says Curry.

One heartening piece of this newer focus on quality is that 76.42% of respondents say they query when it only affects quality measures and not reimbursement. (See Figure 26.) Compared to the *2017 ACDIS Physician Queries Benchmarking Survey* in which 37.89% of respondents say they primarily queried for financial effect, Curry calls this a welcome number.

"All I can say is thank God for that!" she says.

Technology

Gone are the days of the simple sticky note stuck on the chart serving as a query, or using a spreadsheet for tracking queries. Advances in computing, artificial intelligence, and web-based software delivery have raised the bar on the capabilities of the technology that supports clinical documentation improvement (CDI). Properly designed and executed CDI software can greatly enhance efficiency and productivity, thereby eliminating the need to "prioritize" and limit chart reviews. And while computer-assisted coding (CAC) gives a great assist in coding what is already on the chart, true artificial intelligence can now help to determine what is not yet documented. But, as the saying goes, with great power comes great responsibility. It is important to keep in mind the limitations of computer software, and not think that it can replace sound clinical judgment or common sense. Technology still needs the human touch. Our goal should be high touch supported by high tech, and not the other way around.

—Jonathan Elion, MD, founder of ChartWise Medical Systems, Inc.

ChartWise Medical Systems

For the first time in seven years, no one reported using an entirely paper medical record with no plans of changing. Of course, a number of programs still use some sort of paper-record hybrid or are moving toward an EHR system. According to the results, only 47.56% of respondents are entirely using an EHR, while 29.51% have some documents scanned, 18.34% use a hybrid system, and 0.86% use only paper but plan to change to an EHR soon. (See Figure 27.)

"I can't believe there are some people on all paper still. Even still, it's such good news that most people are on or moving toward an EHR now," says Curry.

Related technological solutions are cropping up and being implemented into CDI work. Two such technologies are natural language processing (NLP) and computer-assisted coding (CAC). According to this year's survey, 51.58% of respondents use this technology and 5.44% plan to implement it by the end of the year. (See Figure 28.)

Even more surprising, 86.09% of respondents see NLP/CAC technology as helpful in some way. Specifically, 53.61% say the new technology has improved efficiency and productivity. (See Figure 29.) Those positives, though, were tempered slightly by the free comment field on this question. Some comments include:

- "We still need to review since it also picks up negative words."
- "You need skilled training to wash out what isn't applicable."
- "We discourage use of CAC for all but very experienced CDI specialists."
- "CAC/NLP has been helpful but still requires critical thinking skills of staff to validate appropriate code assignment."

The trend of remote CDI work is often tied to the advent of new technologies as CDI professionals (as well as coders, etc.) can access medical records from their home office. The data consistently show, however, that the increased use of EHRs and similar technologies has not necessarily led to equal increases in remote work opportunities. According to this year's survey, only 6% work completely remotely and 60.46% work entirely on-site. (See Figure 30.)

"I was super surprised about the lack of remote work. If your record is all electronic, then there's no real reason that you can't do a hybrid with remote a couple days a week," says Curry.

For those who have jumped to remote work, very few report decreased productivity, response, and query rates. Most, in fact, report either a null effect to these rates or an improvement. The measure of productivity was the most positively affected by remote work,

with 40.91% of respondents saying productivity has improved. (See Figure 31.)

"When we tried going partially remote, our productivity actually increased by 20%," says Curry. "The concept for CDI was originally to have the CDI specialists on the floor and rounding with the physicians, but now, the physicians don't do lots of documenting while they round because they have to see a lot more patients."

Physician engagement

We are on the cusp of improving care and improving physicians' lives. 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 records without these clicks, is going to improve their satisfaction and decrease the risk that documentation doesn't comply with regulations and patient care.

—Mel Tully, MSN, RN, CCDSM, CDIP, vice president of clinical services and education for healthcare solutions CDI at Nuance Communications

Despite the ongoing battle for physician engagement in CDI, this year's industry survey showed a marked upturn compared to the results from 2012—with the rate of engaged and motivated medical staff doubling from 5% to 10.89%, and citations of disengaged and unmotivated medical staff decreasing from 13% to 5.31%. Overall, those reporting higher engagement rates now hits 63.40% compared to 40% in 2012.

Most of the respondents, though, land in the middle, either reporting their staff as mostly engaged with some exceptions or somewhat engaged. (See Figure 32.)

"There's not many at the top and not many at the bottom. I guess that means we're all making progress still, which is good news," says Curry.

Part of the slow climb toward a more engaged medical staff may be linked to the addition of more and more physician advisors and champions. *The 2016 Physician Advisor Benchmarking Report* showed 64.62% of respondents employed a physician advisor. This is fairly consistent with the data in this year's industry survey, showing that 62.01% of respondents have a part- or full-time physician advisor or champion. Additionally, 12.85% report plans to engage one in the near future. (See Figure 34.) Of course, not all physician advisors are equal, as borne out in many of the free comments in the survey (many indicating their physician advisor is ineffective).

"Sometimes it can be difficult to have a part-time physician advisor when they have a dual role. Mine is a hospitalist too, but I actually think that helps with my communication to the other physicians," says Curry.

Regardless of whether the program has a physician advisor/champion, however, there were some noticeable trends among the answers for expected query response time period. By far the most popular time frame to use is two days, which received 34.36% of the respondents' support. Next was no time frame at all at 17.32%, three days at 9.78%, seven to 14 days at 8.10%, and one day at 7.82%. Each of the other defined options received less than 6%. Though one might think having a set time frame for query responses would be a common trait, the data show a remarkably high amount of respondents without one. (See Figure 35.)

"Not having a response time frame is a little weird to me, honestly," says Curry. "There seems to be either a big push or none at all. Of course, maybe the better question is not whether they're being answered, but how well they are being answered."

Luckily, the data are positive on both counts as 73.18% report having a query response rate of over 80% and 77.93% report having a query agree rate of over 70%. (See figures 36 and 37.) Even with those relatively high numbers, implementing some sort of escalation policy is considered best practice. As to whether or not such a policy exists, the respondents were rather split—50.56% do, whereas 33.52% do not. Many of the "other" responses also specified that they have a policy, but it's unenforced or ineffective. (See Figure 38.)

Despite some areas that lacked movement in one direction or another, overall the survey showed a remarkable amount of change and growth—both currently and upcoming, according to Curry.

"It's a time of change right now, and I think we saw that everywhere in this survey," she says. "As we move forward, we need to get out of our silos and communicate with other groups. That's how we're going to succeed."

2017 CDI INDUSTRY OVERVIEW SURVEY:
The Wild West: New Frontiers in CDI

1. Please indicate your title/role:

Answer Options	Response Percent
CDI specialist	58.79%
CDI supervisor/manager/director	27.38%
HIM/coding supervisor/manager/director	2.02%
HIM/coding professional	1.15%
Physician advisor	0.29%
Hospital executive	0.29%
Consultant	2.02%
Other (please specify)	8.07%

Other (please specify)

- Lead clinical documentation specialist
- CDI/coding educator
- Clinical documentation "associate" created by my director because I am not an RN, even though an RN degree is not always required. I am a CCS and CCDS.
- CDI/coding coordinator
- Operational performance expert
- CDI denials coordinator/appeals nurse
- CDI auditor
- Second-level reviewer/documentation quality coordinator
- Director case management, which includes CDI
- CDI quality reviewer
- Coordinator for UR/CDI
- CDI analyst

2. How long have you been in your current position?

Answer Options	Response Percent
0–2 years	13.29%
3–5 years	32.08%
6–8 years	22.83%
9–10 years	10.98%
10+ years	20.81%

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

Answer Options	Response Percent
100 or less	11.82%
101–200	20.75%
201–300	17.58%
301–400	12.39%
401-500	6.05%
501–600	5.19%
601–700	5.19%
701–800	2.59%
801–900	4.90%
901–1,000	3.17%
More than 1,000	8.36%
Not applicable	2.02%

4. How many CDI specialists do you have on staff? (Please count each part-time CDI as a 0.5 FTE)

Answer Options	Response Percent
Less than 1	0.86%
1	10.37%
2–3	23.34%
4–5	18.16%
6–7	9.51%
8–9	6.34%
10–12	8.36%
13–15	4.61%
More than 15	18.44%

5. What types of professionals work in the CDI role at your facility? Check all that apply.

Answer Options	Response Percent
Nurses	96.25%
Coders	21.61%
Physicians	4.32%
Foreign-trained physicians	10.37%
HIM staff—non-coders	3.17%
Other (please specify)	4.61%

Other health profession (please specify)

- Physician assistant
- LCSW case manager
- Non-RN
- Chiropractor
- LVN
- MSW
- Inpatient CDI = nurses; outpatient CDI = coders w/RN clinical support
- HI director, RHIA/coder

6. What credentials do you hold? (Check all that apply.)

Answer Options	Response Percent
CCDS	64.84%
CCS	15.27%
CDIP	7.20%
MD	0.86%
NP	0.00%
PA	0.00%
RN	77.23%
RHIA	6.05%
RHIT	4.32%

7. Does your facility provide a career ladder within your CDI department or have another means to reward achievement or experience?

Answer Options	Response Percent
Yes, we have steps based on experience, educational level, and certification	9.74%
Yes, we have advancement levels and job description variations (i.e., CDI specialist, CDI educator, CDI team leader, advanced CDI practitioner, etc.)	11.75%
No, but we have regular salary increases	34.67%
No, and we have minimal raises	34.10%
Not applicable	2.29%
Don't know	1.72%
Other (please specify)	5.73%

Other (please specify)

- We are in discussion regarding implementing a career ladder
- Contracted
- Our raises are performance based, so it is a merit raise with no cost of living increase over the past several years. My nurses are level three nurses on hiring, and their pay grade reflects this. Median salary is $90,000.00. We are the only level I trauma center and a teaching hospital in the city of Portland, Maine.
- Depends on the size of the hospital
- We receive $1/hr for CCDS certification
- We have a union. Raises are in the contract.
- Quarterly bonus program
- Only currently have 1 level between manager and staff
- A career ladder has been proposed and in the approval process
- We have not received a raise in over 5 years and our pay is WAY below the current ACDIS salary survey averages
- There is only 1 CDI concurrently & 1 outpatient
- We are working on developing a level 1 and level 2 CDS
- Annual merit raises based on performance/hospital indicators. No nonclinical career ladder.
- We have a CDI quality reviewer and CTL currently. Working on creating a CAP for CDI program for job enhancement.
- Our career ladder offers one step up to a lead position
- Have an education and are considering adding team leads
- No, we have periodic assessment of salaries to within our geographical area
- No, but I have created one and hope to implement in the future
- A plan is in place for ladders
- We are part of the bargaining unit, so it would have to be negotiated in

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

Answer Options	Response Percent
None/very little	14.61%
Moderate	20.34%
Good	32.95%
Excellent	14.33%
Don't know	16.91%
Other (please specify)	0.86%

Other (please specify)

- Not sure I would say career advancement, but certainly lots of options for same work in other venues
- I think the opportunities are there if you want to make life-style changes
- I'm not an RN, so it seems to be a deal breaker for most

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

Answer Options	Response Percent
Yes	65.90%
No	34.10%

10. Please describe how you view the CDI profession.

Answer Options	Response Percent
A career I'm passionate about and want to grow in	60.74%
A solid job that I'm thankful for	34.10%
A temporary stepping stone to bigger or different things	2.29%
Other (please specify)	2.87%

Other (please specify)

- Sometimes uncomfortable nursing job
- Was quite happy where I was, but this last year has been crap—not even sure that I want to stay in nursing, let alone concentrate on CDI
- Passionate; however, wonder with CAC and NLP if RN-CDIs will be phased out as already seeing medical assistants and LPNs performing OP-CDI—however, this is not within the scope of these positions!
- Unsure at present. There are not a lot of opportunities in CDI field in the area where I live.
- It is still a very new profession and we have a lot of work to do to describe ourselves and be recognized by the broader community
- Only one part of my role as physician advisor
- As worker ants recouping millions of dollars and steering the facility towards better quality of care but aren't recognized or compensated for the work
- I am a manager and proud of my department. However, overall I see a lot of problems and lack of understanding in new programs.
- A career I enjoy and want to grow in

11. Does your CDI program currently review (or plan to expand to review) health records for any of the following settings or services? Check all that apply.

Answer Options	Yes	No, but we are planning to do so	No, and we have no plans to do so
Critical access/rural health	13.62%	6.96%	79.42%
Hospital outpatient services: Ambulatory surgery	9.27%	34.55%	56.18%
Hospital outpatient services: Emergency department	10.48%	35.13%	54.67%
Hospital outpatient services: Medical necessity	8.60%	26.07%	66.19%
Hospital outpatient services: National and local coverage determinations	7.29%	15.74%	76.97%
Hospital outpatient services: Quality measures	10.23%	24.65%	65.20%
Long-term care	2.11%	6.33%	91.87%
Long-term acute care	3.60%	7.21%	89.19%
Obstetrics	19.94%	13.49%	67.16%
Neonatal intensive care (NICU)	23.01%	12.39%	64.60%
Physician practice/Part B services	7.10%	12.72%	80.18%
Pediatrics	31.29%	11.11%	57.60%
Psychiatry	8.63%	10.71%	80.95%
Rehabilitation (inpatient or outpatient)	7.46%	10.15%	82.39%
Don't know	20.83%	5.56%	76.39%

Comments:

- We currently review peds, SCN, & medical OBs
- We are strictly reviewing acute inpatient cases only
- We strictly review hospital inpatients
- Plan on outpatient but 1 year or so
- Hospital inpatient, HACs, POA, mortality, and readmissions
- Infusion; wound care center; pain management
- Expansion plans not shared with CDI staff from corporate
- We do a lot of ad hoc MD-specific reviews for education
- Some sort of outpatient, unclear the area of concentration
- HCC for certain specialties
- Mortality reviews
- We are purely focused on inpatient reviews; we started OB-GYN, but stopped due to short of staff
- We also review ED (for inpatient only)

12. Is your CDI program looking to expand its reviews to other payer types beside Medicare? Check all that apply.

Answer Options	Response Percent
Yes, to all patients/all payers	38.62%
Yes, to APR-DRG payers	10.85%
Yes, to Medicaid	7.94%
Yes, to Medicare Advantage/Hierarchical Condition Categories (HCCs)	8.73%
No	5.03%
No, we have already expanded into these payers	45.77%
Don't know	2.65%

Comments:

- We do not review commercial payers
- We already do all payers (Maryland)
- Other payers who use the MS-DRG
- Possibly expand to commercial payers
- Do not know about above
- We have 2 service areas that presently do all payers and plan to expand all others
- Commercial payers—Anthem/Cigna/UHC/ect.
- We are a children's hospital and specifically review Medicaid payers
- We already do all payers
- Currently Medicare, Medicare Advantage, and Medicaid
- We see all payers
- We do all DRG payers, APR-DRG payers, and Medicaid currently
- Have already expanded to Medicaid, MCOs, and Medicare Advantage plans
- We review managed commercial as well
- We do this currently
- We currently do review all DRG payers
- We are a peds facility. We review APR DRG and Medicare carve outs.
- We review all payers
- Adolescent Medicaid is also looked at
- We already cover all payers
- We already review all payers
- We have expanded to a select group of private payers

13. Does your CDI program plan to expand its concurrent review focus to include any of the following healthcare reforms/initiatives? Check all that apply.

Answer Options	Response Percent
Bundled payments	10.32%
CMS Quality Measures (core measures)	17.46%
Hospital-acquired conditions (HAC)	26.46%
Hospital Readmissions Reduction Program (as part of the HVBP)	13.76%
Patient Safety Indicators (PSI)	26.46%
Present on admission (POA)	24.87%
No	4.50%
We already review most of these, so these are no longer "expansion" areas for our team	49.47%
Don't know	11.90%
Other (please specify)	6.08%

Other (please specify)

- We review HAC/PSI/POA
- Already review PSI, HAC, and POA
- Most of these are reviewed but not all by CDI
- We already review for POA
- Potentially Preventable Complications (PPC) Medicaid
- Already review HAC/PSI/POA
- Looking at HCCs
- We are looking into outpatient services
- Special requests from case management—we track all CHF, AMI, and CABG pts for them
- Some are done by us. Some by audit or care coordination.
- We perform holistic reviews for clinical truth
- We do POA and PSI
- Risk assessment
- New program, focus inpatient only, all payers right now
- Aware of PSI and HVBP HAC conditions, but not focused
- We review for present on admission diagnoses and work closely with our quality staff on core measures
- We currently do POA but don't plan to expand further
- We do most of the quality reviews currently
- We already review HAC, POA, PSI; looking at HCC
- SOI/ROM/mortality
- We already do to some extent
- We do mortality risk adjustment reviews on adults
- We are looking into expansion to HRRP

14. Are you planning to expand your CDI program reviews outside of the concurrent cadence? Check all that apply.

Answer Options	Response Percent
Yes, to retrospective/post-bill	3.44%
Yes, to retrospective/pre-bill	7.14%
Yes, retrospectively for denials management	8.20%
No	28.31%
We already review outside the concurrent cadence	36.51%
Don't know	20.11%
Other (please specify)	4.23%

Other (please specify)

- We reconcile with IP coders on DRG mismatches
- We review retro pre-bill at a coder's request
- We perform retro reviews for APR on expired patients and are involved in retro reviews of denials for appeals
- We focus on concurrent reviews but also perform focused reviews on discharged cases for a variety of purposes, but mostly to support quality measures
- We do retro reconciliation, also post-DC reviews of mortality or targeted DRGs
- For education purposes
- Our coders and audit teams do most of this
- We review for denial if we were on the case concurrently
- We currently perform concurrent reviews as well as pre-bill reviews after coder completes
- We already review retrospectively all death charts
- We perform retrospective queries for needs identified by coding
- We compare any differences in working DRG with the final coded DRG and meet regularly with the coding staff to discuss this
- We have a back-end reviewer for open queries and coder-CDI mismatch
- We review post coding for mortality, HAC, and denials cases
- We were doing retro; however, we are only focusing on concurrent

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

Answer Options	Response Percent
Enormously; my role has evolved into something entirely different	22.22%
It has had significant changes	47.35%
It has changed to some degree	23.28%
It has had minimal changes	6.61%
It has had no changes at all	1.59%
Don't know	0.00%
Other (please specify)	1.85%

Other (please specify)

- We have worked for four different companies in 4 1/2 years; challenging!
- I came from an advanced program and moved this program forward
- I am brand-new in this role
- Looking at PSI, HACs, denials, & pre-bills
- I have taken on the manager role for my new team
- We have had a program since 2002; it has changed significantly
- Totally different than what I used to do 7 years ago

16. Does your CDI team track the frequency of clinical validation queries?

Answer Options	Response Percent
Yes, we possess CDI software that tracks clinical validation query frequency	45.12%
Yes, we track clinical validation frequency manually/we do not have CDI software that does this	15.85%
No, we do not track clinical validation query frequency	34.49%
No, we do not perform clinical validation queries	4.63%

17. Approximately how many clinical validation queries have you written in the last month?

Answer Options	Response Percent
0	14.88%
1–2	23.66%
3–4	16.59%
5 or more	44.88%

18. Does your facility have a policy (written or unwritten) on clinical validation querying?

Answer Options	Response Percent
Yes	41.81%
No	45.48%
Not sure	12.71%

19. Which of the following describes your clinical validation queries? Check all that apply.

Answer Options	Response Percent
Our clinical validation queries request confirmation of a diagnosis	69.21%
Our clinical validation queries request additional clinical evidence for the diagnosis	63.30%
Our clinical validation queries include a response option that negates the diagnosis (e.g., ruled out, documented in error, etc.)	71.92%
Our clinical validation queries include an option to provide an alternate (other) diagnosis	71.43%
Our clinical validation queries include the option "unable to determine"	69.21%
We do not have a template or standard for our clinical validation queries	17.98%

20. Do you share documentation trends with physicians regarding validation queries?

Answer Options	Response Percent
Yes	42.36%
No	57.64%

21. At your facility, which of the following diagnoses commonly lead to a clinical validation query?

Answer Options	Response Percent
Sepsis	36.25%
Respiratory failure	31.50%
Encephalopathy	3.00%
Malnutrition	7.25%
Acute renal failure	5.50%
Other (please specify)	16.50%

Other (please specify)

- NSTEMI
- Pathology report findings
- ABLA and shock
- Atelectasis, hypotension, anemia
- Sepsis, respiratory failure, and AKI
- Systolic and/or diastolic heart failure—acute/chronic or acute on chronic
- We do not query for clinical validation
- All of the above
- Postoperative diagnosis/possible complication
- Sepsis, resp failure, and malnutrition quite often
- Sepsis, malnutrition, resp failure, all target dx if not indicators
- Sepsis AND respiratory failure
- All of the above except malnutrition
- Areas that have not provided adequate clinical documentation support
- Sepsis, AKI
- ER-only diagnoses
- Sepsis, stroke
- Cerebral edema/herniation
- AMI/NSTEMI
- I would like to put a check mark by sepsis, resp failure, encephalopathy, and acute renal failure as we write for all of them
- Chest pain
- Resp failure is most often documented without support of clinical indicators, but we do not do validation queries. We make a note to our coders that indicators may not support.
- All of the above except encephalopathy
- CHF, AFIB
- Both respiratory failure and encephalopathy
- CHF
- We have several different queries that verify or specify clinical findings
- Acute blood loss anemia and sepsis
- Complication—was it inherent, expected, ...
- Heart failure
- Substance use or diagnosis for a prescribed medication
- Anything that is questionable that does not meet query standards
- Respiratory failure and opioid dependence
- Unknown—although we have this query, we are instructed not to query for clinical validation

22. Which of the following quality measures and/or quality-related items does your CDI program review on a concurrent basis? Check all that apply.

Answer Options	Response Percent
CMS inpatient Quality Measures, i.e., "core measures" (not specific to HVBP)	31.18%
HACs	61.02%
HRRP	10.48%
PSIs	53.76%
PSI only (not specific to HVBP)	8.06%
Severity of illness/risk of mortality (APR-DRG methodology) concurrent to stay	65.05%
Severity of illness/risk of mortality (APR-DRG methodology) retrospective mortality reviews	45.97%
Severity of illness/risk of mortality (not specific to APR-DRG methodology)	37.10%
Surgical Care Improvement Project (SCIP) or other quality specialty database	7.26%
We don't review quality measures/metrics	15.86%
Other (please specify)	3.23%

Other (please specify)

- Our nursing department reviews
- Care mgmt does quality review in our hospital
- Stroke
- Sepsis is key
- Done by the quality department separate from us in HIM
- Sepsis
- Mortality reviews are being considered at this time, not formal focus yet
- POA
- Complications and mortality
- They are all reviewed as part of our program but not mandatory, just look at these as part of our program
- If we see something that might be problematic, we query regardless of what the diagnosis is related to, period
- Another team does this

23. Does your CDI program perform mortality reviews?

Answer Options	Response Percent
Yes	60.97%
No	37.89%
Don't know	1.14%

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

Answer Options	Response Percent
Yes	36.01%
No	36.61%
We don't track productivity	10.71%
Don't know	16.67%

25. If your department has expanded to include quality-based reviews, were your FTEs (full-time equivalent) increased?

Answer Options	Response Percent
Yes	24.53%
No	57.45%
Don't know	18.01%

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

Answer Options	Response Percent
Yes	76.42%
No	17.91%
Don't know	2.99%

Other (please specify)

- Care mgmt does our quality review
- Quality measures are not done by CDI
- Sometimes
- Yes for severity, risk, and mortality; also with sepsis
- We don't query quality measures
- We query for POA for several diagnoses
- Quality dept tracks quality measures
- We query, regardless of the impact, if clarification or information is necessary for a complete record
- Depends on topic

27. Where does your facility stand regarding implementation of an electronic health record (EHR)?

Answer Options	Response Percent
Currently completely digitalized with EHR	47.56%
Completely digital EHR after discharge, but some records are scanned	29.51%
Currently hybrid medical record (electronic and paper) with plans to be totally electronic by year-end or sooner	18.34%
Currently all paper record with plans to be totally electronic by year-end or sooner	0.86%
All paper medical record with no immediate plans to implement an EHR	0.00%
N/A / I don't work in a facility or hospital	0.57%
Other (please specify)	3.15%

Other (please specify)

- Hybrid now, with plans to go electronic in 18 months
- Hybrid with no timeline for total EMR
- Currently hybrid, plan for EHR in 2018
- Hybrid medical record without plans (that I am aware of) to be totally electronic
- Hybrid; unsure when will be all electronic

28. Do you use computer-assisted coding (CAC) or natural language processing (NLP) to assist with your record reviews?

Answer Options	Response Percent
Yes	51.58%
No	40.11%
No, but we plan to implement by end of the year	5.44%
Don't know	2.87%

29. If you answered yes to the previous question, has CAC/NLP been beneficial for your CDI specialists? Check all that apply.

Answer Options	Response Percent
Yes, it has improved our efficiency/ productivity	53.61%
Yes, it has improved our query response rate	10.31%
Yes, we are now able to work off-site	13.92%
Yes (please specify)	8.25%

- It is beneficial to search for documentation in the electronic records, but we are hybrid so it is not completely effective
- We have access to the CAC but do not use it in our daily reviews. The NLP has been beneficial, but there are some really interesting "interpretations" of the dictated note.
- On occasion, it has assisted us in identifying possible query opportunities
- CAC/NLP has been helpful but still requires critical thinking skills of staff to validate appropriate code assignment
- Only for search purposes ... many times it picks up wrong information

No (please specify)	13.92%

- Recent implementation of NLP that has not proven its benefit
- Still need to review since it also picks up negative words
- Need to validate all dxs/procedures and CAC makes many errors but not always accurate
- You must have skilled training to wash out what isn't applicable
- We use the grouper, not the CAC engine; the engine slowed down productivity
- It has decreased productivity in that the CDI are getting bogged down with the coding piece
- More time-consuming
- We try not to depend on CAC
- Double-check on capturing all diagnoses
- Not very accurate and we often code major conditions from "scratch." The codes rendered by CAC are not reliable.
- Not really beneficial to me; perhaps for a newer CDI it would be helpful
- CAC missed laterality and specificity; created a tunnel vision and does not address quality/core measures
- It has added another process into our daily workflow
- Too many false positives
- We found that it was not helpful, so we requested it be removed
- NLP has NOT improved efficiency/productivity for OB/newborn reviews

Not sure yet	18.04%

30. Do your CDI specialists work remotely?

Answer Options	Response Percent
No, we do not allow/have capacity for this option	60.46%
Yes, about 10% work remotely	12.03%
Yes, about 25% work remotely	7.17%
Yes, about 50% work remotely	7.74%
Yes, about 75% work remotely	6.69%
Yes, 100% work remotely	6.02%

31. If you answered yes to the previous question, please compare the effectiveness of your CDI specialists working off-site versus those on-site.

Answer Options	Better than on-site	Same	Worse than on-site	N/A	Don't know
Query rate	23.03%	48.03%	3.29%	10.53%	15.13%
Physician query response rate	10.97%	59.35%	5.16%	10.32%	14.19%
Productivity	40.91%	31.17%	3.90%	10.39%	13.64%

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

Answer Options	Response Percent
Highly engaged and motivated	10.89%
Mostly engaged and motivated, with some exceptions	52.51%
Somewhat engaged and motivated	31.28%
Mostly disengaged and unmotivated	5.31%

33. How supportive is your organization's administrative team of your CDI department?

Answer Options	Response Percent
Strongly supportive	38.27%
Moderately supportive	32.12%
Somewhat supportive	23.74%
No apparent support	4.75%
Other (please specify)	1.12%

Other (please specify)

- Not sure
- Less supportive: NYC metro area hospitals are hiring consultant companies to run established CDI programs. Possibility of outsourcing.
- Highly supportive when there is a revenue issue—otherwise basically ignored
- Strongly supportive in theory. Our physicians have no definitive accountability to collaborating with CDI.

34. Does your department have a physician advisor or physician champion?

Answer Options	Response Percent
Yes, we have a full-time physician advisor/champion	18.99%
Yes, we have a part-time physician advisor/champion	43.02%
No, but we plan on engaging one in the near future	12.85%
No, we have no plans to engage a physician advisor/champion	6.76%
Don't know	1.68%
Other (please specify)	6.70%

Other (please specify)

- I have requested this but not gotten it
- We now have a hospitalist medical director and CMO that back us 100%
- We have three part-time physician advisors—2 hospitalists and one surgeon
- I had a great candidate for PA lined up, but the facility did not want to pay them for their time
- In our culture no one has been interested
- Yes, two, but no compensation so we cannot ask much of their time
- Part time, but not very effective for our program
- I oversee a health system; some have a PC, others do not
- We had a physcian advisor for a little while but not anymore
- We have a paid physician advisor at each of our 7 sites. Paid for 30 hrs a month.
- Champion in name only
- We have a physician champion but less than part time
- Not a dedicated one, but have a subject matter expert we refer to on hot-topic diagnoses
- About 1 hour/week
- Our director has tried, but admin has so far said no
- Very limited involvement, except for mortality reviews and case management admission status
- We use the care management PA, need one dedicated to CDI
- We have 2 part time, but one retired and the other is assigned a larger role with quality measures in the hospital

35. 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	Response Percent
1 day	7.82%
2 days	34.36%
3 days	9.78%
4 days	1.12%
5 days	1.68%
6 days	0.00%
7 days	3.36%
7 to 14 days	8.10%
Within 30 days	5.87%
We don't have a time frame for query response	17.32%
Don't know	2.51%
Other (please specify)	7.82%

Other (please specify)

- 48 hours, but some of them take months!
- Queries are included in our deficiencies and suspension list, so all of them must be answered within 16 days
- The hope is for one to two, but if not answered, coders send it on and they have to respond within 30 days
- Prior to patient dismissal, but we call at 24 hours
- Try to get all answered prior to discharge
- Different for hospitalists, residents, other
- Within 30 days of discharge
- Open queries average 3–4 days; physicians have up to 30 days to answer
- 10 days, then privileges begin to be decreased, then completely revoked at 30 days
- Supposed to be 2 days, but not enforced
- Two days, then escalation to department chief, then escalation to director
- We have a whole escalation metric if not answered within 72 hours
- 5 days post discharge
- 7 days post discharge

36. What is your physician query response rate (i.e. % of queries meaningfully acknowledged by the physician without your facility's required time frame)?

Answer Options	Response Percent
0%–25%	1.68%
26%–50%	3.07%
51%–60%	2.23%
61%–70%	2.51%
71%–80%	6.42%
81%–90%	27.09%
91%–100%	46.09%
Don't know	7.26%
We don't track this metric	3.63%

37. What is your physician query agree rate (i.e., written response on a query form or in the record that provides clarity in order to apply a new or more specific ICD-10 code or provide clinical validation of a documented condition)?

Answer Options	Response Percent
0%–25%	2.51%
26%–50%	2.23%
51%–60%	2.23%
61%–70%	1.68%
71%–80%	12.57%
81%–90%	35.75%
91%–100%	29.61%
Don't know	10.06%
We don't track this metric	3.35%

38. Does your medical executive committee have an escalation policy or other policy requiring physicians to respond to queries/ CDI clarifications?

Answer Options	Response Percent
Yes	50.56%
No	33.52%
Don't know	0.61%
Other (please specify)	5.31%

Other (please specify)

- We have a policy but it is not enforced
- One was drafted by system office but pulled from implementation because not all facilities agreed to the terms/language
- No, but we don't have a problem with this
- We have a departmental process
- Guidance has been given to the hospitals to write their own P&P
- We are working on it right now
- Policy applies to all outstanding documentation and not specific to queries
- We have an escalation process, but no requirements for response
- Only for the hospitalist team
- Fine of $50
- We have a policy, but it is not owned by the MEC
- No, but our CDI program has an escalation policy that is supported by the administrative team and escalated up to the CMO if necessary

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