Clinical Documentation Improvement Week

Industry Overview Survey

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INDUSTRY OVERVIEW SURVEY

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These days it seems the healthcare industry is all about quality. And no wonder: Underpinning healthcare reform is a fundamental shift from volume-based payment (i.e., fee for service) to paying for quality, patient-centered outcomes, and demonstrable improvements in physician and hospital performance.

According to the 2014 CDI Week Industry Overview Survey, the CDI profession is following suit, as CDI is also shifting from revenue enhancement to overall integrity of the health record, aligned with the overall goals of quality. Approximately two-thirds (66.3%) of our survey respondents now review some form of quality measure or quality-related item.

"Hopefully more and more people are starting to realize, if you get it right—quality and integrity—the money just follows along," says CDI Week survey advisor Mark LeBlanc, RN, MBA, CCDS, clinical documentation manager for Hennepin County Medical Center in Minneapolis. "If you just go after money, you may find $1,000 on one case, but you don't look for the entire picture and you're only getting that money once. It's not a long-term solution, not as good as improving your documentation across the board and getting a higher multiplier."

In other survey developments, CDI departments still struggle with physician engagement and finding an effective physician advisor; have made significant strides in implementation of electronic health records (EHR), with most realizing EHR benefits in their CDI reviews; have slowed down their ICD-10 training timetables with the one-year delay to October 2015; and believe that CDI has lots of room for growth and career advancement, but largely outside their own facilities.

Following is a recap of the survey results beginning on p. 7 and LeBlanc's commentary

CDI and quality

Survey results indicate that most respondents (50.8%) review for severity of illness/risk of mortality (i.e., APR-DRGs) concurrent with the patient's stay, followed by hospital-acquired conditions, or HACs, at 41.1%. Perhaps a bit surprisingly, 24.8% of respondents review CMS inpatient quality measures (i.e., "core measures") on a concurrent basis as well.

Those results weren't surprising to LeBlanc, whose facility uses the APR-DRG grouper and reviews for HACs. But he was surprised by the fact that only 20.2% of survey respondents indicate they review Patient Safety Indicators (PSI), the reporting of which can have a dramatic effect on a hospital's quality rankings.

LeBlanc says his CDI department took on PSI review due to some poor outcomes data and immediately found opportunities where CDI could help. "Sometimes "elective" hadn't been updated to "emergent" when it should have been—a burn victim through the ED didn't elect to come in, but due to an EHR documentation

error they were reported as emergent," he says. "A PSI excludes all emergent admit types, so you have to make sure you get that right. We were able to turn those around and resubmit the data."

At Hennepin, coders identify PSI inclusion criteria (i.e., specifically any ICD-9 code included in PSI 90), and send the case to CDI for a secondary clinical review if a PSI is to be reported. "If the clinical picture doesn't support it, we elevate it to the provider and get the documentation we need for the coder," he says. "If the coder disagrees, it gets elevated to a committee of doctors, a coder, and nurse leaders to talk it through and either make the decision to send the case out the door as a PSI or HAC, or have a change in coding."

An almost equal split of respondents indicate that reviewing for quality measures either has (32.9%) or has not (33.4%) impacted their CDI chart review productivity. LeBlanc says Hennepin's PSI 90 review method results in more work, but he has the luxury of having a lead who performs all of these reviews on a retrospective basis. "It doesn't hinder our reviews—the rest of our CDIs are doing traditional review. But we need to move it up to concurrent and not have it impact our productivity too much."

LeBlanc was surprised that 47.3% of respondents indicate they do not collaborate with quality or patient safety committees. Another 51.7% do not have a referral relation with wound care nurses or infection prevention.

"I don't see how you can try to help impact quality—especially HACs—if you don't have a relationship with wound care prevention/infection control. They're the ones that can help you tell whether something is POA," he says. "In this day and time, you can't run a CDI department unless you have a relationship with all your providers—wound care, etc.—they all help drive documentation in the EHR. You can't isolate yourself to just doctors."

"It is nice to see many of this year's respondents are moving the needle and expanding their CDI responsibilities to review all payers and including the capture of quality metrics. With 49.8% of the respondents indicating their CDI program is staffed with three or less CDI specialists, it will force CDI programs to evaluate their existing CDI software and workflow processes to ensure it is maximizing efficiency to accommodate the extra responsibilities."

—Kelly Gates, RN, MSHA, CCDS, product manager for Optum CDI 3D

Program monitoring

Switching to program monitoring, 45.5% of respondents indicate that they report to HIM/coding, followed by case management (23.5%) and finance/revenue cycle (17.9%).

"I think that we're starting to see a shift—shifting CDI out of HIM and into revenue cycle," says LeBlanc, whose department reports to finance. "There is so much impact that coded data has."

LeBlanc says the fact that 23.5% of CDI departments still fall under case management worries him. "I've never seen a fit between case management and CDI. They're too opposite. Case management is patient-centered, and CDI is documentation-centered, so if push comes to shove, you'll focus on the patient first and the documentation second. I think quality and CDI fit better."

A large majority (66.3%) of respondents audit for query accuracy and compliance, and 56% of respondents indicate that their hospital administration finds query response rate the most compelling metric for evaluating the success of their CDI department.

"Of those four choices, query response rate is probably the best," LeBlanc says. "You want to look at response rate, but also agree rate—if your response rate is up, but your agree rate is down, you want to make sure you are putting out valid queries. A poor agree rate can be a sign of bad queries/query fatigue."

"Regarding monitoring your doctors; you might hear "We love that doctor, because he always answers our queries!" But what if he always needs to be queried on CHF? This is not revealed simply by looking at physician response rate. If you always query the same physician about the same topic, he may need targeted education on how to document that disorder better. Monitoring your response rate to queries is not enough, you need to monitor by topic. "

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

ICD-10 delay and preparedness

The one-year delay of ICD-10 to October 1, 2015, caused Hennepin to slow down its ICD-10 training, but not put it entirely out of mind. "We kind of put it on the back burner. We're still talking about it and developing materials, but not actively doing a lot of training," LeBlanc admits. Many respondents are in a similar state, with 51.8% indicating that the delay has partially affected or slowed their

implementation and training timeline.

Most respondents (34%) indicated that their physicians were relieved with the news of the delay, with 26.7% reporting no noticeable impact among their providers and only 4% indicating that the delay upset their docs.

"I don't know if our physicians really paid attention—we haven't been their face as much about [ICD-10]," LeBlanc says. "But whether we're using ICD-10 or ICD-9, it's really about good documentation. We just need to be getting accurate and complete documentation regardless of the code set we use."

Regarding additional budgeting and staffing in anticipation of ICD-10, 47% of respondents don't know the impact of ICD-10 on their training budget. Most (42.6%) have not asked leadership to add CDI staff in anticipation of the new date, though of those that have asked, 26.8% received approval and 9.5% were denied. In addition, 21.1% of respondents did not know if their CDI department requested additional staff.

"I hadn't asked for staff—we were talking about it before the delay and looking at supplemental staff," LeBlanc says. "I don't know if I could justify it."

"The role of the CDI professional is changing and evolving. These professionals must demonstrate extensive problem-solving and communication skills. Not only does the CDI professional need to understand the clinical presentation of a patient, they need to be able to identify clinical documentation to cue them into situations where additional clarification or information is needed from the physician to capture co-morbidities, complications, associated conditions, treatments, and patient responses. The extra year provided by the delay for ICD-10-CM/PCS implementation is advantageous to allow in-depth training for these professionals."

—Deborah Neville, RHIA, director of revenue cycle, coding and compliance for Elsevier Clinical Solutions

Physician engagement

Most survey respondents (60.8%) have a physician advisor to CDI. 45.7% are employed in a part-time capacity, while only 15.1% are full time.

LeBlanc was surprised that 58.5% say their physician advisor is either only "reasonably" or "somewhat" effective, with 13.4% admitting that their physician advisor is ineffective in his or her role.

"I think there is a need for standards," he observes. "Most are given the job and fly by the seat of their pants. Some pick it up quickly, others don't."

Most survey respondents indicated that their medical staff is "mostly" engaged in CDI and motivated to document well (44.6%). Only a small percentage (4.7%) indicated a high level of engagement and motivation amongst their providers, which demonstrates that physician involvement is still a tough challenge for most in the profession.

"I think it shows about where I expected it be [mostly engaged and motivated]. It depends on the age of your provider staff, and also the leadership," LeBlanc says. "The same 10% that report that their physicians are disengaged and unmotivated are probably the same that don't have a physician advisor."

Regarding query response, most require their physicians to answer within two days (22.7%), followed by three days (9.7%). A full third (35.5%) don't have a time frame for query response, which surprised LeBlanc.

"I think two days should be the standard for some type of response. We're pretty aggressive: We give 24 hours, and if they have not responded we go look for them," LeBlanc says. "The 35% who don't have a query response expectation—how are they holding cases for so long? How do you manage queries, and whether they are good queries or not? We will hold a case for a response if we need to, but we need a response, even if it's disagree."

Most respondents indicate they have a very good response rate—26.8% state that 91%–100% of physicians provide a meaningful acknowledgement/response within their facility's designated time frame. The majority report a slightly lower physician query agree rate (23.2% indicated that it was in the 81%–90% range). Both percentages are where they should be, suggests LeBlanc.

"The expectation of most programs is to have a 90% response rate. That shows engagement by the providers," LeBlanc says. "You won't get 100% agree, so it will be lower than your response rate."

Most respondents, however (53.8%), do not have an escalation policy enforcing response rates, though 32.2% do, and 14% do not know one way or the other. LeBlanc's own escalation policy

is different from the model presented in the survey, which asked respondents if they had an escalation policy backed by the medical executive committee.

"We have an escalation policy where it goes to me, and if I need to get further help, I will escalate to a physician liaison. It's not a true medical executive committee," he says. "We're sort of different; we just bought a practice, and our physicians were all independent until a couple years ago, so the transition is still happening. It's pretty cool that people have these medical executive committees looking at this stuff."

Electronic health records

Arguably the greatest single impact on the CDI profession in the last few years has been the EHR. A combined 56% of respondents indicate that they have either a complete EHR after discharge, with some records scanned, or a complete digitized EHR concurrently and after discharge. That's up from a combined 43% in the 2013 CDI Week survey.

The EHR has been a game-changer, often requiring physicians to respond to a query before proceeding in the health record. It's also allowed for work-from-home, remote CDI options. But not all the changes have been for the better, says LeBlanc, as copy/paste and "note bloat" have given rise to a new crop of problems for CDI specialists to combat. Though the highest percentage of respondents (38.2%) are "mostly satisfied" with their vendor software, 35.5% are only "somewhat satisfied" and 14.7% are dissatisfied.

"The government has made it almost impossible to say no with all the financial incentives they're offering for implementation," LeBlanc says of the high rate of adoption. "I think we thought that the EHR was the be-all, end-all, and we'd never have to struggle to read handwriting or figure out people's thought processes, but now we have copy-forward, note bloat, and copy and paste. That causes a level of dissatisfaction for some CDI—it takes a long time to go through a record and manipulate the record. It can be somewhat frustrating."

Hennepin, which (like the majority of respondents) uses EPIC, also issues electronic queries through its EHR, as do 29.2% of respondents. Most survey-takers say that electronic queries have improved their efficiency, productivity, or query response rates. "We use the vendor software to do our queries—I don't know how you would get a query out without it," LeBlanc says.

Although the EHR can enable CDI specialists to review records remotely, the overwhelming majority of hospitals (80.1%) disallow or lack the capacity for work-at-home arrangements. But LeBlanc is in favor of remote CDI.

"Our staff work from home on Friday as a job satisfier, as long as they maintain their productivity," he says. "I see the CDI world heading in that direction. Coding took a long time to get there, but we will see the same sort of morphing to home base for CDI.

"The newer docs don't want face-to-face interaction—they want electronic communication, and they have phones in hand. That's what they want. They don't want people stopping them in middle of work; they want to respond when they have time. With WebEx, video conferencing, there's no need to have everyone in rooms—it's more space and air conditioning. There is a huge crunch for space at hospitals," he adds.

But what about the worry that some CDI specialists will be less productive, or more distracted, at home? LeBlanc does not believe that is the case, and survey results bear it out. 10.4% of respondents report that at-home CDI query rates are better than on-site, as opposed to only 5.1% who claim those rates are worse; meanwhile, a significantly higher percentage of respondents claim productivity is higher for remote employees (15.5%) than on-site workers (only 2.6%). Query response rate was about the same for off-site vs. on-site.

"I don't think it hurts—you just have to manage people. Most CDI are in cube areas and get wrapped up in conversations about cases," LeBlanc says. "So I'm not surprised, when people go home, that there is less interruptions and more production."

Career advancement

Career advancement remains a bit of a mixed bag, according to CDI Week survey respondents—though data shows it leaning more on the positive side. About two-thirds of respondents say that the CDI industry has a very good/high growth outlook, while less than 2% describe it as poor.

However, tempering that enthusiasm is the fact that most CDI specialists need to look outside their hospitals to further their careers, with 82.3% describing room for career advancement in their CDI department as none/minimal (described as small salary increases and/or no promotion opportunities). On the other hand, 58% of respondents describe their impression of

career advancement opportunities in the broader CDI industry as moderate/good.

"I think it depends—traditionally, a lot of CDI is staffed by nurses unable to do bedside nursing because of injuries or age. They're not looking for career advancement, just stability," LeBlanc says of the results. "But as younger nurses get in to the profession sooner than later, they're looking for more career advancement, other things. Right now, you can just jump one place to another."

LeBlanc feels lucky to have a team at Hennepin that's very satisfied, as he knows that is not the industry norm. "Other places have a revolving door. That's been a problem with nursing all along—you're either a bedside nurse, or a nurse manager. The profession never did build nursing career ladders very well. Bad nurse managers were often great bedside nurses, but it was the only way to make more money. That's sort of been the nursing model, and we've [CDI] sort of mimicked it in some ways. If we could figure out a way to change that model to CDI, it would be nice. But if it goes remote, people won't care; that's a whole new job satisfier."

Adequate pay does not appear to be an overriding concern, as 54.6% of respondents believe they are adequately compensated for their work, with about 38% reporting a salary increase within the last year and another 33% reporting a salary increase in the last 0–6 months.

But with 45% unsatisfied with their pay, and no adequate way for many to earn promotions within their facility, leaving the job for greener pastures is a concern for managers, says LeBlanc.

"There's so much more to job satisfaction than just pay. What happens is they forget what it was like to be a bedside nurse—they get paid to do a very tough job. Our HR department is continually looking at the market; we bumped everyone up in salary after seeing a market survey. Anyone trying to maintain their program has to stay competitive or they will lose people. We're a union state; in our city, our bedside nurses are part of a union, so they are contracted some raises every year. Most hospitals are finding a way to give a small token of a raise to CDI, because people are really working hard."

CDI roles are also changing from traditional CC/MCC capture to areas like all payer/adult population review (25.3% expanding into this area), all patients/all payers (23.9%), outpatient services and procedures (22.3%), and SOI/ROM (about 16.2% plan to expand into this area). Overall, over 70% are planning on expanding their review duties at this time—indicating that for most, change is coming.

"There is so much tied to coded data, but coded data is only as good as the documentation in the chart. If you don't have good coded data, you don't have good outcomes or reimbursement. It's the reality of the healthcare industry," LeBlanc says. "I definitely believe that there is so much buzz about growth areas—HCCs, and CDI is not just inpatient anymore. But when you talk about outpatient, is it clinic or hospital outpatient? Everyone has a different take. There's lots of buzz about where we can expand to—which is good, but you want to make sure you staff, train, and support the work, not just thin out your staff."

CDI Week

About the Clinical Documentation Improvement Week survey advisor

Mark LeBlanc, RN, MBA, CCDS

LeBlanc is clinical documentation manager for 455-bed Hennepin County Medical Center in Minneapolis. He is responsible for overseeing a lead CDI (responsible for day to day operations, PSI/core measures, and staff auditing/assistance) and six CDI staff reviewers.

LeBlanc has over 33 years of nursing experience, including NBICU, pediatrics, homecare, and HIV/AIDS. Prior to entering the CDI arena, he was the VP of operations for a specialty national mail-order pharmacy. LeBlanc began his CDI career in 2004 and went on to become the team lead for the program. He has led the conversion to a new CDI system at two different facilities and has been a leader in capturing SOI/ROM, which leads to appropriate revenue capture rather than revenue capture alone.

LeBlanc earned his nursing degree in 1980 from a diploma program in South Louisiana. He went on to the University of Houston to obtain a BBA in operations management, then completed his MBA in health-care administration in 2005 from the University of Phoenix. LeBlanc was a cofounder of the Minnesota ACDIS chapter and served in a leadership capacity there until this year. He was a speaker at the 2013 ACDIS conference in Nashville and was elected to the ACDIS Advisory Board in 2014.

2014 CDI Industry Overview Survey: Emerging Topics

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

Answer Options	Response Percent	Response Count
0-100	12.5%	95
101-200	20.3%	155
201-300	19.3%	147
301-400	14.4%	110
401-500	9.2%	70
501-600	6.8%	52
601-700	3.0%	23
701-800	2.6%	20
801-900	2.2%	17
901-1,000	1.4%	11
More than 1,000	4.1%	31
Does not apply/outpatient or other	4.1%	31
Total		762

2. How many CDI specialists do you have on staff? (Please count each part time CDI as a .05 FTE)

Answer Options	Response Percent	Response Count
One	19.2%	146
Two to three	31.0%	236
Four to five	20.9%	159
Six to seven	10.4%	79
Eight to nine	4.3%	33
10 - 12	6.0%	46
13 - 15	3.0%	23
More than 15	5.2%	40
Total		762

3. Which payer types do your CDI specialists review?

Answer Options	Response Percent	Response Count
All patients/all payers	47.8%	364
Medicare only	27.6%	210
DRG payers only	23.1%	176
Don't know	1.6%	12
Other (please specify)		98
Total		762

Other (please specify)

- Medicare and Medicaid
- All patients except for self pay, Medicaid, medical assistance, peds
- Medicare, Medicaid, Anthem
- BCBS
- HMO Medicare as well
- All patients/payers as time allows
- Medicare, Managed Medicare, and UHC
- Medicaid
- Medicare and DRG payers
- Medicare, Medicaid, Anthem, and uninsured for quality of our documents
- All payers in ICUs; all payers except self pay/charity everywhere else
- Medicare, Medi-Cal, Tri-Care, and Champus
- Medicare and some Commercial Medicare products
- Medicaid, Managed care
- Medicare/ Medicare Managed Care
- All patients when time permitting
- Medicare & Blue Cross AQC
- Medicare Products
- All except self pay/workers comp
- Medicare and some Medicaid and some commercial

4. Which of the following quality measures and/or quality related items does your CDI program review on a concurrent basis? Check all that apply. If you answered "we don't review quality measures/metrics", please proceed to the next section.

Answer Options	Response Percent	Response Count
CMS Inpatient Quality Measures, i.e., "core measures" (not specific to HVBP)	24.8%	179
Hospital Acquired Conditions (HACs)	41.1%	297
Hospital Value Based Purchasing Metrics (HVBP)	8.0%	58
Patient Safety Indicators (PSI) only (not specific to HVBP)	20.2%	146
Severity of illness/risk of mortality (APR-DRG methodology) concurrent to stay	50.8%	367
Severity of illness/risk of mortality (APR-DRG methodology) retrospective mortality reviews	30.8%	223
Surgical Care Improvement Project (i.e., SCIP) or other quality specialty database	10.7%	77
We don't review quality measures/ metrics	33.7%	244
Other (please specify)		27
Total		723

Other (please specify)

- PNA AMI CHF
- HEDIS, Retrospective review, CRG
- NQIP reviews are retrospective
- Used to do SOI/ROM, new manager focus on MCC/CC dxs
- Do all PSI 90 post d/c, also involved with RAC letter writting
- Severe sepsis and stroke regardless of payer
- LOS
- If we see a potential problem, we forward it to the appropriate quality reviewer
- Asthma core for peds. & core for obstetrics
- We have a separate team that reviews these cases
- PEPPER reports
- Home health quality measures
- LOS
- Quality Department does that
- HEDIS & Stars Measures for clinic setting

5. If you answered yes to reviewing for PSI, which of the following PSIs do you review? Check all that apply.

Answer Options	Response Percent	Response Count
Pressure Ulcer (PSI 03 & element of PSI 90)	43.3%	91
Iatrogenic Pneumothorax (PSI 06 & element of PSI 90)	4.3%	9
Central Venous Catheter-Related Blood Stream Infection (PSI 07 & element of PSI 90)	11.0%	23
Post Op Hip Fracture (PSI 08 & element of PSI 90)	1.0%	2
Post Op Hemorrhage/Hematoma (PSI 09 & element of PSI 90)	3.3%	7
Post Op Physiologic and Metabolic Derangement (PSI 10 & element of PSI 90)	1.0%	2
Post Op Respiratory Failure (PSI 11 & element of PSI 90)	9.5%	20
Post Op Pulmonary Embolism or DVT (PSI 12 & element of PSI 90)	2.9%	6
Post Op Sepsis (PSI 13 & element of PSI 90)	7.1%	15
Post Op Wound Dehiscence (PSI 14 & element of PSI 90)	1.4%	3
Accidental Puncture or Laceration (PSI 15 & element of PSI 90)	15.2%	32
Other (please specify)*		95
Total		210

* Note: Of those who selected "other" most indicated "all of the above."

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

Answer Options	Response Percent	Response Count
Yes	32.9%	138
No	33.4%	140
We don't track productivity	9.5%	40
Not sure	24.1%	101
Total		419

7. Do you regularly collaborate via meetings, etc. with your quality and/or patient safety hospital committee?

Answer Options	Response Percent	Response Count
Yes	45.5%	201
No	47.3%	209
Not sure	7.2%	32
Total		442

8. Do you have a referral relation with wound care nurses and/or your infection prevention department?

Answer Options	Response Percent	Response Count
Yes	40.5%	178
No	51.7%	227
Not sure	7.7%	34
Total		439

9. 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	Response Count
Yes	78.9%	322
No, only if it impacts reimbursement	14.5%	59
Not Sure	6.6%	27
Other (please specify)		45
Total		408

Other (please specify)

- Both quality and reimbursement
- Reimbursement, quality, SOI/ROM get queried
- We query on any issue
- We query both
- We refer to the appropriate department. wound, infection, core measures
- Query regardless of impact
- If it impacts SOI we will query, our priority is $
- If we see an opportunity for clarity we will query but it is not our main focus. CMI, POA, are our main focuses
- Query whenever specificity needed with or without reimbursement
- We query whether it makes an impact or loses impact

10. To whom does your CDI department report?

Answer Options	Response Percent	Response Count
Health Information Management (HIM)/coding	45.5%	290
Quality	13.2%	84
Case management	23.5%	150
Finance/Revenue Cycle	17.9%	114
Other (please specify)		50
Total		638

Other (please specify)

- Medical Affairs
- One reports to HIM, the other nursing CNO
- Information services department
- Compliance officer
- Medical director
- COO
- Physician core group over CDI
- Utilization management
- Physician advisor
- Informatics director
- Clinical informatics
- We report to UR/DC planning manager (finance overview)
- HIM reports to our senior VP of quality
- Utilization management
- Chief Medical Officer
- HIM then up through quality
- VP of medical affairs
- Chief Medical Officer
- AVP of quality and case management
- VP of nursing services
- Clinical Effectiveness/Clinical Informatics
- CDI is stand-alone
- Clinical resource services
- Recently changed from case management to quality

11. Does your CDI department audit for query accuracy and compliance?

Answer Options	Response Percent	Response Count
Yes	66.3%	449
No	25.6%	173
Don't know	8.1%	55
Total		677

12. What quality metric does your hospital administration find most helpful/compelling when evaluating the success of your CDI department?

Answer Options	Response Percent	Response Count
Expected/observed mortality data	19.8%	103
Query agree rate	16.9%	88
Query response rate	56.0%	291
Frequency rate of particular diagnoses	7.3%	38
Other (please specify)		159
Total		520

Other (please specify)

- CMI
- Impact of query response.
- None—Admin does not monitor
- CMI and money found
- Physician engagement and agree rate
- Financial impact of query agree rate
- CC/MCC capture
- They are still looking at the bottom line!
- Both coders and CDI getting the same DRG
- PEPPER report, and CMI
- Not yet evaluated
- Everyone talks about SOI, ROM, etc., but I feel it is mostly money
- Our program started a Core Measure process but it has been transitioned to a team of quality concurrent reviewers

13. How has the one year delay of ICD-10 (to Oct. 1, 2015) affected your training and implementation timeline?

Answer Options	Response Percent	Response Count
Huge effect; training put on hold	16.4%	108
Partially effected; training and implementation slowed	51.8%	341
No effect; proceeding as before	27.5%	181
We have not yet begun any ICD-10 training	4.3%	28
Other (please specify)		12
Total		658

14. Describe the impact of the ICD-10 delay on your training budget:

Answer Options	Response Percent	Response Count
None/very minimal—budget remains the same	23.1%	150
No additional budget will be provided for further training	14.2%	92
We plan to increase our budget for continued ICD-10-CM/PCS training	8.6%	56
We have not ever had an ICD-10 training budget	7.1%	46
Don't know	47.0%	305
Other (please specify)		12
Total		649

15. Describe the impact of the delay on your physician staff/providers:

Answer Options	Response Percent	Response Count
No noticeable impact	26.7%	173
Physicians were relieved	34.0%	220
Physicians were upset/irritated	4.0%	26
We have not yet begun training our physicians	15.9%	103
Don't know	19.4%	126
Other (please specify)		13
Total		648

Other (please specify)

- Our physicians have checked out. Very happy for the delay.
- Some interested, others curious, others indifferent, some relieved
- Relief since we just implemented an entirely new EHR
- And they don't believe it will happen anyway...they plan to try and delay/cancel it
- Physicians have become disinterested and don't believe ICD-10 will ever go into effect

16. Has your CDI department asked leadership to add CDI staff in anticipation of the new ICD-10 implementation date?

Answer Options	Response Percent	Response Count
Yes, and it was approved	26.8%	171
Yes, and it was denied (please describe why in next question)	9.5%	61
No, have not asked	42.6%	272
Don't know	21.1%	135
Other (please specify)		54
Total		639

Other (please specify)

- Discussed with my director but unknown if taken to administration for approval or not. My director is not convinced that ICD-10 will be implemented on 10/1/15.
- Limited support to CDI, poor communication and direction.
- We are already understaffed, not planning for the future at this point.
- Yes but no trained CDIs in our area.
- We did not ask because we know the answer is "No" as we are under budget restraints and all education budgets are on hold.
- The department went from 7 CDI RN's to 15 CDI RN's in the last 6 months.
- Requested, pending approval
- We recently lost 2 FTE's
- Extra CDI not approved by our AVP but coding staff will be doubled
- The consulting firm we utilize for additional CDI staffing denied our request.

17. If you answered that your request for additional staff for ICD-10 was denied, please explain why your request was denied:

- Administration does not see the justification.
- No budget for additional staffing.
- Budget impact for fiscal year.
- Inpatient coders were a priority in hiring.
- Not seen as necessary.
- Low patient census.
- Hospital is in financial crisis actually decreased our staff.
- Supervisor and management do not have the insight to realize we will need more staff when ICD 10 is implemented. Our program will suffer as a result.
- New director not yet sold on documentation specialists.
- Administration does not believe the workload will increase significantly enough to warrant an additional CDS and we have not been able to convince otherwise.
- Based on vendor's recommendation, no additional staff would be needed.
- Our facility has hiring freeze, no additional CDI will be hired, and hours were cut back on one of our current staff.

18. Do you have a physician advisor to CDI?

Answer Options	Response Percent	Response Count
Yes, in a full-time capacity	15.1%	97
Yes, in a part-time capacity	45.7%	294
No, but we have plans to add one	12.6%	81
No, and we have no plans to add one	24.1%	155
Don't know	2.5%	16
Total		643

19. If you answered yes to having a physician advisor, how is your physician advisor paid?

Answer Options	Response Percent	Response Count
Not paid/volunteer	10.0%	41
Part-time/paid hourly or as percentage of time	25.7%	105
Full-time/salaried	16.9%	69
Don't know	47.4%	194
Other (please specify)		33
Total		409

20. If you answered yes to having a physician advisor, please rate the effectiveness of your physician advisor:

Answer Options	Response Percent	Response Count
Very effective (i.e., greatly improved query response rates, handles escalated problems very well, provides successful educational sessions, etc.)	28.0%	111
Reasonably effective	29.0%	115
Somewhat effective	29.5%	117
Ineffective	13.4%	53
Total		396

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

Answer Options	Response Percent	Response Count
Highly engaged and motivated	4.7%	30
Mostly engaged and motivated, with some exceptions	44.6%	283
Somewhat engaged and motivated	40.5%	257
Mostly disengaged and unmotivated	10.1%	64
Total		634

22. 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	Response Count
One day	8.1%	52
Two days	22.7%	145
Three days	9.7%	62
Four days	1.4%	9
Five days	2.2%	14
Six days	0.2%	1
Seven days	3.6%	23
7-14 days	6.7%	43
Within 30 days	7.8%	50
We don't have a time frame for query response	35.5%	227
Don't know	2.0%	13
Total		639

23. What is your physician query response rate (i.e., % of queries meaningfully acknowledged by the physician) within your facility's required time frame?

Answer Options	Response Percent	Response Count
0-10%	0.2%	1
11-20%	1.3%	8
21-30%	2.2%	14
31-40%	2.2%	14
41-50%	1.4%	9
51-60%	2.5%	16
61-70%	6.0%	38
71-80%	14.4%	92
81-90%	22.3%	142
91-100%	26.8%	171
Don't know	15.4%	98
We don't track this metric	5.5%	35
Total		638

24. 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/ICD-10 code)?

Answer Options	Response Percent	Response Count
0-10%	0.2%	1
11-20%	2.0%	13
21-30%	1.7%	11
31-40%	1.9%	12
41-50%	2.4%	15
51-60%	2.5%	16
61-70%	5.5%	35
71-80%	15.9%	101
81-90%	23.2%	148
91-100%	13.7%	87
Don't know	22.0%	140
We don't track this metric	9.1%	58
Total		637

25. Does your Medical Executive Committee have an escalation policy or other policy requiring physicians to respond to queries/ CDI clarifications?

Answer Options	Response Percent	Response Count
Yes	32.2%	203
No	53.8%	339
Don't know	14.0%	88
Other (please specify)		33
Total		630

Other (please specify)

- No escalation policy, just mandatory compliance—100%.
- We are working on one.
- Not all services included.
- Just for coders not CDI.
- Their bonuses are based on the percent of queries answered.
- We are developing one now for the entire system.
- No policy but for employed physicians response is part of their quality performance.
- Unanswered queries that impact the DRG can be escalated to the VPMA.
- Some departments do.
- Query must be completed for medical record to be complete- query is permanent part of the record.
- HIM has escalation policy.

26. Where does your facility stand regarding implementation of an electronic health record (EHR)? If you answer "all paper" or "not applicable" to this question, please proceed to the next section.

Answer Options	Response Percent	Response Count
All paper medical record with no immediate plans to implement an EHR	0.6%	4
All paper medical record, but with a defined plan/process to be totally electronic by 2016 or sooner	2.1%	13
A hybrid medical record (electronic and paper) with no immediate plans to be fully electronic	13.0%	82
A hybrid medical record and we plan to be totally electronic by 2016 or sooner	29.3%	185
Complete EHR after discharge, but some records are scanned	23.3%	147
Complete, digitalized EHR concurrently and after discharge	30.7%	194
Not applicable/I don't work in a facility or hospital	1.1%	7
Other (please specify)		13
Total		632

27. Who is your EHR vendor?

Answer Options	Response Percent	Response Count
EPIC	29.2%	173
Cerner	23.8%	141
McKesson	9.8%	58
Meditech	18.9%	112
Allscripts	4.2%	25
Athenahealth, Inc.	0.3%	2
eClinicalWorks	0.2%	1
NextGen Healthcare	0.3%	2
GE Healthcare	0.8%	5
Greenway Medical Technologies, Inc.	0.0%	0
Abraxas Medical Solutions	0.3%	2
Siemens	4.9%	29
Quadramed	0.5%	3
Don't know	6.6%	39
Other (please specify)		47
Total		592

28. Please rate your level of satisfaction with your EHR vendor's software:

Answer Options	Response Percent	Response Count
Very satisfied	9.2%	54
Mostly satisfied	38.2%	224
Somewhat satisfied	35.5%	208
Not satisfied	14.7%	86
Not satisfied and looking for a new vendor/product	2.4%	14
Total		586

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

Answer Options	Response Percent	Response Count
Yes, it's built into our EHR vendor software and we use it	44.8%	251
Yes, we have this capability but choose not to use it	7.0%	39
No, we don't have this capability	36.8%	206
No, but we use a supplemental electronic query program	11.4%	64
Other (please specify)		66
Total		560

Other (please specify)

- We have workarounds within Cerner but it isn't entirely intuitive.
- Use their Epic inbasket mail.
- In-box message, not to be saved to record. No template for the queries.
- We have developed a work-around process in the EHR.
- We have to cut and paste our queries into the EHR. We use a different software to track Queries and will soon go to CAC w/ CDI module.
- Risk management will not allow this.
- We use a progress note and change the author to route to the physician.

30. If your EHR allows for queries/prompts to the physician, has electronic querying been beneficial for your CDI specialists? Check all that apply.

Answer Options	Response Percent	Response Count
Yes, it has improved our efficiency	38.2%	151
Yes, we are more productive	26.8%	106
Yes, it has improved our query response rate	23.0%	91
Yes, we are now able to work off-site	11.9%	47
Yes (describe in question #31)	5.3%	21
No (describe in question #32)	17.7%	70
Not sure yet	22.8%	90
Total		395

31. If you answered "Yes/electronic querying has been beneficial", please describe why:

- Easier to track, easier for docs to answer.
- Dramatically increased the response rate.
- Concrete reinforcement of verbal discussions and reminders to include documentation in record.
- Quicker response and easy for CDI use, plus ability to have queries as a permanent part of the EHR.
- Less time tracking down physicians.
- Improved query response rate and we can work off-site one day a week.
- The query is in the system so the MD can answer at the same time as documenting and discharging the patient.
- Charts are always accessible. Improved legibility, ability to review previous lab values, etc.
- Consistent message to the physicians.
- Physicians who do electronic notes now are aware the case has a query to be responded to. Prior to e-queries, doctors did not pick up paper chart unless consultant on case.
- IT makes it easier to track. On paper, many queries got tossed in the garbage can.

32. If you answered "No/electronic querying has not been beneficial", please describe why:

- Physicians would not respond to this function.
- Problems with physician being able to respond in "auto" mode or "read" mode which gets the query out of the inbasket without actually replying to it.
- Not all doctors are prompt or responsive or agreeable to the queries. The same doctors that were problematic before are problematic now.
- There are no reports available to evaluate response or impact
- CDI was meant for on the floor. Electronic takes longer. You can definitely accomplish more by being CDI on the floor. What is the purpose of CDI if it isn't taken care of on the floor.
- CDI does not use the EHR to query, we use a different system for CDI.
- The physicians tend not to see our queries as much. They get buried in the progress notes.
- Not as much face to face time with physicians.
- They are hard for physicians to find due to dates and being buried among all their other forms to sign. They often just sign and do not complete.
- Dumps into the inbox which is like a black hole!

33. Do your CDI specialists work remotely?

Answer Options	Response Percent	Response Count
No/our facility does not allow or have capacity for this option	80.1%	495
Yes, about 10% work remotely	9.2%	57
Yes, about 25%	3.7%	23
Yes, about 50%	3.2%	20
Yes, about 75%	1.6%	10
Yes, 100% work remotely	2.1%	13
Total		618

34. Please compare the effectiveness of your CDI specialists working offsite vs. those onsite

Answer Options	Better than onsite	Same	Worse than onsite	N/A	Don't know	Response Count
Query rate	33	54	16	163	51	316
Query response rate	14	72	13	163	55	315
Productivity	48	45	8	161	47	309
Other (please specify)						46
Total						316

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

Answer Options	Response Percent	Response Count
None/minimal (Small salary increases, and/or no promotion opportunities)	82.3%	510
Moderate (Moderate salary increases, and/or opportunity for promotion to CDI manager)	16.5%	102
Very good (Large salary increases, and/or multiple levels of promotion opportunities in CDI dept.)	1.3%	8
Total		620

36. 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	Response Count
None/very little	12.8%	80
Moderate	28.2%	176
Good	29.8%	186
Excellent	16.5%	103
Don't know	12.8%	80
Total		625

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

Answer Options	Response Percent	Response Count
Yes	54.6%	338
No	45.4%	281
Total		619

38. When was your last salary increase?

Answer Options	Response Percent	Response Count
Within the last 3 months	18.7%	111
Within the last 6 months	14.5%	86
Within the past year	38.3%	228
More than a year ago	28.6%	170
Other (please specify)		42
Total		595

Other (please specify)

- 5 years ago.
- Will determine after anniversary date.
- We get 1-3% each year like all employees at this facility.
- Recent cost of living/merit raise but not significant.
- 8 years.
- I have been employed with my organization for 25+ years and have been at the top of the pay scale for a decade.
- Union.
- I am topped out at the salary level for my CDI position.
- Took pay cut to take this position.
- It was an across the board increase for all nurses (not based on CDI role).

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

Answer Options	Response Percent	Response Count
Very good/high growth industry (due to changes/new regulations/need for CDI programs)	65.8%	409
Mixed—depends on state/location, etc.	32.5%	202
Poor—restrictive regulations and other changes have diminished growth potential	1.8%	11
Other (please specify)		10
Total		622

Other (please specify)

- Requiring only RN licensure restricts the opportunity for other people who might have stong clinical and coding knowledge. License is needed if the clinician is providing direct patient care.
- Especially on the outpatient services side of business.
- I think HIM staff would be better utilized rather than all RN's.
- Wonder about CAC decreasing growth.
- Unfortunately, there are more and more RN's in the CDI industry and less and less coding professionals.
- Could see position combining w/ UR/case management.

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

Answer Options	Response Percent	Response Count
All payers for adult population	25.3%	150
All patients/all payers	23.9%	142
Pediatrics	10.1%	60
CMS Quality measures (i.e., core measures)	9.1%	54
Hospital Value Based Purchasing Metrics (HVBP)	9.3%	55
Severity of illness/risk of mortality (SOI/ROM)	16.2%	96
Present on Admission (POA) indicators	9.8%	58
Patient Safety Indicators (PSI)	10.1%	60
Emergency department	15.3%	91
Outpatient services and procedures	22.3%	132
Medical necessity of inpatient admissions	9.8%	58
Dedicated review of targeted Recovery Auditor or other high-risk DRGs	9.1%	54
We are not planning on expanding our review duties at this time	29.8%	177
Other (please specify)		52
Total		593

Other (please specify)

- Providing GMLOS on all input cases for case management department
- Medicaid APR-DRG
- All payers; Hi Risk OB; OB
- Obstetrics
- We already do core measures, SOI/ROM, POA, and we are not DRG/revenue driven. Strictly quality driven. By doing so, the revenue will happen.
- Behavior health and ob/gyn
- We already do most of the above.
- When fully staffed, will expand to all payors
- Complications
- Psych
- Speciality-specific staff assignments
- We just expanded into the outpatient/clinic/physician office
- We review all patients/all payers, might expand to NICU
- We are building a new hospital and will be adding behavioral health
- Inpatient Rehab Facility has requested consultation/education for CMG (case mix group) optimization

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