Clinical Documentation Improvement Week

2018

Industry Overview Survey

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

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Clinical Documentation Improvement Week

CDI Mosaic

Creating a Collaborative Portrait

Eighth annual CDI Week, September 17-21, 2018

About the CDI Week survey advisor

Deanne Wilk, BSN, RN, CCDS, CCS, is the manager of CDI at Penn State Health in Hershey, Pennsylvania. Her experience spans 35 years in the healthcare field. Wilk's primary nursing background includes telemetry and home health nursing, transitioning into an education role and then into CDI. From her original CDI role, she transitioned into consulting and management. Over the years, she has worked on numerous educational projects and articles, contributed subject matter expertise to CDI and coding coursework, and spoken at numerous national and local conferences. Since 2015, she has been the co-host and founder of the Central Pennsylvania ACDIS chapter.

Wilk was elected to the ACDIS Advisory Board in 2017 and will serve through April 2020.

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2018 CDI WEEK INDUSTRY OVERVIEW REPORT

Clinical documentation improvement (CDI) is a diverse field, involving multiple disciplines both directly in a CDI professional role and indirectly through interdepartmental collaboration. That's what the 2018 CDI Week theme is all about—"CDI Mosaic: Creating a Collaborative Portrait." This year's Industry Overview Survey bore out that theme in data as well, showing more expansion, more collaboration, and more diversity than in years past.

"I was really surprised with some of the results because of just how broad this industry is—how many different job descriptions are in a department, how many different types of people are doing CDI," says **Deanne Wilk, BSN, RN, CCDS, CCS,** the manager of CDI at Penn State Health in Hershey, Pennsylvania, a member of the ACDIS Advisory Board, and the 2018 CDI Week Industry Survey advisor.

Each year, ACDIS asks its members and others in the CDI world to weigh in on the state of the CDI profession. This year's survey garnered 605 respondents, up from last year's 410.

The CDI field is changing rapidly, and it involves players from a whole spectrum of professional backgrounds, whether they're working directly in the CDI department or not. This year's survey results show a snapshot of a shifting industry.

Although this report will not discuss every survey question in detail, responses to all of this year's questions begin on p. 10.

The respondents represented a number of positions and titles, with CDI specialists the most common at roughly 57%, followed by CDI managers/directors at 21%, and CDI leads at 6% (see Figure 1). Most, more than 85%, work in traditional, short-term acute care facilities (see Figure 2)—a continuing trend that's illustrated through several years of CDI salary survey analysis.

This year's survey respondents spanned several experience levels. The best-represented group was CDI professionals with between three and five years of experience in their current role (33.88%). Next were those with more than 10 years of experience (23.47%), those with six to eight years of experience (18.02%), those with zero to two years of experience (16.53%), and finally, those with nine to 10 years of experience (8.10%). (See Figure 3.)

Outside of the demographic trends, the survey also gives insight into staffing trends—from required credentials to the number of staff members in relation to a facility's size. The results additionally show a great diversification into other healthcare arenas, such as outpatient services and more.

Staffing

Since the theme for this year's celebration focuses on the diversity represented in the CDI profession, this year's survey asked several questions about how CDI programs are staffed. Perhaps unsurprisingly, the best represented professional background is nursing (92.52%), followed by HIM/coding (36.56%), foreign-trained medical graduates (14.80%), and other clinicians (7.99%). (See Figure 6.)

Survey respondents also had the opportunity to write in professional backgrounds not offered as standard responses. Their responses included case management staff, administrative support professionals, quality specialists, and (most commonly) respiratory therapists. "I had heard of that, but I was really surprised at the number of people who wrote in that response," says Wilk.

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While professionals from a clinical background may be favored at the moment, that trend may change as CDI moves into other settings in the healthcare continuum, according to Wilk.

"I do think we will see more nonclinical people doing outpatient CDI," she says. "I think it'll be more coding professionals working in that setting."

While the data show that the required credentials for respondents with an outpatient/ambulatory program versus without are virtually the same, the professional makeup of those with outpatient programs was slightly more skewed toward the HIM/coding side of things. The majority of those programs (89.45%) still reported having nurses working in the CDI department, but 38.52% said their programs also include HIM/coding professionals, which is about two percentage points higher than the group as a whole.

Even still, there is a noticeable uptick year-over-year in the percentage of respondents who report that their program includes coding professionals in its CDI ranks. Last year, only 21.61% reported employing coding professionals in a CDI role, versus 36.56% this year. (See Figure 6.)

In addition to the team makeup, respondents also shared whether their facility had a written policy specifying necessary credentials for employees. While ACDIS holds that CDI is far more than a specific credential, the survey results show that many programs do not agree on that sentiment. According to the results, 77.55% of respondents' programs require a clinical credential such as an RN, MD, etc., while 15.99% require a coding credential such as an RHIA, RHIT, etc., and 17.35% require a CDI-specific credential such as a CCDS or CDIP. (See Figure 7.)

Although the majority of programs require their CDI specialists to hold a clinical credential, most programs still report to HIM/coding (34.18%). The next most common reporting structure was revenue cycle/finance (22.96%), followed by case management (12.24%), quality (9.86%), and utilization review (1.02%). Little more than 11% of respondents said their CDI program was in a stand-alone department, reporting directly to hospital administration. This, according to Wilk (whose department currently reports to quality), shows a growing recognition that CDI brings a unique skill set to the table and should be evaluated on its own terms. (See Figure 8.)

"I was excited to see how many stand-alone departments there were," she says. "I will definitely be showing my boss that."

HIM/coding was also the most common department for CDI collaborative focus (86.73%), according to the survey. The quality department (50.85%), denials management (35.20%), case management (31.63%), utilization review (25.88%), and compliance (25.51%) were all well-represented when it comes to interdepartmental collaboration, too. (See Figure 9.)

"Traditionally, you have some programs that are sort of sitting by themselves in the HIM/coding world," says Wilk. At her facility, Wilk and the CDI team recently took on reviews for all inpatient DRG-related denials, which raised the need for additional collaborative effort with other departments.

The survey also showed a diversification of job titles within the CDI department such as "manager" (45.41%), "lead" (25.68%), "director" (25.34%), and "educator" (20.92%), among others (see Figure 11). This isn't surprising, according to Wilk, because CDI has expanded its scope so significantly in recent years. (See Figure 11.)

"I think as time goes on, what we'll see in the industry is that CDI really is becoming more specialized," she says. "In a couple years, it'll be, OK, we know you have a quality analyst, but we'll have to ask what they're reviewing in that role."

While the diversity of job titles and professional backgrounds expands, the number of CDI professionals per program remains nearly stagnant year-over-year. According to this year's survey, 19.56% of respondents have more than 15 CDI professionals in their department versus 18.34% last year. The number of respondents with less than one full-time CDI specialist on staff actually rose this year to 1.36% versus 0.86% last year. (See Figure 10.)

For organizations with 100–200 beds, the most common number of full-time CDI specialists was two/three (37.72%). For those with 201–300 beds, the most

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common was six/seven (24.05%), with no respondents reporting one or fewer full-time CDI professionals. The majority of respondents from facilities with 601–1,000 beds (29.03%), unsurprisingly, have more than 15 CDI professionals on staff, but even in this group, 1.08% of respondents said they had only one CDI staff member.

Technology

"To answer the question, 'Will artificial intelligence eat my job?' we, as an industry, need to recognize the value of CDI. Today, these professionals are only able to review a portion of patient stays. We need to expand that ability in a way that's feasible and allows CDI staff to work at the top of their specialization. These technologies can be used to assist the overall healthcare system, particularly in light of these industry needs and changing priorities such as the push for greater quality-of-care measures and treatment setting shifts. The growth and success of CDI programs continues to be a primary factor in the improvement of the healthcare system, and technology will be able to support that continued growth."

—Mark Morsch, vice president of general management at Optum360

CDI specialists know well that this is a time of change—from new regulations to new technologies. This year, 72.92% say they work entirely within an electronic health record (EHR) system.

Previously, roughly half of respondents reported using some sort of hybrid (electronic and paper) medical record. In 2018's results, 13.19% use a hybrid model with plans to go electronic by year's end, 11.63% use a hybrid model with no immediate plans for EHR implementation, and less than 1% still use an all-paper record. (See Figure 12.)

"I was really surprised how many people were still on a hybrid record," says Wilk. "Those few people on all paper could very well be sitting in some little physician office, so that doesn't surprise me as much."

As far as using computer-assisted coding (CAC) and natural language processing (NLP), about half of respondents (52.95%) currently use one or both solutions, but those numbers do not tell the whole story. (See Figure 13.) Of those respondents who have such software, 21.05% said it was not beneficial to CDI work in some way. (See Figure 14.) Some of the common complaints were that the CAC/NLP software:

- Is often incorrect
- Creates dependence on suggested codes, rather than accurate ones
- Is muddied with technical issues and malfunctions
- Misses documentation in the record
- Decreases efficiency
- Reduces face-to-face time with providers
- Inhibits critical thinking
- Increases denials due to incorrect coding

The list goes on.

"I think the respondents really spoke to just how bad that situation is right now," Wilk says. "There were some very harsh comments, and that really says the software may not be where it needs to be yet. [Sometimes I feel that] we'd be faster if we just got it and wrote it on paper, even."

Despite the negativity, clearly such technology has its benefits and supporters. Read this year's related CDI Week Q&A on the CDI Week pages and on the ACDIS Blog for some examples.

And CDI specialists seem to appreciate the increased opportunities to work remotely. This year, 45.65% of respondents, up from 39.56% last year, reported having some capacity to work remotely—plus, many respondents who chose "other" (15.80%) also reported some degree of remote work not represented by the given answer options. (See Figure 15.)

There has been some concern that remote CDI work will negatively affect overall physician engagement due to a lack of CDI and physician interaction, so this year's survey sought to shed light on the real-world performance of remote CDI. According to the results, 43.18% reported no change in physician engagement for remote versus on-site staff members, with 3.79% reporting better results and 10.10% reporting a decline. Similarly, 45.02% said the query rate was unchanged and 49.12% said the response rate was unchanged. And the survey shows that productivity seems to have improved with remote efforts as well. (See Figure 16.)

CDI managers, directors, supervisors, and leads had a slightly different story to tell about remote CDI work, however. When it comes to physician engagement,

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46.02% reported no change, 4.42% reported a positive change, and 15.93% reported a negative change. For query rate, 54.87% said it was unchanged, while 13.27% said there had been a positive change and 1.77% said there'd been a negative one. For query response rate, 56.64% reported no change, 4.42% a positive change, and 7.96% a negative change.

Interestingly, more managers/directors/supervisors/leads (35.71%) said that there had been a positive shift in productivity for remote workers than the group as a whole reported.

"It's one thing for a CDI specialist to give their perspective, but it's another thing to hear what their manager or director thinks," says Wilk.

Wilk also points out that the shift to remote work may not be solely tied to an increased use of technology. It could be something much more low-tech: physical space in the hospital.

"CDI departments are expanding into all these new roles, and they don't have room for people in the department. I know for us, I requested seven new positions. I don't have chairs for them and the facility doesn't have chairs for them, so I have to figure something out," she says. "CDI used to be one or two people who helped; now they're an entire department. Where are organizations putting these people?"

Physician engagement

"If you are implementing more tasks the physician needs to accomplish, then you need to determine how it will benefit the physician in the long run. It can't be additive, and whatever is implemented needs to be done right the first time. Ideally, CDI can ask the physician a question in real time, capture that documentation, and move on without leaving a mess in the medical record for someone else to figure out later. Physicians are tired and feel overworked. Whenever we make changes to our CDI programs or add in new technology, we need to make sure that we are helping them through their day, helping them to improve the care they're providing to their patients."

—Anthony F. Oliva, DO, MMM, FACPE, vice president and chief medical officer at Nuance

NUANCE

Physician engagement in CDI efforts seems fairly flat, with 12.06% of respondents reporting high engagement and motivation among their medical staff and only 4.79% reporting disengagement and a lack of motivation. (See Figure 17.)

Respondents with a full-time physician advisor or champion saw a noticeable improvement in engagement rates, with 25.22% saying their medical staff was highly engaged and motivated and only 0.87% saying they were mostly disengaged and unmotivated. Nine percent of those with a part-time physician advisor or champion reported high engagement and motivation, while only 3.40% reported the opposite.

"When we started, you were lucky if you found anyone to help you," says Wilk. "But now it's not uncommon to have both a physician advisor and a champion, and it makes a difference."

Though more respondents have a physician advisor or champion, still 50.11% of them share their advisor's time with another department such as quality, compliance, utilization review, case management, etc. (See Figure 20.)

Administrative support is also on the rise, according to this year's survey, with 45.57% of respondents saying their administration is highly supportive and only 3.37% saying they receive no apparent support. (See Figure 18.)

When it comes to the practical, measurable side of physician engagement, most respondents (32.45%) give physicians two days to respond to a query. While there was a variety of responses for query response times, 18.26% of respondents said that they do not have a set time frame for query responses. (See Figure 21.)

"That's scary," Wilk says. "You're really not following query guidance by not having a time frame."

Despite the number of respondents without a set time frame, the plurality (44.50%) had response rates ranging from 91–100%, and only 16.85% reported rates of 80% or less. (See Figure 22.)

Programs should remember that it's the CDI specialists' responsibility to ensure physicians understand the goals of the program and how CDI efforts help them. Where physicians aren't engaged, CDI managers need to determine why, and what policies or procedures need to be put in place to move that needle, says Wilk.

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"It may not be that their docs are that bad. There can be other factors."

Hopefully, in years to come, there may be an uptick in physician engagement when it comes to query responses as programs institute escalation policies related to queries. This year, 52.66% of respondents said they currently have such a policy (up roughly 2% from last year), and many of the 5.14% who chose "other" said that their organization was in the process of developing a policy. (See Figure 24.)

When it comes to agree rates, 71.28% of respondents reported agree rates greater than 70%; only 8.5% reported rates under 70%. (See Figure 23.) According to Wilk, however, there still may be room for improvement.

CDI and quality

"Physicians may soon find a reason to welcome the scrutiny of facility CDI specialists. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Merit-based Incentive Payment System (MIPS) will calculate physician bonuses based on risk-adjusted utilization cost analyses. These bonus payments begin in 2021 and risk-adjust according to CMS-HCCs. While simplifying physician reporting, MIPS also increases the burden of documentation and correct code abstraction across the board.

CDI professionals should explain to physicians how their hospital-focused suggestions transfer to evaluation and management documentation and coding in physician offices, which can translate into better MIPS bonuses. Better documentation and coding is the goal, regardless of place of service."

***—Sheri Poe Bernard, CCS-P, CDEO, CRC, CPC, author, AMA's 2018 publication,* Risk Adjustment Documentation & Coding**

AMA

The upward trend of CDI professionals conducting record reviews with an eye toward capturing information needed for reporting quality measures continued in this year's survey. Like last year, the percentage of respondents *not* reviewing quality measures at all decreased by a few percentage points (from 15.86% in 2017 to 12.73% this year).

The distribution of *what* respondents are reviewing did shift this year from years past. For the last couple years, the top slot was always held by severity of illness (SOI)/risk of mortality (ROM), but this year, present on admission indicators (POA) and hospital-acquired conditions (HAC) surpassed it with 72.36%. (See Figure 25.)

It's also important to remember, Wilk says, that not all SOI/ROM reviews are created equal—something borne out in this year's survey results as well. While 60.36% of respondents reported reviewing for SOI/ROM concurrently within the "all patients refined-diagnosis related group" (APR-DRG) methodology, others review for these measures retrospectively through mortality reviews (45.82%), and still others review for SOI/ROM outside of the APR-DRG system (31.64%).

"We want to make sure that we're clear on educating people that SOI and ROM are not the same as mortality risk factors," she says. "There are some risk factors that are not specifically APR-DRG risk factors, and I think people often confuse them."

This year, the survey results also showed an uptick in those respondents reviewing for hospital readmissions, which was included last year as a potential expansion topic. Last year, 13.76% of respondents said they were *planning* to expand their reviews to focus on readmissions; this year, 12.91% are already reviewing readmissions.

"We have been dying to get more involved in readmissions, so it's nice to see that there's a good percentage of people looking at that," says Wilk.

Unsurprisingly, a large number of respondents feel that reviewing for quality measures has hindered their productivity (27.61%). However, this is a slight decrease from last year's results when 36.01% said reviewing for quality had a negative effect on productivity, perhaps suggesting that quality reviews are becoming part of the normal expectations for CDI specialists. (See Figure 26.)

Reductions in productivity may also be due to inadequate staffing, as only 16.33% of this year's respondents saw a corresponding increase in full-time equivalents (FTE) with increased review priorities, thereby splitting and stretching CDI staff time thinner. (See Figure 27.) Wilk nevertheless sees some hopeful messages in the results.

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"We're often told to do more, but 'no more people for you!' " she says. "But, it's encouraging that there *are* some people who *got* more FTEs. That's something people can take to administration and say 'Hey, I think we need to start looking at this.' "

Encouragingly, those willing to query when the response would only affect a quality measure rather than reimbursement rose year-over-year, with 86.20% of this year's respondents querying for more than reimbursement as opposed to 76.42% in 2017. (See Figure 28.)

There's still work to be done in this area, says Wilk, suggesting that programs need to provide more comprehensive education for CDI professionals on the true mission of CDI outside of reimbursement.

The number of respondents conducting clinical validation reviews and queries (i.e., queries for clinical support of a documented diagnosis) declined slightly year-over-year (90.73% this year versus 95.37% in 2017). (See Figure 30.) The distribution of the commonly queried diagnoses remained consistent, with sepsis (85.08%) and respiratory failure (84.30%) holding the top slots and all other listed diagnoses ranging from 38.37% to 49.03%. (See Figure 31.)

"We keep seeing the same things over and over—it's never going to change," says Wilk. It does show, however, that all CDI specialists are in the same boat in terms of documentation opportunities, she says. "And it helps us identify the top five things we should be educating on."

Still, 46.15% of respondents do not track the frequency of their clinical validation queries. (See Figure 32.) Wilk sees this as an indicator of an educational gap for CDI professionals. "If you're just sitting at home sending queries out without tracking them, how is your program going to improve?" she says.

This situation could lead to a program stagnating over time because its staff have no indicator as to where they should focus their education or resources. For instance, if you're tracking the frequency of sepsis clinical validation queries and see an uptick, then you can apply more educational resources toward that particular diagnosis and start a conversation with the providers, which should result in a downturn for that query type.

In addition to the lack of tracking, the majority of respondents (47.81%) also lack a policy (either written or unwritten) on clinical validation queries. (See Figure 33.) While this could indicate that they're using one overarching query policy, Wilk says having a definitive one could make things clearer for CDI professionals. Wilk hopes to move toward that model herself, using the survey results as a justification for the new policy.

"I don't actually have a policy on that. I mean, I have a query for it, but not a policy," she says. "That's actually a really good idea."

Outpatient CDI

"One of the most difficult challenges we face in moving to the outpatient setting is meeting the unique annual documentation requirements for conditions being monitored, evaluated, assessed, or treated ("MEAT"). Traditional CDI queries may be severely limited in their potential application for this specific challenge, given that documentation is restricted to that associated with a face-to-face patient encounter, together with potential limitations about bringing information from previous encounters into a query. While this latter restriction is starting to be addressed, we need to work with our professional colleagues to establish agreement and standardization of the process along with full modernization of query guidelines."

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

ChartWise Medical Systems

Like quality reviews, outpatient reviews are no longer a distant expansion area. According to this year's survey, 53.20% of respondents currently review outpatient or ambulatory records. (See Figure 34.) This percentage was split between eight areas, however:

- Hospital outpatient services: Ambulatory surgery (9.54%)
- Hospital outpatient services: Emergency department (11.19%)
- Hospital outpatient services: Medical necessity of admissions (5.32%)
- Hospital outpatient services: National and local coverage determinations (2.75%)

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- Hospital outpatient services: Quality measures (4.77%)
- Hospital outpatient services: Risk adjustment (9.72%)
- Physician practice/Part B services (7.16%)
- Outpatient rehabilitation (2.75%)

"I really wanted to know how many were doing ambulatory and how many were doing ED," says Wilk. "And I was actually a little surprised how close it was."

Still 31.87% said they "don't know" what they're focusing on for these reviews. (See Figure 35.) "That's a problem," says Wilk. "People are being told, 'Go do it, but we don't want to tell you why.' "

It's a frequent stumbling block: Since the inpatient program is flourishing, administration decides it could have a positive effect in some other area of the healthcare continuum and tells the team to go out and make it happen, without giving a clear reason for the mandate. Hopefully, Wilk says, this year's survey results will give CDI professionals in the outpatient setting an indication of what they should focus on in outpatient endeavors.

"This survey question really hit on why people are doing what they're doing there, which could be really helpful," she says.

As far as the timing of outpatient reviews, the largest group of respondents (22.18%) said that they review retrospectively (i.e., after the patient's appointment), followed by those who review prospectively (14.66%) (i.e., before the physician sees the patient) and those who review concurrently (12.03%). (See Figure 36.)

"I was kind of disappointed because I wanted to see more retrospective," Wilk says. "My thought on that is, if you're doing it prospectively or concurrently, where's the physician engagement, and I wonder whether you're increasing or decreasing his or her productivity."

In Wilk's opinion, the retrospective cadence for outpatient reviews would also allow for more physician education based on what was documented in the chart. However, some argue that this cadence lets mistakes slip through the cracks that could have been caught and corrected had the review been conducted prospectively or concurrently.

One piece of potentially distressing data from this year's survey is that only 14.52% of respondents currently have a policy governing outpatient queries, despite the fact that more than half conduct outpatient reviews. (See Figure 37.) An additional 15.18% of respondents are in the process of creating a policy, though they currently operate without one.

"The only thing I can think about this is that people think they can use the inpatient policy," says Wilk, but she points out that these reviews are quite different from their inpatient cousins. According to the ACDIS position paper, "Queries in outpatient CDI: Developing a compliant, effective process," the brevity of outpatient encounters, the high volume of cases to review, and a need to ease the burden for busy providers are all challenges that should affect CDI query policies in the outpatient setting. Wilk hopes next year's survey will show noticeable improvement in these results.

That said, this year's industry survey represents a move in the right direction for the CDI industry as a whole and how CDI professionals view their work, Wilk says. The increased volume of responses alone (up nearly 200 year-over-year) is encouraging.

"It's not just a job we're doing," says Wilk. "It's a profession. Staff needs continuing education, and they need to know the broader implications of their record review efforts." CDI staff need to be invested in their work and have an understanding of industry standards, such as the ACDIS *Code of Ethics*, facility-approved clinical indicators for certain diagnoses, the *Official Guidelines for Coding and Reporting*, and query policies and procedures, Wilk says. "That's what the expectation should be," she says. "That's what will take our skills and our programs to the next level."

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2018 CDI INDUSTRY OVERVIEW SURVEY
CDI Mosaic: Creating a Collaborative Portait

1. Please indicate your title/role:

Answer Options	Bar Chart
CDI specialist	56.53%
CDI second-level reviewer	0.50%
CDI lead	6.28%
CDI supervisor/manager/director	20.99%
CDI auditor	0.33%
CDI educator	0.99%
CDI physician educator	0.66%
CDI informaticist/analyst	0.33%
CDI-coding liaison	0.17%
CDI quality specialist	0.99%
CDI denials specialist	0.66%
HIM/coding supervisor/manager/director	3.31%
HIM/coding professional	1.32%
Physician advisor/champion	0.33%
Hospital executive	0.33%
Consultant	1.98%
Other (please specify)	4.30%

Other responses:

- Program analyst
- Product manager—CAC and CDI
- Nurse
- Certified senior CDI specialist
- CQA
- Coding/CDI/reimbursement compliance manager
- Coordinator with emphasis on education and audits
- DRG auditor/clinical validation
- Regional HIM director
- Director of CDI and coding
- Quality coordinator RN
- Clinical auditor
- EPIC credentialed trainer
- CDI apprentice
- Compliance manager
- CDI/utilization review specialist
- Quality manager
- Utilization review/CDI coordinator
- Mortality review CDI
- Director of coding education

2. Please indicate your facility type:

Answer Options	Bar Chart
Acute care hospital	85.79%
Outpatient/physician practice	1.98%
Children's hospital/pediatrics	1.32%
Critical access/rural healthcare	1.49%
Rehab (inpatient or outpatient)	0.33%
Home health	0%
Long-term acute care	0.33%
Other (please specify)	8.76%

Other responses:

- Healthcare system
- Contract hospital
- Staffing/consulting
- Medical facility associates
- Third-party reviewer
- Clinic
- Academic medical center and children's hospital

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- Currently not working
- Government research facility
- Division office
- Healthcare analytics
- Cancer treatment hospital
- Teaching facility
- PACE program and health center
- Managed care/PACE and health center
- Population health—accountable care organization

3. How long have you been in your current profession?

Answer Options	Bar Chart
0–2 years	16.53%
3–5 years	33.88%
6–8 years	18.02%
9–10 years	8.10%
More than 10 years	23.47%

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

Answer Options	Bar Chart
100 or less	9.59%
101–200	13.06%
201–300	15.87%
301–400	8.76%
401–500	9.42%
501–600	8.76%
601–700	5.79%
701–800	6.28%
901–1,000	3.31%
More than 1,000	11.90%
N/A	7.27%

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

Answer Options	Bar Chart
CCDS	58.35%
CCS	16.36%
CDIP	8.60%
CPC	3.47%
CRC	1.49%
MD	2.15%
NP	0.50%
PA	0.17%
RN	74.88%
RHIA/RHIT	10.74%
MBBS	2.48%
MHA	2.15%
Other (please specify)	31.57%

Other responses:

- COC
- BSN, CIC
- LNCC
- CCS-P
- MSN, CPAN
- CCM
- CHC, C-CDI
- RCIS, RT(R)(CI)
- CPHQ
- CCRN alumnus
- CNOR
- AHIMA-Approved ICD-10-CM/PCS Trainer
- CMSRN
- ACM
- RRT (Registered Respiratory Therapist)

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- LPN
- CCRN-K
- Certified case manager and certified pediatric nurse
- CHC
- CPC, CUC
- CCM, NEA-BC
- Cardiac-vascular certified nurse
- MSN, ACLS, BCLS, PALS
- RNC-NIC
- CICA (Certified Inpatient Coding Auditor, from HFMA)
- CEN
- MSHI
- BBA
- OCN
- CBCS
- CPCO, CPMA, CEMC
- C-CDI, CP-DAM
- MBA, CPHQ
- PhD
- DC
- CHDA
- DDS, OMS, CCA
- ACDIS-Approved CDI Apprentice
- All have expired
- CCA
- DNP
- CHAM
- DC
- MPH, ACM
- CPHQ and JD
- CTR
- BSHA
- LNC specialist (Legal Nurse Consultant)
- RN-BC, CHTS-CP

6. What professional backgrounds are represented in your CDI department? (Check all that apply.)

Answer Options	Bar Chart
Nursing (RN, BSN, etc.)	92.52%
HIM/coding (RHIA, RHIT, etc.)	36.56%
Foreign-trained medical graduates/MBBA, etc.	14.80%
Physician champions/physician advisors (MD, DO, etc.)	35.37%
Other clinicans (PA, LPN, etc.)	7.99%
Other (please specify)	3.91%

Other responses:

- Cardiovascular critical care, radiologic technologist
- Case management staff
- Respiratory therapist
- Just getting our team together
- Nurses, although we work closely with coders daily
- N/A
- LCSW
- MSW
- Administrative support professionals
- Mortality review RN CDI
- Quality specialists & IT liaisons

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7. Does your facility have a written policy specifying necessary credentials for employees? (Check all that apply.)

Answer Options	Bar Chart
Yes, we require a clinical credential (i.e., RN, MD, etc.)	77.55%
Yes, we require a coding credential (i.e., RHIA, RHIT, etc.)	15.99%
Yes, we require a CDI-specific credential (i.e., CCDS, CDIP)	17.35%
No, we do not require a specific type of credential	14.29%
Other (please specify)	8.16%

Other responses:

- Varies by area and individual; CDI is a new focus.
- We require either a clinical or coding credential.
- Testing for CDI specialist credentials post two years.
- Requires BS in life science, such as RN or RHIA.
- LPNs were grandfathered in.
- N/A
- I don't know.
- We hope to establish that soon.
- Require CDI certification to be promoted to CDS II.
- RN or RHIA/RHIT or extensive coding experience.
- We require at least one credential and need CCDS within a year of employment.
- We have CDI with coding credentials and LPNs that are grandfathered in; however, we currently require an RN or MD.
- Within the job description, but looking to change and diversify that requirement.
- We prefer, but do not mandate a CDI credential.
- Bachelor degree preferred.
- Job description, not policy.
- We require clinical, coding, or foreign doc credential.
- We require a BS degree.
- CCDS or CCDS-O is highly encouraged.

8. Which department does your CDI department report to?

Answer Options	Bar Chart
HIM/coding	34.18%
Quality	9.86%
Revenue cycle/finance	22.96%
Case management	12.24%
Utilization review	1.02%
CDI (stand-alone department, reporting to hospital administration)	11.05%
Other (please specify)	8.67%

Other responses:

- I work with providers who educate providers on CDI.
- We don't have a CDI department as such, but HIM and revenue cycle are involved.
- I'm a consultant.
- N/A
- Medical records.
- Administration.
- Audit.
- Clinical effectiveness.
- Medicare risk operations.
- Quality management/CDI.
- Medical director (MD chain of command).
- Informatics and technology.
- Office of patient experience.
- Medical staff director.
- Information services.
- Compliance and risk management.
- Care management (UM, CM).
- Strategic source.
- Department of medicine.
- Medical director and COO.

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- Facility department; most are HIM.
- Medical affairs.
- COO.
- Outsourced to ATOS.
- CMO.
- Corporate structure.
- Clinical resource service.
- Ambulatory quality and safety network.
- Centralized under division leadership.
- Social services.
- Outsourced with off-site management.

9. Does your CDI team formally collaborate with any other department (through meetings or in accordance with a set policy)? (Check all that apply.)

Answer Options	Bar Chart
HIM/coding	86.73%
Case management	31.63%
Utilization review	25.85%
Quality	50.85%
Compliance	25.51%
Denials management	35.20%
Other (please specify)	8.84%

Other responses:

- No.
- We're supposed to, but we're meeting resistance.
- We're starting to work with the revenue integrity analyst who help with provider professional billing.
- Administration
- Revenue cycle
- Not formally.
- CFO, COO, CEO
- Occasionally, we have a joint meeting with the coders and their management.
- Meeting with hospitalists.
- Risk management
- Data analytics
- Senior leadership meets with coding, the CDI does not.
- Medical care committee
- We are joined with HIM/coding
- Business office
- Physician rounds
- I'm a consultant.
- Healthcare and finance team collaboration
- Compliance oversight
- Contracting/managed care
- Sepsis coordination
- Quality and coding on an informal basis
- Clinical departments, ambulatory care
- CFO
- Hospitalists/medical staff section/committee meetings
- Inpatient CDI
- Hospitalists and various other physician groups
- Patient safety/population health

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10. How many CDI specialists do you have on staff at your facility? (Please count each part-time CDI as a .5 FTE.)

Answer Options	Bar Chart
Less than one	1.36%
One	8.67%
Two to three	18.03%
Four to five	16.67%
Six to seven	11.56%
Eight to nine	7.31%
10–12	8.84%
13–15	7.99%
More than 15	19.56%

11. Which of the following job titles/roles do you have in your CDI department? (Check all that apply.)

Answer Options	Bar Chart
CDI specialist	94.22%
CDI second-level reviewer	11.05%
CDI auditor	9.52%
CDI educator	20.92%
CDI physician advisor	11.22%
CDI manager	45.41%
CDI lead	25.68%
CDI director	25.34%
CDI informaticist/analyst	4.59%
CDI-coding liaison	8.50%
CDI quality specialist	4.93%
CDI denials specialist	4.93%
Other (please specify)	10.71%

Other responses:

- Our CDI are: HIM data quality analyst and data quality lead; certified coder.
- CDI supervisors
- CDI consultant
- CDIS level I, II, III
- Senior director of CDI
- CDI medical director, MD
- N/A
- CDI coordinator
- CDI quality reviewer
- Nurse
- My senior CDI position is a provider auditing educating role.
- CDI QA analyst
- PRN—denials
- Senior care manager
- Our manager rotates between four facilities. Our director has HIM experience (not CDI) and the "educator" is a coder.
- CDI coders
- CDI physician advisor shared with UM department.
- I'm the only one at a critical access hospital, so I do it all!
- Facility dependent
- Physician advisor/champion
- Clinical documentation quality auditor
- Leadership is working on a career ladder, but have not seen this yet.
- CDI/coding manager
- Data analyst
- Utilization review
- Mortality retrospective CDI
- Clinical validation specialist
- Coding staff
- Outpatient CDI specialists and inpatient CDI specialists
- VP of clinical excellence, quality managers
- All staff with same title, but one dedicated to PSI/HAC reviews.

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

Answer Options	Bar Chart
Completely digitalized with EHR	72.92%
Hybrid medical record (electronic and paper) with plans to be totally electronic by year-end or sooner	13.19%
Hybrid medical record (electronic and paper) with no immediate plans to be fully electronic	11.63%
All paper	0.35%
Other (please specify)	1.91%

Other responses:

- Involve multiple facilities, so some are all electronic and some are hybrid.
- It varies by client/I'm a consultant.
- Hybrid with plans to be fully EHR by 2020.
- N/A
- Both with plans for 2019.
- 99% electronic with some on paper at times

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

Answer Options	Bar Chart
Yes	52.95%
No	38.37%
No, but we plan to implement by end of the year	6.08%
Don't know	2.60%

14. If you answered yes to question 13, has CAC/NLP been beneficial for your CDI specialists? (Check all that apply.)

Answer Options	Bar Chart
Yes, it has improved our efficiency and we are more productive	57.60%
Yes, it has improved our query response rate	14.04%
Yes, we are now able to work off-site	18.13%
Yes, it has improved the clinical depth of our reviews	23.98%
Not sure yet	32.16%
No (please describe)	21.05%

Other responses:

- It is often incorrect.
- No, too many "false positives" leads to confused coding.
- Creates dependence on suggested code and inhibits new CDI learning correct codes appropriate for the patient's diagnosis. Also, inhibits in-depth review using code book, coding clinics, PCS root ops.
- No, the CAC/NLP is not always correct. If you don't read the chart, you will be picking up codes from prior admissions also. Yet management wants more reviews with the CAC.
- There are many inaccuracies of diagnoses as it just picks up words. It does not populate many procedures, and some, if they do, are completely different to what is final coded.
- Tool was trialed; not as accurate, productive, or time-efficient.
- Mixed based on the poor transcribing of the information/language barrier issues create poor translation of information.
- It has not made a difference.
- When we tried it, it disrupted our database.
- CAC has been problematic; there are technical issues often.
- We're considering purchasing a system.

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- We have seen a reduction in face-to-face CDI/provider contact and increased review times in the office, making it difficult to round and interact with providers.
- It decreased efficiency and response rate.
- Takes the CDIS down a concurrent coding path rather than a clinical perspective.
- It has helped, but there are currently significant issues with not all documents flowing from the EHR to CAC, so it cannot be trusted to contain the whole story of the admission.
- Not all notes come through in a timely fashion depending on requirement for cosignature or dictations. This presents a fragmented narrative. Also, we want our CDSs to "read between the lines." We are looking for what's not there, not just picking up the codes that are there.
- We use CAC as a backup as it has not been reliable to use as a primary source of info.
- We're not using it for CDI.
- We recently changed CAC vendors and my efficiency in completing reviews and coding, including sequencing, has really slowed down.
- It inhibits more involved decision-making/critical thinking.
- CDI used it and it was beneficial, but it has since been retracted from CDI use and is only for coders now that we do concurrent coding.
- I think CDI relied on it and got lazy.
- It has increased denials because the CDI do not focus on conflicting documentation, but rather the diagnoses.
- It's beneficial for information that is electronic, but not for handwritten notes.
- We find that it provides alerts for documentation already in the record and unnecessary alerts. CDS review the record and use as a check system to validate their findings, but it does not drive their review.

15. Do your CDI specialists work remotely?

Answer Options	Bar Chart
No, our facility does not allow or have the capacity for this option	38.54%
Yes, about 10% work remotely	7.81%
Yes, about 25%	10.59%
Yes, about 50%	9.20%
Yes, about 75%	10.76%
Yes, 100% work remotely	7.29%
Other (please specify)	15.80%

Other responses:

- Several personnel involved in CDI work remote some or all of the time; no CDI specialist title here yet.
- On the weekends only.
- Pilot of two at home, Monday, Wednesday, and Friday.
- May work remotely once a month if metric goals are met.
- We can work one day a week remotely.
- Each CDIS works remotely two or three days per week, then on-site for the other two or three days a week.
- All CDS work remotely four out of five days per week.
- The CDI staff are remote 40% of the time.
- Eligible to work remotely if CDI meets/maintains productivity and quality reviews.
- After being a CDI for six months, can work from home one day per week on Mondays.
- One day a week or for inclement weather and illness.
- It's possible in the near future.
- 100% may work remotely one hour per day if desired.
- On occasion.
- 5% remote.
- They work within the facility, but may review records from other facilities.

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- Mixed model. A staff member is at the facility every day while the rest work remotely—19 facilities in our system covered by CDI.
- The CDS group do not; some of the coders do.
- Only in severe winter weather.
- Some work remotely 100%; others work remotely 50%.
- We have one remote employee.
- Unknown how many are working remote.
- About 75% work remotely one day a week, working at the hospital the other four days of the week.
- We have the ability, but it's discouraged.
- We work remotely one day per week if we meet our rigorous metrics. Biweekly (or so) we get a bonus work from home day for reviewing long LOS cases that have languished—via an emailed "grab bag" get a "special prize." No, by choice. We have the option to work from home, but the team prefers to work on-site.
- We rotate weekly who works remotely.
- Facility dependent.
- We have floaters who work from home.
- Lead works remotely on occasion.
- Our team earns home passes based on personal and team metrics.
- Outpatient CDI specialists work remotely. Inpatient CDI specialists work on the inpatient units.
- A trial is being done currently.
- I work remotely about 1–3 times per month.

16. If you answered yes to question 15, please compare the effectiveness of your CDI specialists working off-site vs. those on-site.

Answer Options	Better than on-site	Same	Worse than on-site	N/A or all work on-site	Don't know
Query rate	13.68%	45.02%	2.24%	20.15%	18.91%
Query response rate	5.51%	49.12%	5.26%	20.80%	19.30%
Productivity	33.33%	26.57%	2.01%	20.55%	17.54%
Physician engagement/ buy-in	3.79%	43.18%	10.10%	20.96%	21.97%

Other responses:

- Have a problem with one employee's productivity only.
- Basis for a query is same—any/all written queries must be compliant, and location in this regard is not a factor.
- Not able to tell because we are just beginning to work remotely.
- We have continued rounding schedule days when CDI is on-site.
- Only have one CDI specialist.
- It would be beneficial to work remotely; I would be more productive.
- Difficult to separate CDI metrics and productivity for days or hours worked remote. Most feedback are perceptions only.
- Only CDI auditors work off-site.
- We are currently piloting this hybrid model—so far seems to be going well. There will always be someone on-site.
- Our CDISs do both. And we transition to campus if query follow-up is urgent on that WFH day.
- The change in software from 3M to Clintegrity has a learning curve and so my production is about the same. I query 27%. My query response rate is 88%. My review numbers are less. I was doing total initial, re-reviews, and reconcillia-tion of about 40 charts/day. Now half that number.

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- We also use an on-site, client-facing manager.
- Face-to-face is best.
- There are only two of us in the ambulatory setting for 18 family medicine practices at this time. We need to be able to work effectively anywhere because we are so frequently in the practices.
- I require six months on-site for orientation, but most of our CDI staff are internal transfers, so they have relationships with the providers. I believe operating on a hybrid model helps to continue development of those collaborative relationships.
- All our staff work remotely.
- Not applicable since two different jobs. Outpatient CDI specialists have a better productivity and query rate, though, and they work remotely—but again, it is a different job than inpatient CDI.
- Our department has been remote from the beginning (8 years), so I don't have the answer.
- The last place I worked had a full-time remote CDI who had higher productivity.
- On-site CDI collaborate with the physicians, off-site CDI send unanswered queries to on-site CDI.

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

Answer Options	Bar Chart
Highly engaged and motivated	12.06%
Mostly engaged and motivated, with some exceptions	50.53%
Somewhat engaged and motivated	32.62%
Mostly disengaged and unmotivated	4.79%

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

Answer Options	Bar Chart
Strongly supportive	45.57%
Moderately supportive	29.43%
Somewhat supportive	20.39%
No apparent support	3.37%
Other (please specify)	1.24%

Other responses:

- Yes and no; we have the same issues that we were dealing with since 1998. You would think that the issues would be different but they are not. Beyond frustrating!
- Strongly supportive, but directives and education all come from corporate.
- Varies by client.
- Some facilities are better than others.
- More supportive of adult CDI; need more administrative support of pediatric CDI after years of showing ROI & positive impact.

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

Answer Options	Bar Chart
Yes, we have a full-time physician advisor/champion	20.39%
Yes, we have a part-time physician advisor/champion	41.67%
No, but we plan on engaging one in the near future	10.82%
No, we have no plans to engage a physician advisor/champion	15.25%
Don't know	2.48%
Other (please specify)	9.40%

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Other responses:

- CDI director is MD.
- CMO doesn't follow through with engaging physicians.
- We have a physician advisor assigned as an ancillary duty (not reimbursed)—very little engagement from the advisor to the CDI program.
- We had one to help implement ICD-10 only; we no longer have one.
- Multiple PAs utilized, none full-time.
- Physician available as needed with other job duties.
- Champion assigned by specialty, last revised 12/2016.
- No, we have been turned down for this position by administration.
- We use our division chiefs but do not have a specific champion.
- CDI and coding physician medical director.
- Physician champion focuses on utilization review.
- Do not have one at present. Did have one in the past. Do not know if we will have one later.
- Varies by client.
- Per diem but no availability to the CDIs .
- No official champion, but they are involved and interested.
- Most have a part-time physician advisor and some have a full-time.
- We had a physician advisor for approximately one year, but his position was eliminated and we've been without him for two years now. We are told that the prospect of having a new physician advisor is talked about, but I don't believe we'll have one any time soon, unfortunately.
- Our CMIO assists us when needed.
- Physician champion in name but no hours allotted to her specifically for CDI collaboration.
- We have three dedicated physician advisors that rotate through the role on a weekly basis. They are also hospitalists.
- VP of medical affairs handles conflicts.
- We use the CMOs at each care site as our champion/advisor, and we have a physician advisor at the system level who provides minimal hours of support.
- We have 24 physician champions, driven by specialty line.
- Unpaid physician advisor.
- We have clinical documentation committee with physician input.
- Just got a volunteer physician advisor in December 2017, but now he is leaving in two months.
- A different department decided to hire a "physician advisor" and send him to ACDIS boot camp without my department's knowledge.
- Case management has a part-time PA who has been supportive of CDI efforts and assisted in physician education at medical staff meetings.
- We partner with a physician advisory service.

20. If you have a part-time physician advisor or champion, do you share their time with another department?

Answer Options	Bar Chart
Yes	50.11%
No	20.61%
Don't know	13.32%
Other (please specify)	16.05%

Other responses:

- Physician champion who assists with unanswered queries.
- Even though full-time, we still share with case management.
- Our physician "champions" still do patient care full-time. They simply avail themselves to us on an as-needed basis. There is very little MD-to-MD communication on our behalf.
- Varies by client.
- Full-time internist champion.
- She is a full-time hospitalist, rotating to office hours regularly. She is very accommodating for my CDI inquiries, but I must be mindful of my timing.

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- He has a private practice.
- One full-time and one part-time with shared time.
- Yes, but she is not part of our CDI staff. She is very engaged & offers potential troubleshooting options to our program barriers. She also works with any providers that may need workflow & CDI assistance.
- Yes, our CDI physician advisor is a practicing gastroenterologist. I believe his CDI FTE is 0.2 or 0.4.
- He also works with UM.
- Our PA is a full-time trauma surgeon, so many conflicts with call and his daily work; he dedicates some time to us during the month.
- The physician champion is a liaison to our dept. Their job is not dedicated to CDI.
- He is a peds hematologist/oncologist full-time. Only a volunteer physician champion for CDI.

21. 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	Bar Chart
One	10.64%
Two	32.45%
Three	12.59%
Four	1.60%
Five	1.60%
Six	0.00%
Seven	4.08%
Eight to 14	4.96%
Within 30	5.14%
We don't have a time frame for query response	18.26%
Don't know	3.37%
Other (please specify)	5.32%

Other responses:

- Concurrently or two business days after discharge.
- Hopefully within 48 hours, but there is no deficiency if they take longer.
- Technically 30 days, but our goal is to get them answered before discharge.
- Within a few days and query will be closed within a few days of discharge.
- Seven days due to some doctors working on seven, off seven, but no written rule
- Consultant-facilities have different requirements.
- We don't have a time frame for concurrent response. They're encouraged to answer post-discharge queries within 30 days.
- We start escalation policy at two days—they have til 14 days to answer.
- Physician practice will address the query during face-to-face encounter with patient
- Until HSCrc closing
- One for residents, two for attendings.
- We usually prefer five days but does not usually happen many times.
- Concurrent escalation in two days; retro stays open for 30 days.
- In outpatient setting, general TAT is two business days.
- Varies by service and if patient in-house or discharged.
- By time of discharge.
- 20 days.
- Our bills drop in five calendar days, regardless of whether they have answered.
- Varies with each CDI, but mostly 2–5 days with escalation occurring after the second attempt for an answer has failed.
- Two days for inpatient CDI. Response expected at time of appointment for outpatient CDI.
- Expectation is that it's answered by the end of their shift.
- Two days if on service, otherwise ~8 days.

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22. 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	Bar Chart
0–25%	1.95%
26–50%	2.13%
51–60%	1.95%
61–70%	2.66%
71–80%	8.16%
81–90%	21.10%
91–100%	44.50%
Don't know	12.06%
We don't track this metric	5.50%

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

Answer Options	Bar Chart
0–25%	1.77%
26–50%	3.19%
51–60%	1.24%
61–70%	2.30%
71–80%	8.87%
81–90%	35.28%
91–100%	27.13%
Don't know	15.43%
We don't track this metric	4.79%

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

Answer Options	Bar Chart
Yes	52.66%
No	34.40%
Don't know	7.80%
Other (please specify)	5.14%

Other responses:

- N/A
- Care management, who we report to, has an escalation process.
- We are a multi-entity system, some entities have a policy, others do not.
- in draft form, soon to be implemented I hope.
- We did until we lost our full time PA.
- Currently, it's a part of the score card measure.
- As a consultant we strongly recommend it.
- We do, but only effective to our hospital owned hospitalist group. He have another hospital group who is not employed by our hospital.
- Our CDI department does; however, the Med Exec portion is very flexible in their adherence to our process.
- Only escalation to physician advisor.
- Informal one
- Queries are treated the same as all other documents pending physician completion.
- I believe they do for coding queries but not CDI queries.
- It was our CDI Executive Steering Committee that established this policy - not MEC.
- We have vague policies on this.
- Yes, but it's not effective.
- Not a written policy. Any CDI issues handled by VP Medical Affairs.

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25. 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	Bar Chart
CMS Inpatient Quality Measures, i.e., "core measures" (not specific to Hospital Value-based Purchasing [HVBP])	25.64%
Present on admission indicators (POA)/ hospital-acquired conditions (HAC)	72.36%
Hospital Readmissions Reduction Program (HRRP)	12.91%
Patient Safety Indicators (PSI)	56.91%
HAC reduction program	33.09%
PSI only (not specific to HVBP)	14.91%
Severity of illness/risk of mortality (APR-DRG methodology) concurrent to stay	60.36%
Severity of illness/risk of mortality (APR-DRG methodology) retrospective mortality reviews	45.82%
Severity of illness/risk of mortality (not specific to APR-DRG methodology)	31.64%
Surgical Care Improvement Project (SCIP) or other quality specialty database	6.36%
We don't review quality measures/metrics	12.73%
Other (please specify)	5.27%

Other responses:

- We are just laying the groundwork for this initiative within our organization; quality measures have not been clearly defined at this time.
- This is done by a different department.
- Risk adjustment/HCC.
- I don't know.
- Reviewing records for incomplete documentation.
- Vizient mortality risk.
- Varies by client.
- MIPS quality measures, CPC+ quality measures, HEDIS/ STARS quality measures, OCM quality measures.
- Stroke.
- Pressure ulcers and other case-by-case topics as applicable.
- Sepsis.
- Quality measures in relation to outpatient setting.
- Mortality reviews.
- Orthopedic conservative measures.
- Corporate compliance/medical necessity requirements for spinal procedures and orthopedic procedures—query if needed.
- Potentially Preventable Complications (PPC); population health (heart failure specific).
- We review accounts when quality requests.
- We do this; however, not a collaborative effort with quality.
- PSI 11: Postop respiratory failure.
- Monitor queries for HAC/PSI/complications.

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

Answer Options	Bar Chart
Yes	27.61%
No	43.82%
We don't track productivity	9.27%
Don't know	19.31%

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

Answer Options	Bar Chart
Yes	16.33%
No	61.75%
Don't know	21.91%

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28. Does your CDI department still query if the query only impacts a quality measure, not reimbursement?

Answer Options	Bar Chart
Yes	86.20%
No	7.37%
Don't know	4.35%
Other (please specify)	2.08%

Other responses:

- N/A
- Sometimes.
- Both.
- Varies by the client.
- It doesn't matter the outcome, we query.
- Only concurrently.

29. Does your CDI program perform mortality reviews?

Answer Options	Bar Chart
Yes	62.91%
No	34.00%
Don't know	3.09%

30. At your facility, do you send clinical validation queries (i.e., queries for clinical support of a documented diagnosis)?

Answer Options	Bar Chart
Yes	90.73%
No	6.36%
Don't know	1.09%
Other (please specify)	1.82%

Other responses:

- N/A
- Due to perception of clinical validation queries by some physicians, we are no longer able to send this type of query.
- We're in the process of developing escalation policy/query.
- Sometimes.
- Just beginning clinical validation queries at our facility.
- We have started doing more of these, but just recently.
- We do not have a query template for this but will send a rule-in/rule-out query to clarify if clinical indicators are not present to support the diagnosis—usually it is for acute respiratory failure or sepsis.

31. If you answered yes to question 30, which of the following diagnoses commonly lead to a clinical validation query at your facility? (Check all that apply.)

Answer Options	Bar Chart
Sepsis	85.08%
Respiratory failure	84.30%
Encephalopathy	44.38%
Malnutrition	49.03%
Acute renal failure	38.37%
Other (please specify)	9.88%

Other responses:

- Oncology & hematology practice; queries tend to be for specificity.
- Pancytopenia.
- Active problem list pulled into note that is out of date.
- None.
- HIV/AIDS.
- N/A
- CHF acuity, pneumonia types, CKD staging.
- Don't know.

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- NSTEMI; pneumonia; neonatal hypoglycemia.
- Questionable diagnosis without evidence of treatment, and diagnosis documented acute when actually the diagnosis is chronic or not applicable to patient (possible copied and pasted).
- Major depressive disorder; DM associated complication(s).
- Acuity of conditions.
- Postop complication.
- Acute blood loss anemia.
- Diabetes with manifestations, CKD and CHF specificity.
- Acuity of tons of diagnoses! Back and forth....
- BMI/obesity is also being denied (CV denials). Payers state they aren't "clinically valid" to the admission despite being documented by providers & addressed by an RD.
- Anemia, heart failure type and acuity, pneumonia, UTI.
- AMI.
- Stroke with visual disturbance.
- AKI.
- Sometimes ATN.
- Multiple types as well as the above diagnoses.
- Depression specified.
- ARF, BMI, any other conflicting documentation.
- Other MCC, shock, etc.
- HTN.
- Anemia, hypotension.
- For acute renal failure, there is often conflicting documentation as to whether the patient has AKI on CKD, or CKD without AKI. For malnutrition, there is one physician who uses serum albumin as the clinical indicator and has been resistant to using ASPEN criteria.
- Pancytopenia.
- All of our clarifications are based on clinical validation.

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

Answer Options	Bar Chart
Yes, we possess CDI software that tracks clinical validation query frequency	37.00%
Yes, we track clinical validation frequency manually/we do not have CDI software that does this	8.79%
No, we do not track clinical validation query frequency	46.15%
No, we do not perform clinical validation queries	8.06%

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

Answer Options	Bar Chart
Yes	36.31%
No	47.81%
Not sure	15.88%

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

Answer Options	Bar Chart
Hospital outpatient services: Ambulatory surgery	9.54%
Hospital outpatient services: Emergency department	11.19%
Hospital outpatient services: Medical necessity of admissions	5.32%
Hospital outpatient services: National and local coverage determinations	2.75%
Hospital outpatient services: Quality measures	4.77%
Hospital outpatient services: Risk adjustment	9.72%
Physician practice/Part B services	7.16%
Rehabilitation (outpatient)	2.75%
We don't review outpatient records	59.45%
Don't know	15.23%
Other (please specify)	6.24%

Other responses:

- Professional fee services.
- We only review for physician practice for risk adjustment.
- Alternate department performs outpatient reviews.
- Possible expansion into pediatric CDI; we currently do not review patients under 18 years old.
- We have an outpatient CDI who did/does many of the above. Several of these roles have been "outsourced" by our facility (recent merger a few years ago, so lots of changes).
- My manager is working on reviewing outpatient records but I do not know which areas.
- Currently do not review—looking to expand in next 2 years to outpatient.
- Varies by client.
- Medicare Advantage OBS reviews for HCC capture.
- Presently do not review, but plan to in next year.
- We have looked into it; had it evaluated by outside company and is on hold.
- We "put out fires" and query on issues as they arise and are presented to us.
- Primary care services are also reviewed—some, not all.
- Clinic visits—HCC.
- Internal medicine groups only.
- OP hospital program is being developed at this time.
- Contract CDI reviews specific service lines.
- Heart cath lab and focus on HCCs.
- Capture HCCs on inpatient encounters. Hoping to expand to outpatient/ambulatory CDI.
- ER pre-auths.
- In the process of expanding to office.

35. If you answered yes to question 34, what is the primary focus of your reviews?

Answer Options	Bar Chart
Hierarchical Condition Category (HCC) capture	35.06%
Evaluation and management coding	3.98%
Denials prevention	6.37%
Medical necessity	3.19%
Emergency department reviews/observation	2.39%
Don't know	31.87%
Other (please specify)	17.13%

Other responses:

- Will be HCC in the future.
- N/A
- Currently review ED notes as part of inpatient record; we are currently exploring expanding into a dedicated ED review process.
- DRG validation.
- All of the above; not limited to one area of focus.
- Diagnosis clarifications.
- Accuracy and specificity of dx and comorbids.

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36. When do your CDI specialists perform outpatient chart reviews? (Check all that apply.)

Answer Options	Bar Chart
Prospectively—before the physician sees the patient	14.66%
Concurrently—while the patient is in the office	12.03%
Retrospectively—after the appointment	22.18%
Don't know	34.21%
Other (please specify)	32.33%

Other responses:

- N/A
- Planning to initiate this.
- Currently only review ED records on inpatients.
- Outpatient CDI program in implementation phase.
- During the acute care hospital observation stay.
- In the ED and follow to next patient status.
- As presented to us with specific questions, not routinely.
- Planning to do concurrent.
- We are developing this process so it is still in the preliminary stages.
- Program being implemented will be retrospective.
- As requested by outpatient coding staff.

37. Does your facility/CDI program have a set policy governing the outpatient query practice?

Answer Options	Bar Chart
Yes, we have a policy based on the recent ACDIS position paper "Queries in outpatient CDI: Developing a compliant, effective process"	4.29%
Yes, we have a policy based around the ACDIS/AHIMA query practice brief "Guidelines for Achieving a Compliant Query Practice"	7.59%
Yes, we have a policy that was homegrown within our program	2.64%
No, but we're developing one	15.18%
No, we do not have an outpatient query policy	38.61%
Don't know	21.45%
Other (please specify)	10.23%

Other responses:

- VA facility; use VA query guidelines.
- N/A
- Varies by client.
- Yes, but I don't know what it is—I am on inpatient side and our policies are not easily accessible and all in one place.

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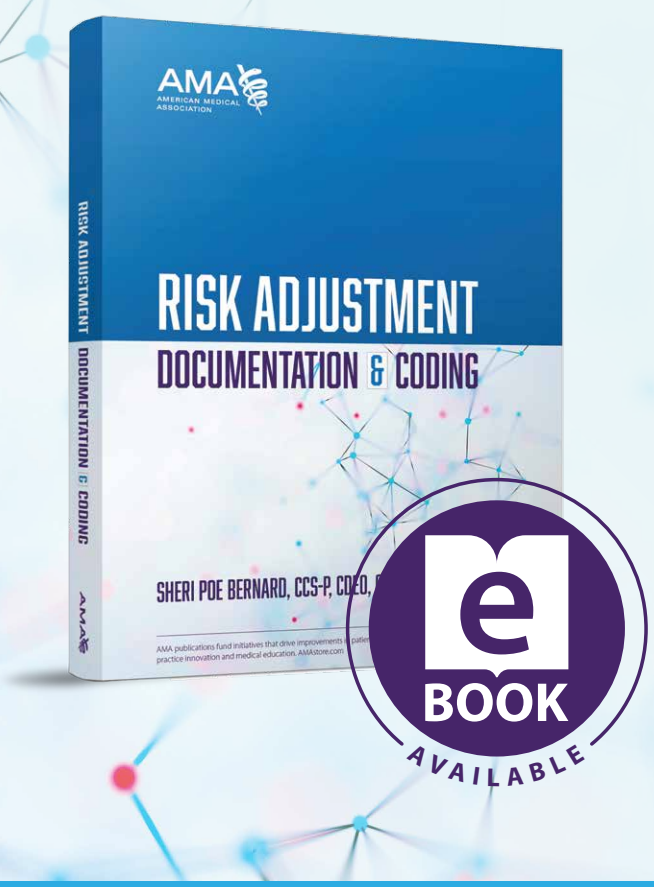

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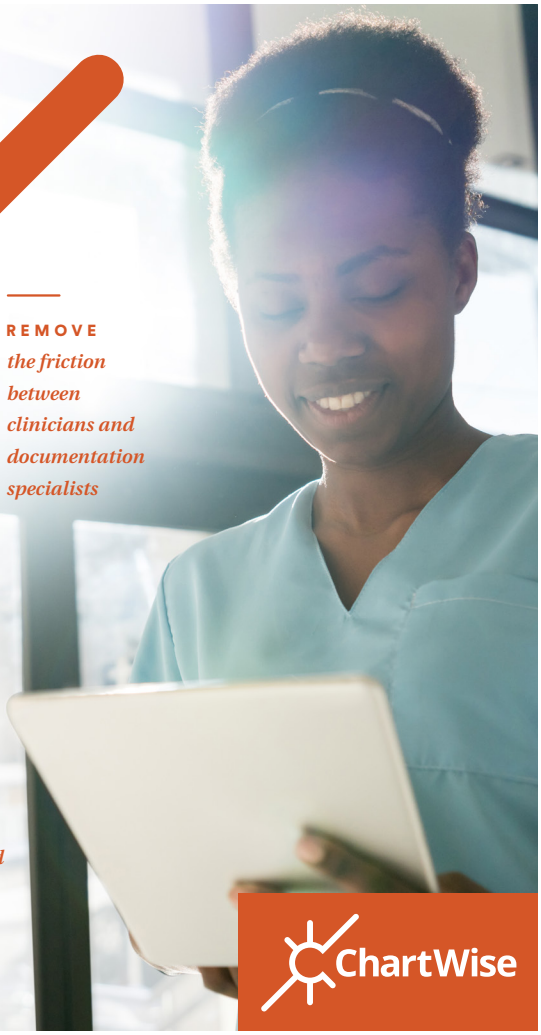

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