Industry Overview Survey

October 1, 2014—the compliance date of ICD-10—is looming larger and larger. So how prepared are the nation's CDI specialists for this impending change? Most are well underway with training, but the results still concern Clinical Documentation Improvement Week survey advisor ***Walter Houlihan, MBA, RHIA, CCS,*** *director of health information management and clinical documentation at Baystate Health in Springfield, Mass.*

"I'm a little surprised that only 50% have begun formal training, and even more so that 7.3% [of respondents] say they have not begun and have no plans in place," he says.

In other survey developments, physician engagement continues to be the most difficult obstacle for most CDI programs; most CDI specialists see little room for advancement in their own hospitals but believe there is plenty of room for growth in the broader healthcare industry; and CDI specialists are growing more accustomed to electronic health records (EHR), finding them beneficial to their CDI efforts.

Following is an overview of the survey results beginning on p. 5 and Houlihan's commentary.

ICD-10

Survey results indicate that exactly half of respondents (50%) have begun formal ICD-10 training in their facility, while another 25% have begun informal/superficial training. That's good news to Houlihan, but the combined 25% that have not begun training is a concern.

"Those that haven't begun training should have already started. There is so much to do," Houlihan says. "If you're a very small hospital, maybe that's okay not to have begun training, but even a 100-bed hospital has a lot to do between budgeting, staffing, testing of IT systems, and raising awareness of what systems will be affected, and who needs to be trained at their facility. ICD-10 is not just a CDI or coding issue. We have 10,000 employees at Baystate, and the IT piece was a hard nut to crack."

The survey shows there is much to do to get ready for October 1, 2014, as 83% of respondents indicate that ICD-10 is a major change for everyone. Twenty-two percent of respondents have already begun training their physicians for the increased demands of ICD-10 documentation, but Houlihan wonders about the 21 respondents who do not plan to do any formal physician training.

"I would wonder why there is no formal training planned," he says. "The sooner the better to change physician behavior. Grab the benefits right now in ICD-9."

Survey results also reveal that physician apathy/lack of response and interest in ICD-10 is the biggest obstacle to successful implementation (as indicated by 53% of respondents). Houlihan recommends that CDI specialists read and share with their physicians an August 6, 2013 article on the ICD-10 Monitor website entitled "Why Physicians Should Care About ICD-10" (read it here: *http://icd10monitor.com/index.php?option=com_content&view=article&id=989:why-physicians-should-care-about-icd-10&catid=48:icd10-enews&Itemid=168*).

More than two-thirds of respondents (69%) indicate that ICD-

ICD-10 *(Continued)*

10-PCS (procedure coding) training will be extended to their CDI specialists, which Houlihan says is a good thing. However, he warns that the 36.8% of respondents who aren't planning to add staff in anticipation of ICD-10, as well as the 27.9% who don't know whether staff will be added, should have a backup plan in place.

"Focus on what needs to be done specifically to address the documentation gaps in your hospital. For example, in children's hospitals, the No. 1 diagnosis is asthma because the coding has completely changed. If you get physicians used to new specificity/granularity documentation requirements related to asthma, then you can move on to another diagnosis."

—Donna Smith, RHIA, project manager and senior consultant, consulting services business of 3M Health Information Systems

3M

"If you're not adding staff, you should at least have contingency plans to contact with external companies—if stuff hits the fan, you'll be able to send off coding backlogs to a company to help you," he says. "You don't want to be looking around in October of next year."

Physician engagement

Survey results indicate that many hospitals employ a physician advisor (PA) to CDI in a part-time capacity (45.4%), with another 15.2% enjoying the benefits of a full-time PA.

"It's good to see that 60% do have a physician advisor—they are definitely needed," Houlihan says. "Our advisor is not only the physician advisor for CDI, but is joined at the hip with ICD-10 to conquer similar challenges for ICD-10."

Houlihan is concerned, however, that 40% of respondents report their PA as only "somewhat effective"; he suggests that CDI specialists should be sharing the resources on the ACDIS website with their PAs to improve their effectiveness. Less surprising to him is the significant portion of respondents (48.9%) who report that their medical staff is only somewhat engaged and motivated in CDI.

While most respondents (77%) indicate that one-on-one conversations on the floor are the most effective tool to ensure physician participation, Houlihan sings the praises of data for achieving buy-in.

"Docs like data—when we go out to educate, we use benchmarking data here at Baystate," he says. "When they see that they are not rated as good nationally or with their peers, that works. They want to be better; the competition is what motivates them."

Houlihan is impressed that many respondents (about 30%) report an 81%–90% physician query response rate, although he acknowledges that some facilities might define "response" differently (i.e., only counting scenarios where the physician responds to a query within 24 hours, vs. responding post-discharge). "We're around the low 80s at Baystate, so this is great. Kudos to those with 91–100—obviously that's the goal." He finds the fact that 14% don't know or don't track their physician response rate alarming, however.

Significant numbers of respondents (about 49%) do not have a medical executive committee policy that requires CDI participation. Baystate doesn't either, Houlihan says; he plans to draft one and admits he has some homework to do. More concerning for him, though, is the fact that 38% of hospitals do not provide any CDI orientation for new physicians and residents.

"Be careful about using any straight data without contemplating the information and trends that the data represents. For example, when reviewing the physician response rate, a particular physician may respond 100% of the time, yet the topic of the queries are the same as when the program started. If you still have to ask Dr. Elion to clarify whether a patient's congestive heart failure was acute, chronic, or acute-on-chronic after a year of query and education efforts, then additional or alternative methods may be needed."

—Jonathan Elion, MD, founder of ChartWise Medical Systems, Inc., in Providence, R.I.

ChartWise Medical Systems

"I have a program [at Baystate] that new attending and residents go through orientation—it's required," he says. "We work with our residency departments to ensure that happens, and it's really excit-

ing. We work one on one with attendings, and with our residents in a group. I would encourage that 38% to change."

Career advancement

In the career advancement section of the survey, an overwhelming majority of respondents (85%) indicate they have no or minimal opportunities for advancement within their CDI department. Houlihan says this represents an opportunity for ACDIS to help those stuck in their jobs by developing a sample career ladder (for example, clinical documentation specialist [CDS] 1 and CDS 2, with CDS 2 defined as 10 years of experience and higher pay).

"Essentially, the shift to the electronic health record and electronic query universe is not unlike the move to computer-assisted coding. Coders were anxious that computers would take over their jobs, but that just isn't the case. Just as it was for coders, electronic tools are just that—tools. The key is to leverage these tools and look for additional opportunities for program growth."

—Michelle M. Wieczorek, RN, RHIT, CPHQ, product manager for Optum's Clinical Documentation Improvement Module

"Our coding department has Coder 1, 2, 3, but our CDIs have nothing, just CDS and assistant director. I need to do my due diligence here, and maybe as an organization we need to develop a job description of entry-level CDS vs. CDS level 2," he says. "We all need a career ladder and a way to strive to increase our pay."

The survey does show that there is career growth outside of hospitals, however, with about 30% of respondents indicating that career advancement opportunities in the broader CDI industry are "good." "I agree that there are opportunities outside the hospital, and it's good to see opportunities in consulting, even if there are not as many opportunities in the hospital," Houlihan says.

Additionally, most respondents (54%) believe they are compensated adequately for their work, and a majority (70%) received a salary increase within the past year. "With the overall down market, that's a good sign for the profession," Houlihan says.

Some 43.6% of respondents are planning to expand their review to all payers, which could open up more opportunity for CDSs skilled in private-payer coding and billing requirements.

Electronic health records

Baystate has a full EHR, and Houlihan is quick to point out its benefits, though he does admit that EHRs bring with them some problems and unintended consequences.

Many respondents (34.8%) indicate that they have a hybrid medical record and plan to be totally electronic by 2015 or sooner; 43.6% have a complete EHR with perhaps a few scanned records. However, the field is split nearly equally on EHRs that allow for electronic queries/prompts to the physician—half have this option, the other half do not.

Houlihan says that CDI specialists should advocate to their vendors to put electronic query systems in their EHR, as the benefits are immediate.

"We use email queries, but we're working diligently on building it into our EMR," Houlihan says, noting that he expects the system to be up and running in a matter of months. "Physicians will see a message/query on that patient, right in the patient file. It's fewer clicks as opposed to an email that requires you to exit out of email back into the EMR."

Most respondents (51.5%) indicate that electronic querying makes life easier for the CDI specialist, as physicians are more likely (47%) vs. less likely (16.3%) to answer an electronic query. Very few respondents (less than 8%) indicate that EHRs harm physician education/buy-in to CDI.

"It has made life easier—it's easier to type than write. Efficiency is improved with the EHR, and for the CDI too, not just the doc," Houlihan says. "You can answer anywhere, at home, not just on the clinical floor, if the EHR is set up right."

The plurality of respondents (45.7%) indicate that advances like computer-assisted coding, natural language processing, and computer-generated queries will allow CDI specialists to review records remotely. Others (41.4%) also indicated that such advances will allow CDI specialists to become documentation coaches and spend more face time with physicians.

"Reviewing records remotely is good as it gives them more flexibility," Houlihan says. "Coaching docs and spending more face-to-face time is good. Technology is a good thing."

Still, most CDI specialists (84%) do not work remotely, and most respondents (about 68%) don't know enough to say whether working remotely is as effective an arrangement as being on site. Houlihan, however, says that he has found both coders and CDI specialists to be more productive at home, and that an at-home option aids with employee retention.

"Face to face is a good thing," Houlihan says. "I do allow 1–2 people on a four-person team to be remote, but I always have people on site. But working at home enabled me to hire two nurses from hospitals that did not have a remote option. They are seasoned people. I do it for my coders too—the ability to attract and retain coders with ICD-10 coming is critical."

Of large concern is the near 40% of respondents who indicated that copy/paste is a severe, widespread problem in their facility.

"We have an internal policy at Baystate, and it's improving. But that's where technology hurts us," Houlihan says. "If we see habitual copy/paste and the documentation is not accurate, they are spoken to by their physician leader, and we remind them of the policy."

CDI's role in Recovery Audit defense/compliance

CDI specialists that take an active role in Recovery Audit defense/compliance are in the minority, as only 28% of respondents say they are part of a Recovery Audit team. Most indicate that Recovery Auditors are focused on denied inpatient admissions/lack of medical necessity (42%), which is typically seen as a case management issue.

"We have a team, but we're [CDI] not a part," Houlihan admits. "We haven't been hit hard by the RAC here—we have been hit with RAC audits, but it's all medical necessity, not HIM/coding or DRGs. But when we are, I will definitely involve my four-member CDI team."

Most respondents (67%) say that CDI remains business as usual, despite the takebacks by Recovery Auditors. However, most (56%) receive no notification when a case is denied or downgraded, which Houlihan says is not ideal.

"Everyone needs to know what the RAC is focusing on while they are reviewing records. They need to be aware and not just working in silos—there should be collaboration," he says. "Most CDI managers or staff don't write appeals because they are busy with queries, but they can definitely help out with their clinical knowledge. It's a collaboration."

Most respondents (63%) do not review records for medical necessity, or do so only on the periphery.

"I'm part of the 63% [that indicated "no"]. We've been asked by care management to help with medical necessity, but we don't have the luxury of time. We're focused on quality of documentation overall but not medical necessity," Houlihan says.

CDI Week

About the Clinical Documentation Improvement Week survey advisor

Walter Houlihan, MBA, RHIA, CCS

Houlihan has worked in the HIM field for over 30 years, initially coding medical records at Columbia Presbyterian Medical Center in New York City in the 1970s, then overseeing physician documentation in medical records at academic teaching facilities in New York City and Chicago. Fourteen years ago he came to Baystate Health in Springfield, Mass., an integrated healthcare system composed of three hospitals and over 50 ambulatory sites. At Baystate, Houlihan has assisted with developing a CDI program that has improved the quality of documentation and subsequently administrative data. Baystate Health has received numerous national quality awards, most notably being recognized as a top 60 U.S. medical center by Reuters and Leapfrog, and has enjoyed financial improvements as a result of its better quality data.

Houlihan promotes collaboration with hospitalists and the entire medical staff, which includes providing ongoing CDI education to attendings and residents. He led the effort to prepare Baystate Health for ICD-10 and plans to start the process of dual coding with ICD-9 and ICD-10. Houlihan has spoken at numerous association meetings and conferences on the importance of improving clinical documentation, most crucially for the continuity of quality patient care and an accurate representation of hospital and provider patient care services. He enjoys the collaboration between ACDIS professionals at meetings in the New England and New York City areas. Houlihan is currently a member of the ACDIS advisory board.

2013 CDI Industry Overview Survey: Emerging Topics

ICD-10

1. Has your CDI department and/or HIM department begun ICD-10 training?

Yes, we've begun formal training	178	50%
Yes, but informally/at a superficial level	90	25.3%
No, but we have a plan in place	62	17.4%
No, and we have no plans in place	26	7.3%
Total	***356***	***100%***

2. What's your overall impression of the anticipated impact of ICD-10?

It's a major change for everyone	292	83.2%
It's a major change, but primarily for CDI/documentation	10	2.8%
It's a major change, but primarily for HIM/coding	24	6.8%
It's a moderate change	18	5.1%
It's a minor change	2	.06%
Unsure at this time	5	1.4%
Other (please specify)	7	
Total	***351***	***100%***

3. When do you plan to train your physicians in ICD-10 documentation?

We've begun training them already	78	5%
Immediately	7	35%
By the end of 2013	65	46%
In the first quarter of 2014 (Jan.-March)	75	13%
In the second quarter of 2014 (April-June)	20	5%
In the third quarter of 2014 (July-Sept.)	8	5%
A few weeks prior	3	35%
At or after projected start date of Oct. 1, 2014	0	46%
We do not plan to do any formal physician training	21	13%
Other, please specify	72	13%
Total	***349***	***100%***

4. Which of the following are the biggest obstacles to ICD-10 implementation in your facility? Choose up to three answers.

Physician apathy/lack of response and interest	189	53%
Foreign appearance of codes and new coding rules	71	20.2%
IT/technical issues	77	21.9%
Inadequate plan/support for physician education	97	27.6%
Inadequate budget to prepare staff	67	19.1%
Inadequate time to prepare staff	36	10.3%
Lack of internal knowledge on ICD-10	68	19.4%
Lack of leadership/someone taking the initiative	61	17.4%
Lack of coordination with other strategic initiatives	59	16.8%
Don't know	40	11.4%
Other, please specify	23	6.6%
Total	***351***	***100%***

5. Does your facility plan to extend ICD-10-PCS (procedure coding) training to its CDI specialists?

Yes	241	68.9%
No	22	6.3%
Don't know	87	24.9%
Total	***350***	***100%***

6. Does your facility plan to add staff in anticipation of ICD-10?

Yes, both CDI and HIM/coding staff	60	17.1%
Yes, CDI staff only	13	3.7%
Yes, HIM/coding staff only	51	14.5%
No	129	36.8%
Don't know	98	27.9%
Total	***351***	***100%***

7. Do you have a physician advisor to CDI?

Yes, in a full-time capacity	54	15.2%
Yes, in a part-time capacity	161	45.4%
No, but we have plans to add one	41	11.5%
No, and we have no plans to add one	87	24.5%
Don't know	12	3.4%
Total	***355***	***100%***

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

Very effective	47	21.8%
Reasonably effective	52	24.1%
Somewhat effective	87	40.3%
Ineffective	30	13.9%
Total	***216***	***100%***

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

Highly engaged and motivated	14	4%
Mostly engaged and motivated, with some exceptions	112	31.6%
Somewhat engaged and motivated	173	48.9%
Mostly disengaged and unmotivated	55	15.5%
Total	**354**	**100%**

10. What are the most effective strategies you use to ensure physician participation and collaboration (choose up to three)?

Posters and other visual elements	77	21.9%
One-on-one conversations on floor	271	77%
E-mail alerts	37	10.5%
CDI newsletter	42	11.9%
Tip of the week	26	7.4%
Candy/other small handouts	44	12.5%
Educational presentations conducted in med staff meetings	150	42.6%
Providing benchmark data to physicians	76	21.6%
Rewarding top physician performer of the month	10	2.8%
Clear CDI policies and procedures	23	6.5%
Directives from hospital administration	83	23.6%
Other, please specify	26	7.4%
Total	**352**	**100%**

11. What is your physician query response rate (i.e., % of queries meaningfully acknowledged by the physician)?

0-10%	6	1.7%
11-20%	1	0.3%
21-30%	8	2.3%
31-40%	8	2.3%
41-50%	13	3.7%
51-60%	13	3.7%
61-70%	22	6.2%
71-80%	47	13.3%
81-90%	105	29.7%
91-100%	82	23.2%
Don't know	33	9.3%
We don't track this metric	16	4.5%
Total	**354**	**100%**

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

0-10%	5	1.4%
11-20%	5	1.4%
21-30%	8	2.3%
31-40%	12	3.4%
41-50%	10	2.8%
51-60%	11	3.1%
61-70%	20	5.6%
71-80%	48	13.6%
81-90%	102	28.8%
91-100%	60	16.9%
Don't know	48	13.6%
We don't track this metric	25	7.1%
Total	***354***	***100%***

13. Does your Medical Executive Committee have a policy or policies requiring CDI participation?

Yes	61	17.2%
No	173	48.9%
Don't know	108	30.5%
Other, please specify	12	3.4%
Total	***354***	***100%***

14. Do you provide new physicians and residents CDI orientation as a standard practice?

Yes, all physicians	113	32%
Yes, but only attending staff	31	8.8%
Yes, but only residents	52	14.7%
No	135	38.2%
Don't know	22	6.2%
Total	***353***	***100%***

15. Please describe the opportunities for career advancement within your CDI department:

None/minimal (Small salary increases, and/or no promotion opportunities)	295	85%
Moderate (Moderate salary increases, and/or opportunity for promotion to CDI manager)	48	13.8%
Very good (Large salary increases, and/or multiple levels of promotion opportunities in CDI dept.)	4	1.2%
Total	***347***	***100%***

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

None/very little	40	11.3%
Moderate	94	26.5%
Good	106	29.9%
Excellent	70	19.7%
Don't know	45	12.7%
Total	***355***	***100%***

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

Yes	189	54%
No	161	46%
Total	***350***	***100%***

18. When was your last salary increase?

Within the last 3 months	73	21.7%
Within the last 6 months	44	13.1%
Within the past year	119	35.4%
More than a year ago	100	29.8%
Other (please specify)	29	
Total	***336***	***100%***

19. Before assuming your current role in CDI, were you working in another department at your hospital (i.e., did you move into CDI through an internal transfer/promotion)?

Yes	239	67.7%
No, I was working as a CDI specialist in another hospital and applied	35	9.9%
No, I was placed by a recruiting or consulting firm	13	3.7%
Other, please specify	66	18.7%
Total	***353***	***100%***

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

Very good—high growth industry due to changes/new regulations/need for CDI programs	271	39%
Mixed—depends on state/location, etc.	78	23%
Poor—restrictive regulations and other limitations have diminished growth potential	4	38%
Other (please specify)	2	
Total	***353***	***100%***

21. Which review area(s) is your hospital considering expanding its CDI program into? Check all that apply.

All payers	153	43.6%
Pediatrics	45	12.8%
Quality measures	68	19.4%
Severity of illness/risk of mortality (SOI/ROM)	88	25.1%
Present On Admission (POA) indicators	55	15.7%
Patient Safety Indicators (PSI)	47	13.4%
Emergency department	51	14.5%
Outpatient services and procedures	44	12.5%
Medical necessity of inpatient admissions	54	15.4%
Dedicated review of targeted Recovery Auditor or other high-risk DRGs	47	13.4%
We are not planning on expanding our review duties at this time	79	22.5%
Other, please specify	37	10.5%
Total	***351***	***100%***

22. Where does your facility stand regarding implementation of an electronic health record (EHR)? If you answered "all paper" or "not applicable" to this question, please proceed to question 33.

All paper medical record with no immediate plans to implement an EHR	3	0.8%
All paper medical record, but with a defined plan/process to be totally electronic by 2015 or sooner	13	3.7%
A hybrid medical record (electronic and paper) with no immediate plans to be fully electronic	56	15.7%
A hybrid medical record and we plan to be totally electronic by 2015 or sooner	124	34.8%
Complete EHR after discharge but some records are scanned	79	22.2%
Complete, digitalized EHR concurrently and after discharge	76	21.3%
Not applicable/I don't work in a facility or hospital	0	0%
Other, please specify	5	1.4%
Total	***356***	***100%***

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

Yes, and we use it	147	48%
Yes, we have this capability but choose not to use it	17	5.6%
No, we don't have this capability	142	46.4%
Other (please specify)	37	
Total	***306***	***100%***

24. If you answered yes to question 23, has electronic querying made life easier for CDI specialists?

Yes	94	51.4%
No	41	22.4%
Not sure yet	48	26.2%
Total	***363***	***100%***

25. Do you find physicians more or less likely to answer an electronic query, or less so?

More likely	28	46.8%
Less likely	43	18.5%
About the same as other types of queries	81	34.8%
Other (please specify)109	21	
Total	***233***	***100%***

26. Do electronic query systems enhance or harm physician education/buy-in to CDI?

Enhance	63	26%
Harm	22	9.1%
Neutral	157	64.9%
Other (please specify)	12	
Total	***242***	***100%***

27. What is your opinion of technological advances like computer assisted coding, natural language processing, and computer generated documentation queries? Check all that apply.

Coders will evolve into code technicians	43	13.2%
CDI specialists will become query validators/verifiers	104	31.9%
CDI specialists will become documentation coaches and spend more face to face time with physicians	138	42.3%
CDI specialists will review records remotely	152	46.6%
CDI specialists will take on more responsibility for quality and care management functions	88	27%
Coders and/or CDI specialists will be replaced or reduced	29	8.9%
Productivity will be reduced	21	6.4%
Productivity will increase	124	38%
Quality of reviews will improve	122	37.4%
Quality of reviews will diminish	27	8.3%
No impact/CDI and coding will largely remain the same	18	5.5%
No opinion	38	11.7%
Other, please specify	15	4.6%
Total	***326***	***100%***

28. If you have a completely digitized EHR, approximately what percentage of your CDI specialists work remotely?

None/our facility does not allow this option	209	83.9%
10%	17	6.8%
25%	3	1.2%
50%	8	3.2%
75%	5	2%
100%	7	2.8%
Total	***249***	***100%***

29. Are your remote CDI specialists as effective as those working onsite?

Yes	23	19.7%
No	13	11.1%
Not sure	81	69.2%
Total	***117***	***100%***

30. Do you believe that offering a remote work option is an incentive for CDI recruitment and retention?

Yes	237	76.9%
No	29	9.4%
Don't know	42	13.6%
Total	***308***	***100%***

31. How big a problem is copy/pasting and/or cloned documentation by physicians in your facility?

Severe problem/widespread	128	41.4%
Somewhat of a problem/some physicians are offenders	85	27.5%
Minor problem	26	8.4%
Not an issue	40	12.9%
Don't know	30	9.7%
Total	***309***	***100%***

32. Regarding CDI technology, what do you believe to be the greatest influence on physician adoption of tools such as electronic queries?

Mobility or portability of the application	24	7.5%
How real-time the presentation of the query is in relation to the patient encounter	84	26.3%
The amount of mouse clicks or key strokes it takes to respond to a query	97	30.4%
The clinical relevance of the information in the query tool to the patient's care	46	14.4%
How integrated the tool is within the EHR	68	21.3%
Total	***319***	***100%***

CDI's Role in Recovery Audit defense/compliance

33. Are CDI specialists a part of your Recovery Audit defense/response team?

Yes, we're a part of the team	90	28%
No, we have a team but we're not a part	204	63.6%
We don't have a Recovery Audit defense/response team	27	8.4%
Other (please specify)	21	
Total	***321***	***100%***

34. Is your CDI staff or managers involved in writing appeals?

Yes	98	29%
No	217	64.2%
Don't know	23	6.8%
Total	***338***	***100%***

35. What have been your biggest challenges with the Recovery Audit program? Choose up to three answers.

Denied/downcoded MS-DRGs	88	27.2%
Denied inpatient admissions/lack of medical necessity	135	41.8%
Fear/overcaution in reporting certain diagnoses by physicians	19	5.9%
Fear/overcaution in reporting certain diagnoses by coding staff	61	18.9%
CDI not being involved or overlooked in Recovery Audit defense/denials	78	24.1%
Don't know	102	31.6%
We have not had any Recovery Audit activity/denials	6	1.9%
Other, please specify	4	1.2%
Total	***323***	***100%***

36. Has the Recovery Auditor program changed the way your CDI department operates?

No, it's business as usual	206	68.4%
Yes, we're more cautious about physician queries as a result	66	21.9%
Yes, it has increased our workload as a result	26	8.6%
Yes, we've had to add additional CDI staff members	3	1%
Other (please specify)	25	
Total	301	100%

37. Does your CDI department monitor or receive notification of cases that are denied or downgraded by auditors?

Yes	102	31.7%
No, but other departments monitor this	182	56.5%
No, we don't monitor denials in our facility	15	4.7%
Don't know	23	7.1%
Other (please specify)	19	
Total	322	100%

38. Does your CDI program review records to help ensure medical necessity of inpatient admissions?

Yes, this is a focus	22	6.7%
Somewhat, though its primarily a case management function	100	30.4%
No	202	61.4%
Don't know	5	1.5%
Other (please specify)	14	
Total	329	100%

Open-ended responses

Following are some representative open-ended responses from survey takers.

Question: What's your overall impression of the anticipated impact of ICD-10?

- For some providers it will be a major change, while others a minor change
- It is a major shift in focus for both CDI and coding, however, it seems like Y2K and won't be as bad as is presumed
- I believe it will be a good change and much needed

Question: When do you plan to train your physicians in ICD-10 documentation?

- Starting to revise query forms to include ICD 10 information
- Physicians will probably have to make their own plans
- Do not know what the plan is for physicians
- I am not aware of any formal plan.
- No formal plans at this time - will be one-on-one encounters and perhaps some I-10 introduced when we educate regarding general documenation needs.
- I've been giving them tips/info as it relates to what's being documented now, but they are under a bigger umbrella of physicians not controlled by our hospital so I 'm not sure what is being planned by their leaders.

Question: Which of the following are the biggest obstacles to ICD-10 implementation in your facility? Choose up to three answers.

- Lack of physician advisor
- Deciding on a vendor for the facility
- Adoption and focus on EMR which will take place Feb 2014
- Staff coverage while training
- Time, just implemented new financial and EMR system - too many changes at once
- Lack of staff
- Lack of CDI staff
- No big obstacles--We have plans in place in all areas, but we do have a number of older physicians that are not on board with ICD-10. They may be a challenge.
- There are no DRG groupings put forth to know what strategies we need to develop!
- Only 2 CDS to train a 500+ bed teaching hospital. Time limited with working up the patients and teaching
- Not a senior admin priority at this time

Question: What are the most effective strategies you use to ensure physician participation and collaboration *(choose up to three)*?

- Physician advisor
- Lunch and Learns
- Info posted on intranet MRD website
- "Think in Ink" educational email re. documentation tips sent from medical director to staff physicians
- It is actually in the contract of some of our hospitalists
- Physician to physician training
- Online computer training
- New provider orientation
- Brief Friday morning after their exchange of reports for about 5-15 min
- Quarterly scorecard of compliance with query response
- none
- We are working to prepare a CDI curriculum for physicians for one to one education. We feel this is the most effective strategy.
- Article in monthly med staff newsletter

Question: Does your Medical Executive Committee have a policy or policies requiring CDI participation?

- Cardiology and hospitalists have incentives
- Not specific to CDI but good citizenship is defined as completing records
- This is being developed
- CMO has stated all queries must be answered.
- Some physicians incentivised
- Unaware of a policy but docs that don't cooperate are mentioned in MD meetings
- Was in contracts, MD refused to sign, taken out of contracts.

Open-ended responses *(Continued)*

Question: When was your last salary increase?

- this was due to a union contract for all RN's and not due to my position as a CDI specialist.
- After 5 yrs. no salary raise. We are not even compensated for our certification
- Capped, none
- Represented within the RN union at our facility
- I had to ask repeatedly for increase, was told salaries were compressed throughout healthcare. New hire was making 90 cents less than me, with no CCDS, no BSN, and not in manager role.
- No increase in the 5 yrs I have been here, none for anyone
- We are topped salary-wise and merit raises are frozen across board.
- Promoted to supervisor with minimal pay increase
- Just lost $1.00/hr. told my RHIT & CCDS didn't mean anything.

Question: Before assuming your current role in CDI, were you working in another department at your hospital (i.e., did you move into CDI through an internal transfer/promotion)?

- Relocated
- I was a case manager before
- Recruited by a CEO from another facility
- I worked as a RN in another facility
- Rehired for new CDI position for program start up
- Rehired by hospital where I previously worked
- Student at an accredited HIT program
- Staff nurse at another hospital
- I applied for the CDI position from another hospital as nursing manager
- No, I worked for a major insurance carrier.
- I got this job while finishing my RHIT
- Hired off the street - on attitude

Question: What is your opinion on the growth outlook of the CDI industry?

- There needs to be more of a coder/RN mix to be completely successful!
- Concern that position will go to lower trained/untrained people with increased computer technology.

Question: Which review area(s) is your hospital considering expanding its CDI program into? Check all that apply.

- Long term care
- OB, newborns and psychiatry
- Utilization Review
- OB/GYN
- We do all payors currently, and added psych (limited)
- We already review all payers and participate in quality measures, SOI/ROM, and POA indicators.
- Already do all but outpatient and ER
- Long term care and rehabilitation
- Rounding with physician groups
- Medicaid patients
- Coordinating efforts with Case Managers regarding working DRG and LOS
- Medicaid for RAC
- We already are doing all these. No expansion plans.
- We already cover all units/specialities. Also involved with Infection Control, ET nurses, Quality, and Nursing
- Already collarborating w quality/safety reviews: also LCD/NCD determinations

Open-ended responses *(Continued)*

Question: Does your EHR allow for electronic queries/prompts to the physician?

- We are trying to figure this out!
- When EPIC is fully implemented we will have this ability
- Used only by coders
- Only retrospectively
- Yes, we have capability for prompts but needs fine tuning
- I wish!
- The EHR has the capability, but the medical staff still charts on paper so it would not be effective
- We want to move toward this but have IT issues and constraints at this time
- We send a message directly to the MD as well as provide a paper query
- Paper query but electronic notification that query is on chart
- May have capability but we are not allowed to use it.

Question: Do you find physicians more or less likely to answer an electronic query, or less so?

- Physician may be more likely respond to your query if they are blocked from further viewing their patients' lab results and others
- Can only generate a query to one physician, whereas, the paper chart and query allowed all providers who touched the chart to see the query.
- Some ignore them until I speak to them face to face....
- They still need to be prompted to open /read it
- Physicians complain it is a more cumbersome process, however we have a higher response rate with the electronic query.
- They answer them if they see them. Built poorly into EPIC. MD must go into his inbasket to find the query.
- Concern is the ability to conduct verbal query alongside e-query

Question: What is your opinion of technological advances like computer assisted coding, natural language processing, and computer generated documentation queries? Check all that apply.

- We have had CAC for over a year and it is STILL in testing/ learning mode. It doesn't work well for trauma/ortho.
- Productivity will decrease intitally then increase after fully engaged in new software and processes
- Loss of human interaction is never a good sign!
- Appropriateness of queries will improve and query impact will improve
- These technologies are in their infancy and need time to grow into effective tools
- Non-professionals will take over this role - RN's will be pushed out.

Question: Are CDI specialists a part of your Recovery Audit defense/response team?

- We are part of the team only to be aware of the types of denials, but we do not actually write the responses.
- We are consulted but not routinely
- We assist when asked for clinical judgement
- We assist the team as needed with clinical insight.
- We used to be but this job has recently been taken away from us to expand to all payer reviews
- We are RAC exempt
- CDI manager is a consultant to the RAC response team
- We play a minor role, are asked how we got the DRG , clinical evidence to support our position
- Only to review questionable records; not member of a team
- Done at corporate, CDI team not kept in the loop

Question: Has the Recovery Auditor program changed the way your CDI department operates?

- CDI not involved with RAC but plans currently being made for CDI to be on RAC committee
- The recent query brief has been wonderful in shoring up/ supporting query necessity, the format, etc.
- More input to the case management team as we review documentation for medical severity and not meeting inpatient criteria
- Cause to increase focus on certain DRG's
- We work more closely with our UM team to assure patients are observation or inpatient more appropriately
- We are encouraged to rac proof the chart with additional cc/mcc but aren't involved in admission denials.
- Getting more savvy at query wording

Open-ended responses *(Continued)*

Question: Does your CDI department monitor or receive notification of cases that are denied or downgraded by auditors?

- Yes but limited release of this info from managers-poor policy
- Some denials are shared but a complete report of denied DRG's is not given.
- Sporadically
- Sometimes if the coding manager mentions it, but not usually involved

Question: Does your CDI program review records to help ensure medical necessity of inpatient admissions?

- We used to, we do not anymore
- CDI reviews for accurate complete clinical documentation, so yes that ensures med necessity of inpatient and observation admissions
- They are getting ready to be moved back to case managment and will begin doing this as a blended role
- Not intentionaly but we will point out to UR our concerns
- We review all charts and while reviewing if patient doesn't appear to meet critieria for inpatient we notify UR nurses who sit right behind CDI staff; we work collaboratively.
- We look at the admit order for diagnosis and if none, query as appropriate, for example in a outpatient surgery patient admission following surgery, what is the reason for admission?

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