Manage CDI Progress
CONTENTS

FEATURES

11 What managers worry about
Staff productivity, assessing meaningful metrics, advancing CDI efforts in new ways, and providing career opportunities to CDI professionals—two managers share their top concerns in leading CDI programs to success.

15 Catapulting case management and CDI coordination
Managing multiple departments can be challenging (to say the least), but these ACDIS members heading both case management and CDI find a way not only to be effective, but to enable teams to work together harmoniously.

24 Electronic records change processes, interactions
While many healthcare systems have already transitioned to an electronic medical record and query system, many more remain paper-based or hybrid or have only recently made the transition. Read how such shifts affect CDI programs.

DEPARTMENTS

3 Associate director’s note
Sometimes the best advice comes straight from the field, as we found out during recent site visits and check-in calls with ACDIS members.

5 Note from the Advisory Board
Karen Newhouser, RN, BSN, CCDS, CCS, CCM, CDIP, ponders the potential limitations of CDI without coding collaboration.

13 From the Forum
What measurements demonstrate a CDI program’s effectiveness? Participants in ACDIS’ online CDI Forum community offer their opinions.

19 Radio recap
Cheryl Ericson, MS, RN, CCDS, CDIP, discusses the challenges associated with new bundled payment models and how CDI staff can help.

26 Meet a member
Claudine Hutchinson, BSN, RN, started her nursing career without so much as a thought about CDI. It was her above-par nursing documentation that caused her manager to recommend a career shift.

OPINIONS & INSIGHTS

7 Physician advisor’s corner
Trey La Charité, MD, FACP, CCDS, offers recommendations for discussing case-mix index fluctuations with hospital administration.

22 Pediatric concerns
Valerie Bica, BSN, RN, presents some documentation improvement ideas for addressing developmental delays in children.

CONTINUING EDUCATION CREDITS

BONUS: Obtain one (1) CEU for reading this Journal
ACDIS members are entitled to one continuing education credit for reading the CDI Journal and taking this 20-question quiz. Click here to download the quiz for CCDS credits.
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How have you been?

Sometimes, we forget to ask. Sometimes, when we ask, we neglect to listen to the answer. Consider the times you’ve passed someone in the hall and intoned “How are you?” as you held the door and hurriedly went on your way. Consider the times someone has done the same to you.

Now, consider the times when a thoughtful stranger has not only held the door a few extra seconds, but helped with your bag or coffee while asking that same question.

Members of the ACDIS administration periodically allot time to reach out to ACDIS members, say hello, and check in to see how things are going. Sometimes we learn sad news about family or personal illnesses, difficult transitions, and challenging workloads. And sometimes we hear amazing success stories about second chances, newborn children and grandchildren, retirement adventures, fresh CDI initiatives, collaborative and cross-disciplinary efforts, and advanced record reviews.

In the past few months, a number of facilities hosted members of the ACDIS team as we shook the office dust off our shoulders and ventured out for on-site visits to see firsthand how things are with a handful of nearby programs.

I enjoyed my visit with Patricia Barry, CDI manager for Cape Cod Health at Falmouth Hospital in Massachusetts, and with the CDI team at my hometown facility of Beverly Hospital (shout-out to Cheryl Beaulieu, Debra Womersley, Kathy McDiarmid, and program manager Dale Stevens). The folks at Pen Bay Medical Center in Maine hosted ACDIS Editor Katy Rushlau and talked about their transition to Epic, physician education, and expanding reviews to service line–specific efforts.

At Carolinas Healthcare, Andrea Johnson hosted ACDIS Associate Director of Membership and Product Development Rebecca Hendren, who was lucky enough to time her visit to coincide with CDI Week and the facility’s annual CDI celebration luncheon.

Throughout the past month, I’ve also been fortunate enough to talk on the phone with Debbie Ashworth, Amy Rector, Anna Winkowski, Diane Healy, Jeanette Fox, Jenny Prescia, Julie Ann Tardi, Mary O’Connell, and Tricia McGinn, among others. You’ll hear from many of them throughout this edition of the CDI Journal.

In discussing CDI collaboration efforts, Ashworth, director of CDI
and case management at Jackson Madison County General Hospital in Tennessee, underlined the importance of effective communication and true collaboration when she said:

“The days of not caring about what others do are over. Everything depends on everyone else [in healthcare]. Be it transport or dietary or coding or case management or CDI, every bitty piece that everyone does matters. Being able to hear what each other does and how it matters helps us all do better in our jobs.”

May the stories in this edition, from these amazing professionals, be as helpful to you in your daily job as they’ve been inspirational to us.

If you’d like to share your CDI stories with us here at ACDIS, just shoot us an email—say hello, and let us know how you’re doing.

Photo by Rebecca Hendren
Andrea Johnson, RN, BSN, CCDS, CDI specialist at Carolinas Rehabilitation in Charlotte, North Carolina, hosted ACDIS Associate Director of Membership and Product Development Rebecca Hendren during CDI Week in September as members of the Carolinas CDI team gathered for a celebratory luncheon.
All professional backgrounds welcome
Proficiency and ability matter most in CDI competency

by Karen Newhouser, RN, BSN, CCDS, CCS, CCM, CDIP

I have been pondering the clinical validation conundrum with the publication of the AHA Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2016, as well as a practice brief published in the August 2016 edition of the Journal of AHIMA, “Clinical Validation: The Next Level of CDI.”

When CMS and the National Center for Health Statistics published the 2017 Official Guidelines for Coding and Reporting, in August, they included a new convention, I.A.19, which notes that the assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists; the guidelines further note that the provider’s statement attesting the patient has a particular condition is sufficient. Code assignment, according to this new convention, should not be based on the clinical criteria that the provider used to establish his or her diagnosis.

Carrying this thought forward, the convention tells us that although we should use clinical criteria to identify query opportunities as well as to identify diagnoses that may or may not be present, we must understand that the provider is the only one who can determine the presence or absence of a diagnosis. As ACDIS Boot Camp Instructor Laurie Prescott, RN, MSN, CCDS, CDIP, wrote in an article in the September/October edition of CDI Journal, “We can assist the provider to better document the reasoning related to an identified diagnosis, but we should never choose to not code a diagnosis because we feel it is not clinically supported.”

The recent Coding Clinic regarding I.A.19 clearly stated that the new convention addressed coding, not clinical validation, but then took the opportunity to identify clinical validation as being outside a coder’s scope of practice. I find this interesting, as we’re now faced with a conundrum regarding who performs queries.

When I read this Coding Clinic, I worried that down the road, such guidance could limit the ability of nonclinician coders to serve in a CDI role. I use the term “nonclinician coder” because there are those who hold both a clinician credential (nurse, physician, therapist) and a health information management credential (RHIT, RHIA, CCS, etc.).

Consider the skills used to clinically validate a diagnosis: a knowledge of anatomy, pathophysiology, and disease progression, and a deep understanding of clinical indicators (which, as we know, are the signs and symptoms of a condition).

I say “deep understanding” because again, clinical indicators can be seen as pieces of a puzzle, and not clearly defined within a textbook of conditions/diseases and clinical indicators. Therefore, it takes a unique skill set to put the puzzle pieces together in the context of a patient’s current treatments and diagnoses.

With that in mind, are not the skills used to clinically validate a diagnosis the same exact skills used to identify clinical indicators that may describe a particular, yet-to-be-documented condition, thus warranting a query for clarification?

In my opinion, yes: The skills used to identify the clinical indicators and clarify the presence and significance of a condition are the same skills necessary to determine whether those clinical indicators
are present to validate the same condition after the encounter. Furthermore, the same clinical indicators and consequent skills play a key role in denials management.

I turn to a portion of AHIMA’s “Clinical Validation: The Next Level of CDI,” under the subheading of “Gaining Consensus on Clinical Validation,” which states:

The coding professional is responsible for accurately reporting the diagnoses associated with the claim as coded data, but clinical validation precedes code assignment since ensuring the condition meets UHDDS guidelines for reporting and adherence to coding guidelines is no longer the only consideration.

The verbiage “clinical validation precedes code assignment” piqued my interest, for this tells us that clinical validation is performed prior to the coder receiving the record, either after discharge (and subsequently holding up coding of the record and also billing) or concurrently. Concurrent validation, in my opinion, is the best approach, and it makes the most sense when we look at the alternative of increasing the number of discharged-not-final-billed records.

I also sat in on the “Clinical Validation: What Does It Mean for Coders?” presentation at the October AHIMA conference in Baltimore. One of the speakers, Laura Legg, RHIT, CCS, began by reminding the audience that coders can only code the record and reiterated recent information from AHIMA and Coding Clinic. Legg went on to say that clinical validation happens during the clinical review by a clinician and is separate from coding.

However, she added, these statements do not mean that coders and CDI cannot work together to establish CDI and coding best practices. When asked whether she viewed the clinical validation role as separate from that of CDI, Legg said no, they were one and the same.

If it is out of the scope of practice for a coder to clinically validate a diagnosis, is it out of the scope of practice for a nonclinician coder to perform a clinical review of the record, identify clinical indicators, and query for clarification, if necessary?

In the September/October edition of the CDI Journal, my fellow ACDIS Advisory Board members Anny P. Yuen, RHIA, CCS, CCDS, CDIP, and Paul Evans, RHIA, CCDS, CCS, CCS-P, who both hail from coding and HIM backgrounds, made a salient argument for inclusion of individuals with such backgrounds in the CDI role.

In that issue, they reiterated ACDIS’ longtime stance that facilities should identify the candidate best suited to the particular position, noting that ACDIS has long expressed itself as an inclusive organization, welcoming coders, nurses, physicians, case managers, quality staff, and all who are interested in learning more about the value of complete and accurate documentation in the clinical record.

“Not all coders can serve as CDI specialists, and neither can all nurses. Being a CDI specialist takes creativity and strong understanding about clinical documentation and indicators,” they wrote. “The first step to true collaboration requires a deeper awareness and appreciation of the talents each individual, regardless of professional background, brings to the table.”

Perhaps we’ve come to a point where CDI can be recognized as its own profession—one that stands on its own, not merely existing as an extension of coding, nursing, or other healthcare department.

Perhaps we’ve come to a point where the CDI profession can be recognized as its own profession, having the ability to stand on its own and not as an extension of coding, nursing, or other healthcare department.

Of course, I’ve personally felt strongly about this for a long time, and I wonder if we, as a profession, have grown large enough and become sufficiently ensconced within the healthcare system for our independence to be fully (and finally) recognized. In fact, the 2016 CDI Salary Survey seems to show an increasing number (19%) of respondents indicating they report to a CDI manager/director. In the early years, this wasn’t even an option.
Haven’t we (the CDI profession and those who perform the job) proven that the CDI role requires a wholly unique set of skills? While there is overlap with coding and nursing, the CDI profession is not defined by the backgrounds of those who perform the work, but by the expertise those backgrounds bring to the skill set required by the role.

I concur with my colleagues and sincerely hope that we will continue to work together in a collaborative manner and will not find ourselves at the crest of a job/responsibility/role shift of grand proportions.

Editor’s note: Newhouser is the director of education for MedPartners in Tampa. An RN with 36 years’ experience, and 12 years’ experience as a CDI professional, she earned the CDI Professional of the Year award in 2015 and is a member of the ACDIS Advisory Board. The opinions expressed are her own and do not necessarily reflect those of ACDIS, the ACDIS Advisory Board, or MedPartners. Contact her at knewhouser@medpartnershm.com.

PHYSICIAN ADVISOR’S CORNER

Your CMI: What is (and isn’t) in your control

by Trey La Charité, MD, FACP, CCDS

Your CDI program successfully obtained consistent results over the last few years, and all is right within the CDI world. Then, the facility case-mix index (CMI) unexpectedly drops. Provided it rebounds, one or two months below its usual average is probably not cause for a great deal of concern. But what happens when the CMI shows an overall downward trend for six months, or a year, or two years?

To be blunt, making an initial positive impact with your new CDI program is the easy part. Maintaining that momentum over the long haul, year after year, is a more difficult task. After reviewing the CMI trends seen at my facility and investigating the causes of those trends, I have some insight to share if your facility, too, is experiencing this problem.

Getting a handle on CMI fluctuations can be difficult. First, note that your facility’s CMI is not solely attributable to you, as the CDI physician advisor, nor is it solely attributable to your CDI program. Too many factors that directly affect your results are beyond your influence. You have no control over the patients that walk into your hospital on a daily or monthly basis, for example. Sometimes, this week’s patients simply aren’t as sick as last week’s (or last month’s) patients were. Sometimes, the physicians in your most profitable service line go on vacation.

Despite these facts, administrators generally attribute the facility’s CMI results solely to you and your CDI program. So when hospital management comes looking for answers, you need a comprehensive understanding of the variables at play.

For simplicity’s sake, I will lump the considerations affecting your facility’s CMI into two buckets—those that are extrinsic to your CDI program, and those that are intrinsic. To adequately address both categories, I will examine the extrinsic factors in this article, and I will review the intrinsic factors in a future article.

Examining extrinsic factors is a complicated and time-consuming process. Since big data is a component of this investigation, you need input from various sources outside your program. Undoubtedly, your revenue cycle staff, including your chief financial officer, will share their insight. Quality control, development, and operations also have a keen grasp on the healthcare market forces at play, and can be a valuable resource. Sadly, investing the time and effort to discover and decipher the extrinsic factors that affect your program often reveals those elements as, like many other factors, beyond your department’s ability to influence.
Hospital status

Hospital status determination is the beginning point of the extrinsic review. If you interact with your facility’s case management, utilization review, or compliance departments, you’ve likely experienced the pressure of this seemingly simple designation—the implications of not getting it correct are staggering.

Too many observation cases lead to unhappy patients and lower hospital reimbursement. Too many inpatient stays lead to increased auditing and regulatory inspections. Your facility may have initiated intensive efforts to get this admittedly arbitrary determination as accurate as possible.

One result of strict scrutiny is a higher percentage of observation cases being converted to inpatient hospitalizations. Since observation cases are billed under Part B services, they normally have no impact on the CMI. However, once observation cases are converted to inpatient stays, they fall within Part A billing.

This results in lower-weighted MS-DRG submissions, since those observation patients are probably not “as sick” as your usual inpatient population (after all, they weren’t sick enough to immediately warrant admission). Therefore, while the number of inpatient stays increases, the overall CMI drops.

While a decrease in CMI is generally perceived as a negative, in this instance, it is actually a positive because lower-weighted MS-DRGs reimburse more appropriately than observation stays. Additionally, Medicare beneficiaries do not lose their three-day skilled nursing facility benefits and have no hospital copays or medication expenses as they would if kept under observation status. My facility and CDI department have experienced this challenge and “setback” firsthand.

Patient population

The third extrinsic factor that affects the CMI is the makeup of your patient population. If you haven’t heard, the United States is aging. Every day, 10,000 people in our country turn 65. And because the human condition naturally deteriorates with time, more hospitalizations naturally occur with this older patient population.

More hospitalizations are generally considered a good thing for your medical institution, right? However, the more important question is what kind of admissions these hospitalizations will be.

To be sure, an older patient population will result in an increased percentage of medical MS-DRG admissions as opposed to surgical admissions. This is another situation my facility has encountered firsthand. And it will continue to be an issue for my hospital, since East Tennessee is one of the retirement capitals for the
country. The area’s moderate climate and absence of state income tax will continue to result in an increased percentage of medical admissions, further decreasing our overall CMI.

**Healthcare reform**

The last extrinsic factor to understand is the current reform-driven effort to keep patients out of the hospital. Falling under the moniker of “population health,” everyone has determined that it is cheaper to treat patients in the lower-cost outpatient arena than through an expensive inpatient hospitalization.

Therefore, there has been a tremendous effort to keep all but the sickest medical admissions out of the hospital, including “unnecessary readmissions.”

While this seemingly is positive since lower-weighted medical MS-DRGs dilute the CMI, please do not ignore the concurrent transition of many surgical cases from the inpatient operating room to the outpatient day-surgery center.

While the total number of surgical procedures performed at my hospital grows significantly every year, the inpatient surgical volume makes up an increasingly smaller percentage of the total number of surgical cases. The outpatient surgical volume, meanwhile, is growing at a greater pace.

Again, at my facility, overall patient volume has increased due to the numerous demographic factors previously mentioned. However, inpatient surgical MS-DRG submissions have decreased in comparison to the number of inpatient medical MS-DRG submissions.

Obviously, there are substantial outside forces which shape your CMI, and this is certainly not an exhaustive list of those forces. Other potential considerations that I did not address include commercial carriers’ contracting strategies and changes in your local market competition.

Furthermore, the things that affect my facility may not be the same as those that matter to yours. And, as mentioned earlier, there are intrinsic factors that affect the CMI as well (which I will address in my next article).

The bottom line is that, while you may not be able to alter the outside influences from within your CDI program, you must be able to understand and explain those influences to your hospital administrators when they start asking just how effective your program is.

**Editor’s note:** La Charité is a hospitalist with the University of Tennessee Medical Center (UTMC) at Knoxville. He is board-certified in internal medicine and has been a practicing hospitalist since 2002. He is also a clinical assistant professor with the department of internal medicine, serves as the medical director for UTMC’s clinical documentation integrity program and coding, and is a past ACDIS Advisory Board member. His comments and opinions do not necessarily reflect those of UTMC or ACDIS. Contact him at Clachari@UTMCK.EDU.
In a world where clinical quality outcomes drive patient care and business practices across the care continuum, complete and accurate clinical documentation is more important than ever before.

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Ever make mud pies? A hose running rivers in the backyard sandbox or a collection of buckets and throwaway pie tins lining an oversized puddle after a rainstorm make the best kitchens for such non-culinary fun. How CDI managers must long for those moments when they needn’t worry about how each slice seems to slide back into its larger whole, how the separate ingredients meld and stick.

Sometimes, perhaps, attempting to manage a CDI program can be like making mud pies. So we asked a couple ACDIS members to see how they sliced up their CDI management duties and program priorities to serve up the best pies (ahem, results) possible.

**Dee Banet, RN, CCDS, CDIP**, director of CDI at Norton Healthcare in Louisville, Kentucky, has two children in college, one getting married in 2017. So, she worries principally after her family and friends. Professionally speaking, with responsibility for the career development and productivity of more than 20 CDI staff members over five facilities—and with most of those staffers new to the profession—Banet has her share of day-to-day concerns. Not surprisingly, hiring and mentoring her new employees tops the list.

Getting the right candidate in the door comes down to understanding the scope of the CDI program and its needs and nuances, Banet says. At Norton, physician education and communication represent core ingredients, as does team collaboration, along with the essential elements of critical and clinical thinking necessary to interrogate the medical record not only for what it contains, but also for which details and diagnoses might be missing.

In the nearly 20 years she’s worked in CDI, Banet has honed an awareness regarding the personality type and professional experience that serve Norton’s program best.

“I know the skill set I’m looking for and can see from a candidate’s background and experience how it might enable them to communicate with physicians and transition into the CDI role,” she says.

Once a candidate accepts the position, Banet and her team set to providing the new staff member with comprehensive training specifically geared to that individual and Norton’s needs.

“We developed a strong orientation program, including a homegrown orientation handbook, hands-on educational activities, and mentorships,” Banet says. After six to eight months, new staff also get to attend a CDI Boot Camp.

Although Norton doesn’t currently have career ladders in play, staff training and mentoring continue even after the initial onboarding processes. One method is to have staff, who are anchored to a specific facility, spend time cross-training at other facilities with other staff.
members to “help them learn how each other works.”

Some CDI specialists initially balked at the idea, viewing such shadowing as a form of intrusive observation. “They didn’t want to be told what to do in some cases, and in others, felt that such observation was meant to be punitive in some measure if they weren’t performing up to snuff,” says Banet.

After a while, the CDI team found shadowing offered them tips on record reviews, helped them identify clarification opportunities that might have otherwise been missed, and gave them new physician engagement ideas to bring back to their own facilities.

“In the end, it helps us build a more cohesive team,” says Banet. “There’s a value to having those consistent relationships amongst the staff, and it’s good to see what it’s like to work in a different facility with different clinical and documentation priorities. We can identify particular skill sets and bring everyone up in the process.”

CDI specialists at North Shore University Health System in Chicago cross-train too, says Tricia McGinn, RN, CDI manager there. McGinn’s staff consists of eight CDI specialists spread across four hospitals. Seven staff members hail from nursing backgrounds, while the eighth is a foreign medical graduate. Two team members hold the CCS certification for inpatient coding, and one holds the CCDS credential from ACDIS. The cross-training typically takes places across units rather than across facilities, in order to ensure continuity when census needs rise or staffing numbers decrease. Like Banet, McGinn hopes to put some type of formal career ladder in place for her team, her program, and herself.

The CDI program started in 2011 as most programs do: with CC/MCC capture and DRG reviews. But in 2014–2015 the team took on Patient Safety Indicators (PSI) and hospital-acquired condition (HAC) reviews, and in 2015–2016 they added mortality reviews into the mix. Each type of review began as a pilot program conducted by McGinn and a few of her more experienced team members.

It was administrators from the quality department who reached out to McGinn seeking help on PSIs. “Clinically, they had made all the improvements they thought they could make,” says McGinn, “so they reached out to see if there were potential documentation improvements that could make a difference.”

The CDI team dug into the matter, identifying particular inclusive and exclusive conditions for their system’s frequent PSI targets, and found “there were things we could tease out, particularly with present on admission conditions. We moved the needle,” she says. Structurally speaking, though, the CDI team responded to the quality administrators’ request for assistance on a reactive basis.

“I didn’t know what the workload would be like. I didn’t have the staff, really. Now, two years later, we need to reevaluate these type of activities and plan for a better structure.”

Collectively, CDI specialists at North Shore conduct a mix of traditional and advanced reviews. Medicare patients appear first on the work list, but staff then conduct reviews regardless of payer. They also conduct all queries, both concurrent and retrospective. If coders have a question about the documentation, they kick it back to the CDI professional who initially reviewed that record.

“With more than 40 remote coders, and considering the regulatory environment we’re in, we really wanted to reduce the number of people interacting with the physicians,” McGinn says.

Although coders work remotely, the CDI staff does not. They occupy an office space, each staff member with his or her own cube. If there’s a snowstorm or family situation, staff can request remote time, but “when a doctor needs to get a hold of you, you need to be there,” she says.

While the team seems to have been successful improving PSIs and HACs, McGinn worries about proving the return on investment of these activities throughout the system, as well as maintaining productivity on typical legacy targets that move the case-mix index and represent high dollar value to the chief financial officer.

“We still need to demonstrate the CMI, the CC/MCC, and MS-DRG gains,” she says. “The financial goals associated with advanced quality reviews in a mature program remain
somewhat ambiguous and difficult to pin down, considering all the variables involved."

Furthermore, McGinn worries about managing claims denials, which she handles personally.

"It doesn’t matter if the CDI staff capture one MCC if the auditors simply deny that claim," she says. "If it’s all just going out the door, then what’s the point? You really need to bulletproof the chart."

Because auditors sometimes have a look-back period of three years or more (meaning they can pull chart samples from the past), those attempting to shore up medical record documentation often feel stuck in a proverbial time warp.

"I always feel like we’re behind," says McGinn. "What we think to be optimal documentation now might not be considered best practice three years down the road. When I consider how the robust nature of the role and how far we’ve progressed in that regard from where we were three years ago, I just have to wonder how much more robust the documentation will need to become, and that’s daunting to think about."

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**FROM THE FORUM**

Productivity depends on record review expectations

The CDI profession often focuses on engaging providers and other medical staff members in documentation improvement efforts. However, CDI managers also need to examine productivity standards, accountability, and staff engagement.

Assessing the quantity of staff reviews does not gauge whether a CDI specialist performs a meaningful job related to physician documentation, revenue cycle, quality initiatives, or physician education, says Christina Rivera, RN, BSN, CCDS, CDI specialist at MedPartners in Tampa, Florida, in response to a recent ACDIS Forum discussion.

Related to CDI productivity standards, staff accountability, and daily CDI engagement, the staffers at one program, which covers a six-hospital network with 15 CDI specialists, are expected to review eight to 10 new cases per day and conduct 12–15 follow-up reviews per day.

At their facility, CDI specialists reconcile cases with coders and examine records with an eye toward mitigating Patient Safety Indicators (PSI). They also pursue “no response” queries and, after two follow-up requests with the provider, escalate the case to management. The network has a full electronic health record and CDI software program. However, many of the CDI specialists struggle to meet productivity benchmarks.

Productivity standards can be detrimental to a CDI program if the CDI leadership does not consider the program’s specific practices, Rivera says. CDI managers consider whether staff are on site or remote, fully electronic with integrated CDI query software or hybrid, supported by the physician and administrative staff.

“All these variables and more play a role in a CDI specialist job performance [and productivity expectations], in my opinion,” says Rivera.

In ACDIS’ 2016 CDI Productivity and Structure Benchmarking Report, the highest number (59.7%) of facilities review one to 10 new patient records per day. In addition, 31.8% review 11–15 records per day. Only 4.9% review more than 16 records per day, and no respondents indicated they review more than 25 records daily. These standards will
differ greatly depending on the size of the facility and the number of CDI specialists. (ACDIS will publish the complete report later this month, so check out the Survey section under Resources on the ACDIS website.)

When CDI specialists review the record for quality in addition to legacy targets such as CC/MCC capture, productivity will absolutely be reduced, says ACDIS Advisory Board member Paul Evans, RHIA, CCDS, CCS, CCS-P, clinical documentation integrity leader at the Sutter West Bay Hospital Administration in San Francisco.

As for the number of reviews a CDI specialist can feasibly do each day, Evans says 25 is much too high when quality review is involved. Additionally, the more coding rules and conventions CDI specialists must apply, the less “productive” they will be.

“Coding along with concurrent reviews performed by CDI specialists can be challenging and technically difficult,” says Evans. “[As a manager,] I do not sweat the small stuff, and ask my staff to review for limited factors—such as present on admission, confirmation or identification of major diseases—that one may expect to reasonably [affect] an important metric.”

CDI specialists at Vanderbilt University Medical Center must complete 13–16 reviews per day, which includes new and concurrent reviews, says Amy Stremming, RN, CCDS, a CDI nurse auditor at the Nashville facility. Their CDI specialists query for severity of illness/risk of mortality (SOI/ROM) and CC/MCC capture, as well as quality issues like PSIs and hospital-acquired conditions. Because it’s a teaching facility, most patients have multiple consult notes as well as regular daily progress notes, says Stremming.

“I agree that once you put quantity into the mix, quality may suffer,” she says. “There are so many variables between services and CDI specialists that should be considered.”

One ACDIS Forum member says there should only be two metrics to measure in terms of evaluating CDI effectiveness: response rate and provider agree rate. Too many metrics may skew the data, she says.

“Focus on what matters,” wrote another ACDIS member. “CDI specialists too often have to prove their worth to an institution.”

Stremming also tracks the financial impact of queries in addition to SOI/ROM. The laborious process to track financial gains from CDI queries requires the CDI team to identify what the payment would have been without the query, and then compare it to what was actually billed.

By showing the clear financial gains alongside quality improvements, the number of cases a single CDI specialist reviews each day becomes less significant.

“For executives who do not have a clear grasp on the concepts as CDI specialists, the quality and financial metrics [combined] speak volumes,” says Stremming.

While financial metrics are useful, Don Butler, RN, BSN, CDI manager at Vidant Health in Greenville, North Carolina, cautions against their limited representation of CDI’s broader contribution. Other measures should be tracked ahead of financial gain to understand program processes, outcomes, successes, and opportunities.

“Present the financial successes separate from quality metric when discussing the benefit to the organization with executive leadership,” says Butler. “Otherwise, you’re selling CDI programs and their successes short.”

No single metric, or handful of metrics, will ever capture a comprehensive CDI program, says Katy Good, RN, BSN, CCDS, CCS, clinical documentation program coordinator for Flagstaff (Arizona) Medical Center. While it is impossible to throw out metrics entirely, managers need to ensure data shows that CDI specialists work and are affecting the medical record, says Good. Her facility tracks a number of things, including review amounts, query rates, response rates, agree rates, case-mix index, and CC/MCC capture. Additionally, anyone who uses the data needs to understand how to use it properly, she says.

“There are issues with all the metrics,” says Good. “But the reality is that we have to track something. Anyone using these metrics must understand that, in isolation, they are meaningless, but they can be tools that potentially guide us to identification of successes and areas of opportunity and improvement.”

Editor’s note: This article’s content was taken from a couple of recent posts on the ACDIS Forum. To participate in this discussion, or other discussions on the forum, click here.
Catapulting case management and CDI coordination

A physician admits a patient with dementia, yet provides no further definitive diagnosis. The CDI specialist recognizes the scenario as similar to a case reviewed the week before, so she reaches out to the case management (CM) team to see whether they have additional insight. The CDI specialist believes the dementia is due to the elderly patient’s inability to self-medicate appropriately, so CDI and CM bring the case back to the physician, who agrees and documents the additional information in the medical record. That documentation, in turn, enables the case management staff to recommend alternative discharge plans, including greater supervision of the patient’s medication intake.

That’s just one example of how beneficial open lines of communication between the CDI and CM teams can be. And while most CDI programs report to HIM, the 2016 CDI Salary Survey shows nearly 15% of the more than 1,000 respondents report to CM. There’s a synergy there, to be sure, but those managing CM and CDI programs warn against too much overlap and emphasize the need for collaboration, communication, and caution.

The common denominator is change. Change and clinical thinking, critical thinking, regardless of department.

Julie Anne Tardi, RN, CCDS

As the ICD-10-CM/PCS implementation date neared, Ashworth won support for additional CDI staff members and leveraged their efforts on educating physicians about documentation needs, increasing her staff to nine and adding a dedicated manager over each team.

In the beginning, CDI efforts were “a work in progress,” Ashworth says. CDI staff thought management only cared about CM issues, and the CM felt management focused more on CDI concerns. CM staff thought CDI nurses focused only on record reviews for optimizing coding data, while CDI thought CM only looked...
at length of stay (LOS) and inpatient admission criteria. They only saw the slim line of what they thought the other team’s principal function to be and “couldn’t see how it worked together,” Ashworth says.

“Getting people to understand their contributions to the bigger picture is one challenge I struggle with,” says Anna Winkowski, who worked in outpatient CM in Chicago when CHRISTUS St. Frances Cabrini Hospital in Alexandria, Louisiana, offered her a job two years ago as manager of its CM and CDI department.

Back at Jackson Madison County General Hospital, each team now has the support of additional staff and direct managers. The teams hold monthly departmental meetings that provide an overview of everyone’s efforts. They reinforce the need to bring documentation deficiencies forward to the appropriate individuals as needed. The CM team asks CDI to help with physician education on repeat documentation concerns. The CDI team contributes information that might help ensure the accuracy of the LOS, as well as reviewing records for present on admission, hospital-acquired conditions, and other areas of overlap.

“The days of ‘this is my job and I don’t care what you do’ are over,” says Ashworth. “In healthcare, everything depends on everyone else. Be it transport or dietary or coding or case management or CDI, every bitty piece that everyone does matters. Being able to hear what each other does and how it matters helps us all.”

**Marriage woes**

When CM and CDI work collaboratively, the potential for improved patient outcomes increases, agrees Julie Ann Tardi, RN, CCDS, CDI specialist with Nthrive, based in Alpharetta, Georgia.

Consider the following scenario. A physician admits an elderly woman and places her on a ventilator. The CM staff reviews the record but doesn’t pursue any additional reviews or inquiries because the patient meets medical necessity for an inpatient admission according to InterQual protocols. The CDI reviewer, however, queries the physician because the documentation doesn’t include any codable diagnosis. Such situations illustrate the need for case managers and CDI staff to work closely together, says Tardi. The CM team can see the whole picture clinically and understand what’s going on with that patient, yet without specific documentation of whether the patient came to the ED in respiratory failure or whether the ventilator was related to an elective intubation, the coders cannot accurately depict the care provided.

In her previous role as director of CM and CDI at a Florida-based hospital, Tardi’s team started off relatively small with 12 staff members, but she helped grow it to a robust team of nearly 40 staff members encompassing both CDI and CM. “Traditionally, all these departments are divorced from each other—siloed. We needed to get some recognition of the interconnectedness of these groups for the sake of the patients,” she says.

It wasn’t easy. “Some staff had been in these roles for many years and were married to the way they traditionally did things,” says Tardi. Advancements in payment reform, however, are pushing organizations to look past checklist methods of assessing patient admissions and adopt broader considerations related to clinical validation, medical record documentation support, readmission reduction efforts, and present on admission indicators, among other items.

“It’s no longer a simple cookbook recipe that case managers can follow step-by-step,” Tardi says, but a collaborative, critical assessment of the patient’s conditions, medical record documentation, and regulations governing patient care and assessment.

“The common denominator is change,” says Tardi. “Change and clinical thinking, critical thinking, regardless of department.”

**Shared priorities**

Take another example from Jenny Prescia, MSN, RN, ACM, CCDS, NE-BC, director of case management at Northwestern Lake Forest (Illinois) Hospital. In a casual conversation with a CM staff member, a physician reveals telling an abusive spouse not to hit his wife anymore. Unfortunately, that conversation with CM took place a week after the physician saw the spouse’s wife in the ED. The physician never documented the abuse and hadn’t brought CM into the loop. Such
anecdotes represent one reason Prescia believes CDI and CM teams need to work closely together. Had the CDI specialist noticed evidence of the abuse in the medical record and brought it to CM’s and/or social workers’ attention, the team may have been able to secure more appropriate discharge planning or helped the patient obtain outpatient support services or housing.

“We can change patient outcomes,” she says.

Prescia actually oversees CM, CDI, recovery auditor and denials management, social services, and outpatient orders management, among other items. One of the benefits of working in a small hospital (Lake Forest has just over 200 beds), she says, is that “I know everything about everything.”

Although CDI and CM teams at Lake Forest traditionally shared duties, Prescia says neither team seemed to excel or even progress with related efforts. “We weren’t getting anywhere on physician education,” she says. “I knew we needed to do something.”

In January 2016, Prescia separated CDI from CM and refocused efforts on traditional responsibilities associated with each department. Within six months of making the move, the team improved the case-mix index to 6%, getting it to within 80% of national norms.

“We hadn’t realized how surface-level our CDI efforts had been until we separated the duties,” says Prescia.

Both teams continue to collaborate on LOS and transition planning. Because CDI staff enter the working DRG into the EHR, they can also provide thoughtful insight to the CM team about what conditions the physician may be treating and alert CM staff if outstanding queries could improve the expected LOS or affect discharge planning. Conversely, the CM team can use the EHR to run reports highlighting which patients passed their expected LOS and bring those cases to the CDI team for review if necessary.

At St. Frances, Winkowski’s CDI team bounced around from department to department, first in CM and then in quality, where staff were expected to help with core measure reviews. Its current iteration, back under CM, employed formal CDI training (two staff members attended a CDI Boot Camp session in New Orleans), and while staff initially reviewed records principally to identify CC/MCC capture and reviewed only DRG payers, they now review all payers and help CM with LOS concerns.

“Specificity of the documentation plays a huge part in obtaining an accurate LOS expectation,” she says. “That specificity could be simply laterality or Gram-negative versus Gram-positive pneumonia, but each detail matters.”

CDI staff review records by hospital unit and join other hospital disciplines during daily “huddles” or rounds. “We have a really good relationship across the departments,” says Winkowski. “Each team also serves as subject expert for each other, and CM staff knows if something is going on they can ask the CDI staff to look at the record.”

Like Ashworth, Winkowski has a CDI program coordinator who tracks productivity and identifies areas of additional opportunity and education for her staff. Overall, Winkowski manages nine CM staff, six social workers, three utilization review nurses, four CDI staff members, and three patient intake staff.

“It’s a good group of women,” she says. “I really enjoy their personality, collectively. Every morning I stop by and say hi, and if I’m feeling sad they pick my spirits up.”

While Rudy Braccili Jr., MBA, CPA, CRCE, executive director of revenue cycle services at Boca Raton (Louisiana) Regional Hospital, hasn’t combined CM and CDI at his facility, he’s heard of more and more hospital bringing their teams a bit closer together. At Boca Raton, CDI staff review core measures along with hospital-acquired conditions, while medical necessity reviews to ensure appropriate inpatient admissions remain under the purview of the CM team, he told ICD-10 Monitor during its September 19 Talk Ten Tuesday web broadcast.

Braccili’s CDI team is “looking for the reality of what happened and making sure it gets documented,” he says. Those considering tighter relationships between CM and CDI need to “measure each of your CDI program goals to see what’s right for your hospital.”
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Bundled payments and the role of CDI

CMS continues to transition from volume-based to value-based payments and Alternative Payment Models (APM), including bundled payment models, with the goal to have 30% of its payments tied to APMs by 2016 and 50% by 2018.

In 2011, CMS sought out providers to test four broadly defined bundled payment models, which evolved into the voluntary Bundled Payments for Care Initiative (BPCI) project. In 2013, more than 500 organizations signed on to test whether grouping payments by episode of care could help improve quality and lower costs.

As of October 1, 2015, 1,500 providers were participating in BPCI, and in April 2016, CMS instituted its first mandatory bundled payment model, the Comprehensive Care for Joint Replacement Model (CJR).

Trying to convince providers that good documentation has “something in it for them” is an everyday struggle for many CDI specialists. Bundling provider and hospital payment into a lump sum, and incentivizing financial and quality performance, could represent a long-term solution to that age-old question. With the high number of proposed changes and additions to CMS’ existing bundled payment models, here’s what CDI specialists need to know.

Defining bundled payments

Bundled payments, sometimes referred to as episode-based payments, reimburse hospitals and providers based on expected costs for clinically defined episodes of care.

These payment arrangements include financial and performance accountability for episodes of care and reward or penalize organizations based on levels of expenditure.

There are two different types of bundled payment models, though healthcare professionals often confuse or lump them into one program, says Cheryl Ericson, MS, RN, CCDS, CDIP, manager of clinical documentation services with DHG Healthcare, who spoke on the subject in a recent edition of ACDIS Radio. These models include:

1. Voluntary or elective models (BPCI)
2. Mandatory models (CJR)

Initially, the BPCI was voluntary. The program offers four models of payment, and organizations pick from 48 DRGs for their clinical episodes that will be grouped together and monitored, says Ericson.

In the beginning, participating organizations are not incentivized or penalized for quality performance, though it is monitored.

Unfortunately, participation in the BPCI wasn’t as high as CMS anticipated. To elicit more participation, CMS implemented mandatory bundled payments, including the CJR bundled payment model.

The agency picked 67 metropolitan statistical areas and required hospitals in those regions that were not already involved in a BPCI to participate. Quality performance in the CJR is monitored and does factor into rewards and penalties.

In general, the thing to keep in mind with bundled payments is that they cover an episode of care that starts with an anchor DRG assignment, says Ericson.

Once a patient is admitted for, say, a total hip or knee replacement, that will start the clock, and for 90 days following the patient’s discharge, subsequent Medicare Part A and Part B payments will be rolled into that episode of care, she says.

Advancing care coordination

In addition to existing voluntary and mandatory bundled payments,
CMS proposed development of bundled payment models for cardiac care and hip surgeries in a July 25 announcement. If approved, these new episode-based payments would be implemented July 1, 2017, though agencies including the American Hospital Association expressed their concern regarding the expedited expansion.

These models would reward hospitals that work with providers to avoid complications, prevent hospital readmissions, and speed recovery. The proposed rule also would expand the existing CJR model to include other surgical treatments for hip and femur fractures beyond hip replacement, says Ericson.

Specifically, CMS is looking to include acute myocardial infarction and coronary artery bypass graft. Participation in the new models will be mandatory for 98 randomly selected hospitals, including the 67 facilities already using the CJR model. CMS would phase in implementation of the new payment models over five years, says Ericson.

A number of the proposed changes and requirements have to do with the “behind the scenes” APM approach to healthcare reimbursement, says Ericson. Traditionally, Medicare Part A covered the inpatient stay and Medicare Part B covered the provider services. However, bundled payments encourage a coordinated effort for all hospital and provider services that occur within the patient’s 90-day episode of care, and will be “bundled” into the reimbursement, including postacute care, such as inpatient rehabilitation.

A quality component for these payment models affects whether an organization gets rewarded or penalized. The hospital will be paid by the applicable MS-DRG. However, there is a target value, and if the hospital has an actual price below the target price, it will be eligible for a reward or inventive.

Depending on how the facility performs on quality, it might lose the incentive for poor performance or get an additional reward for good performance.

“We’re going to start seeing more of an emphasis on the quality component,” says Ericson, “including the episode-based payments that will be potentially coming out in 2017.”

**CDI role in bundled payments**

New CDI programs may not be involved in bundled payments, says Ericson. This initiative is typically tackled by more mature CDI departments due to the complexity of the process.

However, departments with the knowledge and capability can dig into this type of documentation, as it has a significant effect on reimbursement. Cheryl Ericson, MS, RN, CCDS, CDIP
organizational operations and reimbursement, she says.

The established CDI department helps with DRG maximization, which affects the target prices under bundled payments, Ericson says. Additionally, CDI specialists can help validate ICD-10-PCS coding, which can assist in determining whether the patient has a condition that falls under a bundled payment model.

Confirming elective procedures is one thing CDI programs may not think about that does affect quality, including Patient Safety Indicators. “This seems pretty basic,” Ericson says, “but a lot of us don’t validate whether a procedure is elective, and those are the ones that are going to be included in this measure.”

Additionally, CDI staff can help educate providers and those involved with care coordination, says Ericson. CDI professionals should work across the continuum of care to ensure all healthcare professionals involved understand what affects bundled payments.

For example, a patient’s discharge disposition affects whether the organization is reimbursed under a bundled payment model. When a patient leaves against medical advice, that will exclude the patient from this population, Ericson says.

CDI programs focused on the inpatient setting and traditional fee-for-service methodology can verify the status of all present on admission (POA) conditions, says Ericson. CDI specialists often work to capture conditions like sepsis as POA, as they can affect sequencing.

However, for organizations using bundled payment models, CDI professionals should verify all POA conditions. CMS risk-adjusts target prices—higher reimbursement for higher-risk patients—based on those conditions present prior to the indexed admission. Chronic conditions POA can help with that risk adjustment, Ericson says.

These types of reviews can also serve as a stepping stone toward expanding CDI efforts into the outpatient setting, focusing on risk adjustment to explain poor outcomes, Ericson says.

Risk adjustment is based on condition categories, so CDI specialists tackling this aspect of bundled payment reviews should familiarize themselves with these conditions, as CDI professionals may not look out for them since they don’t often result in a CC or MCC.

“Adverse things do happen to patients, and we do have complicated patients,” says Ericson. “We want to make sure [documentation] accurately reflects the patient’s condition and the care provided.”

Going forward

For those CDI programs that are new to bundled payment concepts, Ericson offers two pieces of advice.

First and foremost, CDI must know its mission. If a mission is extremely broad—such as “quality”—operationalize and clearly define what quality is and how CDI efforts affect it, and establish measurable goals. Continuously monitor performance and improvement in the determined measures, says Ericson.

Second, take the opportunity to engage physicians, she says. Bundled payments affect provider reimbursement. CDI professionals should take advantage and engage or re-engage providers, especially surgeons, who are notorious for their indifference toward CDI efforts.

“Make sure they understand the importance of giving a complete and accurate picture of patient health,” says Ericson.

Editor’s note: ACDIS Radio is a free, bimonthly web-based discussion with industry experts and stories from practicing CDI specialists.
PEDIATRIC CONCERNS
Six tips to improve developmental documentation

by Valerie Bica, BSN, RN

Providers often document “global developmental delays” in pediatric charts. The phrase is used to describe when a child takes longer to reach certain development milestones than other children the same age, such as walking or talking. Children with conditions such as Down’s syndrome or cerebral palsy may also have a global developmental delay.

To any pediatric provider or clinician, this term represents a combination of physical and mental challenges that may require extensive support and resource use. Many children with global developmental delays have comorbid conditions, and regardless of their admitting diagnosis, the presence of the delay affects code assignment and, in turn, reimbursement.

Many providers ask, “What’s the difference?” Developmental issues significantly affect all hospital and outpatient coding. In the world of risk-adjusted payment structures, these will contribute to the picture of a more severely ill child and may directly influence the reimbursement rate. The diagnoses add severity of illness and risk of mortality (SOI/ROM) to an inpatient chart. When documented, they indicate a child who requires more time from the provider, a longer hospital stay, and increased use of resources while hospitalized. The diagnoses may affect the patient’s ability to assume self-care, and the patient may require additional effort by nurses and providers.

When reviewing clinical documentation, CDI professionals and
providers must consider the following questions:

- Are there mild, moderate, severe, or profound intellectual disabilities? These diagnoses weigh heavily on the SOI/ROM in certain cases. They also predict an extended hospital stay and increased use of resources. If these disabilities are not specifically documented, a hospital may lose that SOI and, in turn, reimbursement. In addition, “severe” and “profound” intellectual disabilities add a CC in Medicare terminology.

- Is there expressive/receptive language delay? “Nonverbal” is not an interchangeable term and should not be written. Documentation must paint a complete picture of the child’s functional level. The information allows researchers to identify conditions noted in certain diseases.

- Are there gross and/or fine motor delays? Watch for documentation of “non-ambulatory” patients and query the physician as needed because these terms mean different things to different people. Once again, documentation should clearly indicate the functional level of the child and the need for intervention or ongoing therapy services.

- Are blindness or cortical visual delays present? Document any vision deficits. This information is obviously necessary to identify obstacles to independent functioning.

- Is the patient deaf? If the child goes on to receive cochlear implants, physicians should document the diagnosis to justify the significant expense.

- Does the patient experience dysphagia or oropharyngeal dysphagia? Check the speech therapist’s notes for the specifics of the dysphagia and document accordingly. ICD-10 codes require the identification of the particular phase of dysphagia for specificity. These diagnoses are useful for research purposes, as well as identifying a child who should be restricted from attempting oral feedings.

CDI professionals should “wave the red flag” for all children admitted with the general term “global developmental delay” in their history and physical. CDI specialists must determine the meaning of the term. Is this a child who has a simple apraxia, or is this a child who is totally dependent for all activities of daily living and existence? Our goal is a complete and specific medical record for each of the children we treat.

**Editor’s note:** Bica is the lead CDI specialist at Nemours/A.I. duPont Hospital for Children in Wilmington, Delaware. She has 35 years of pediatric/NICU nursing experience; is a co-leader of APDIS, the Association of Pediatric Documentation Improvement Specialists, an ACDIS networking group; and served on the 2015–2016 ACDIS Pediatric Respiratory Failure Work Group. Contact her at Valerie.Bica@nemours.org.

**DEVELOPMENTAL DOCUMENTATION EXAMPLES**

The following examples of documentation improvement opportunities related to developmental delays in the pediatric setting come from Valerie Bica, BSN, RN, lead CDI specialist at Nemours/A.I. duPont Hospital for Children in Wilmington, Delaware.

**Example 1**

Resident: “5-year-old girl with high-risk medulloblastoma s/p gross total resection in 2015, posterior fossa syndrome after radiation”

After clarifications: “5-year old girl with high-risk medulloblastoma s/p gross total resection in 2015, posterior fossa syndrome, seizures, oropharyngeal dysphagia, g-tube dependence, expressive language delay, gross and fine motor delay, suspected CMV viremia”

Benefit: A more complete picture of this child post-treatment, support for the request for all rehab services post-discharge, and complete research data for children with brain tumors

**Example 2**

Resident: “16-year-old male with chromosomal abnormalities, seizures, global developmental delays”

After clarifications: “Chromosome abnormality, chronic static encephalopathy, focal epilepsy, hypotonia, severe intellectual disability, diplegic cerebral palsy, severe expressive speech delay (nonverbal), mild persistent asthma, chronic lung disease with history of tracheomalacia, tracheostomy dependence status post-decannulation, recurrent episodes of pneumonia (viral, bacterial, and aspiration) requiring prolonged intubations in the past, GERD, dysphagia, and chronic constipation”

Benefit: This child has remained intubated/ventilated in the ICU for a prolonged period of time, but is physically unable to assist with movement and unable to understand directions to improve his pulmonary function. He will be sicker and stay longer. Dysphagia did require further clarification.
Electronic records change processes, interactions

The advent of the electronic health record (EHR) changed how CDI specialists work with providers and coders. Gone are the days of misplaced paper queries and handwriting woes. As more and more healthcare organizations take on the arduous process of implementing an EHR, new challenges and considerations arise.

At Beverly Hospital, a member of the Lahey Health system in Massachusetts, those struggles include less face-to-face time with providers, says Kathy McDiarmid, RN, CDI specialist at the facility.

Lahey implemented its EHR, Epic, and coding software, 3M 360, in August 2015—just a few months before the ICD-10-CM/PCS implementation date. The hospital provided education to providers and the CDI and coding teams for several months before the new systems went live, and continued to offer support afterwards. “Process-wise, it was as seamless as it could have been,” says McDiarmid.

Before going electronic, the CDI team struggled with inconsistent query processes, she says. Different providers wanted different things—some wanted queries in systems cannot be CDI-only or provider-only, or the efficiency of the system overall becomes problematic

Electronic records change processes, interactions
the chart, others wanted an email so they didn’t have to use the chart. The EHR streamlined that process. Now, queries don’t go into the record, but are filed by the CDI specialist through the EHR. All providers receive a notification via email, and they are expected to check their queries regularly. The CDI team worked with the vendor to create a separate query folder for each provider, so the queries don’t get mixed in with providers’ other emails.

Additionally, EHR implementation shifted CDI staff from the floors to the computer, which, at Beverly Hospital, means fewer interactions with providers. This has been the biggest transition, says McDiarmid.

However, CDI specialists are encouraged to meet with physicians in person, if needed, and tailor processes to ensure queries get answered. For example, some prefer to receive a text notification in addition to email when they receive a query. Others prefer electronic sticky notes, and the Epic system does offer this functionality—the notes appear in the record itself and serve as a reminder for providers to address their queries.

“As a team, we worked really hard to make sure everything works and that our processes and interactions were the best that they could be,” says McDiarmid.

Cape Cod Health in Massachusetts is currently implementing an EHR, and the CDI team is working with the IT department to develop a process for providers and CDI specialists working in the record, says Patricia Barry, RN, BSN, M.Ed, manager of clinical documentation integrity and education at both Falmouth Hospital and Cape Cod Hospital. Their concerns are similar to Beverly Hospital’s—keeping providers engaged in the query process. While Barry expects to come across some “traditional” EHR issues—copy and paste, note bloat, etc.—communicating queries to providers represents her principal concern.

Barry hopes to have an alert system that notifies the providers and brings them directly to a separate screen to answer the query.

By the end of the month, the EHR will be fully implemented, so Barry is meeting with physicians and leadership regularly to come up with best processes during the transition. She echoes McDiarmid’s sentiments on customizable features.

“CDI teams need to use their software to its fullest capacity,” says Barry. “Figure out how to get the most out of the system and use all features that benefit query and communication processes.”

**Vendor perspective**

From the vendor’s point of view, one challenge CDI teams face is taking separate systems—coding software and the EHR—and integrating them to make communication between providers and CDI easier, says Michael Bee, business director for the 3M 360 Encompass System. While there may not be a one-size-fits-all solution, opportunities exist for CDI programs to tailor tools and content to different users’ needs. For example, CDI specialists, coders, and providers need access to similar capabilities, functionality, and content, but their workflows are different. Successful technology recognizes each staffer’s needs and then connects them to ensure ease of communication.

“Systems cannot be CDI-only or provider-only, or the efficiency of the system overall becomes problematic,” says Bee.

EHRs do provide a number of opportunities for improved CDI processes. At Beverly Hospital, the query response rate actually improved, jumping from 76% to 84%. Engage with fellow CDI specialists, coders, providers, and leadership to ensure a seamless transition and new processes that benefit all parties, says McDiarmid. In addition, continue to evaluate the systems and brainstorm new solutions if issues arise.

“With any new system, there are issues that are going to have to be addressed,” says McDiarmid. “Work with your vendor, and work as a team, to customize the features to suit both physician and CDI needs.”
MEET A MEMBER

Excellent nursing documentation led to CDI career

When Claudine Hutchinson, BSN, RN, started working as a pediatric staff nurse at the Children’s Hospital at Saint Francis in Tulsa, Oklahoma, she didn’t know the first thing about clinical documentation improvement. In medical/surgical, orthopedics, hematology-oncology, and pulmonology, she developed a reputation for pristine documentation skills. After switching to the night shift as a pediatric float nurse for five years, Hutchinson decided it was time for a change and took her first job as a CDI specialist in October 2010.

Hutchinson met her fiancé a few years ago while hiking and is currently planning an outdoor wedding for next fall. Her daughter is studying to be a veterinary technician, and her soon-to-be stepdaughter is in the 11th grade and very active in the color guard. When she’s not working, Hutchinson spends time with her family, hiking, kayaking, and enjoying the great outdoors.

**CDI Journal: Why did you get into this line of work?**

**Hutchinson:** My former manager actually recommended me for the job because I had a reputation for having great documentation skills. It was a wonderful opportunity, and I looked forward to a change professionally and for my personal life. I needed more normal work hours with a teenager at home—the flexible schedule was a bonus.

**CDI Journal: What has been your biggest challenge?**

**Hutchinson:** Physician engagement. It improved from where it started, but also has a way to go. But who doesn’t love a challenge?

**CDI Journal: What has been your biggest reward?**

**Hutchinson:** My position was originally intended to be a pilot, temporary, six- to nine-month position. I was able to turn it into a permanent job. I would also say seeing the “light bulb” moment in a physician’s face when he or she understands the personal and global benefits of clear, concise, and consistent documentation. It’s a great feeling when a previously unengaged physician becomes engaged in CDI.

**CDI Journal: How has the field changed since you began working in CDI?**

**Hutchinson:** The growth in pediatric CDI and the number of available pediatric CDI resources. It will be exciting to see where the field goes from here.
CDI Journal: Can you mention a few of the “gold nuggets” of information you’ve received from colleagues through ACDIS?

Hutchinson: The ACDIS Forum has been a goldmine and a lifeline, especially in times of frustration or uncertainty as a solo pediatric CDI specialist. At my facility, acute respiratory failure has been a challenging diagnosis, and I have gotten many insights and tips from fellow CDI specialists from the forum and the numerous resources on ACDIS.

CDI Journal: What piece of advice would you offer to a new CDI specialist?

Hutchinson: Network with other CDI professionals. ACDIS is an invaluable asset. Join ACDIS and bookmark their site—you can find all sorts of resources and information. I recommend anyone working in CDI attend at least one ACDIS conference, as it is an excellent way to gain knowledge, resources, and to expand your knowledge on CDI and also network with others in the field.

I would also say don’t take things personally. We all have our good days and bad days. Try to remember that the same goes for physicians and residents. Try to start each day with a clean slate.

CDI Journal: What resource would you recommend for a new CDI specialist?

Hutchinson: Get the CDI Pocket Guide. I call it my CDI bible.

CDI Journal: If you could have any other job, what would it be?

Hutchinson: Owning and operating a dog or animal rescue shelter. I am passionate about animal rescue and adoption. Currently, I have five “rescues”—three dogs and two cats.

CDI Journal: What was your first job (what you did while in high school)?

Hutchinson: I worked at Baskin-Robbins. I loved it when I got to advance to making the ice cream birthday cakes and clown cones.

CDI Journal: Tell us about a few of your favorite things:

- Vacation spots: Anywhere I can hike.
- Hobby: Reading, watching movies, and listening to 80s music.
- Non-alcoholic beverage: Pepsi as an occasional treat.
- Foods: Chocolate, Chinese food, and a great burger with sweet potato fries.
- Activity: I am a runner at heart but had to give it up due to bad knees. Now I love hiking, kayaking, and walking with my fiancé and friends.

Editor’s note: Interested in being featured in our “meet a member” segment? Contact Associate Editorial Director Melissa Varnavas at mvarnavas@acdis.org.