CLINICAL DOCUMENTATION IMPROVEMENT ROAD MAP
THE CLINICAL DOCUMENTATION IMPROVEMENT (CDI) ROADMAP IS INTENDED TO PROVIDE INDUSTRY STANDARDS AND BEST PRACTICES FOR THE ESTABLISHMENT AND ONGOING MAINTENANCE OF CDI PROGRAMS.

Presently, the Roadmap includes guidance relevant to pre-CDI program implementation & implementation phases. Phases for ongoing maintenance & advanced CDI/program expansion will be added at a later date. The original Roadmap documents were reviewed & approved by the ACDIS Advisory Board and updated by the CDI Practice Guidelines Committee in 2018. Please note that these are only sample documents & policies. They are intended to be tailored to fit the individual culture and processes of a given hospital. Where links are provided readers will see their cursor turn into a hand icon indicating a live link.

DATE August 30, 2018
SIGNED ACDIS Practice Guidelines Committee
ROADMAP HIGHLIGHTS
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PRE-IMPLEMENTATION
The Clinical Documentation Improvement Universe

Now that you've been tasked with creating a CDI program at your facility you'll have a wide-range of research to tackle, analysis to perform, & education to plan & provide.

There are a number of reasons to implement a comprehensive CDI program--appropriate assessment of healthcare costs, government initiatives such as meaningful use related to electronic health record (EHR) creation, alternative reimbursement methods, greater specificity required by ICD-10-CM/PCS code sets, accountability for quality of care as well as improvement in healthcare data & tracking which holds implications for massive changes in population health throughout the United States.

Ultimately, CDI programs aim to close the gap between physician documentation & documentation needs for complete and accurate coding. Beyond this underlying premise, however, exists a myriad of intricacies which CDI leaders much consider & regularly re-evaluate in order to maintain their efforts & ensure the success of their programs.

This document will walk through a selection of these elements & provide a variety of helpful materials for programs to adapt to their own processes.


See also the following supportive materials:
- The Complete Guide to CDI Management
- The CDI Specialist's Complete Training Guide
- The Essential Guide to Provider Queries
Steering Committee

The steering committee should meet weekly until the start of the CDI program to keep the project moving forward & everyone on task. Subsequently, the committee may decide to meet monthly or quarterly to address ongoing CDI needs, program metrics, & program advancement opportunities.

Individual members of the committee should each have set responsibilities & action items to accomplish outside the regular meeting time. At a minimum the committee should include:

- Chief financial officer
- CDI director/manager
- Health information management (HIM) director/manager
- Coding director/manager (if separate from HIM)
- Information services/information technology (IT) (lead application developer or manager, to discuss the hospital’s capacities to track data, software capabilities, and electronic health record integration)
- Data analysis/management (to develop and run detailed reports for pre-program baseline analysis)
- Chief medical officer or vice president (VP) medical administrator
- Case management director/manager
- Director/VP of quality
- Director/VP of compliance
- Medical staff secretary (ad hoc member)
- Compliance (ad hoc member)
Project plan

As the steering committee begins its process, the team will need to identify the CDI program's objectives/purpose. As indicated on the previous slide, physician & administrative involvement at this stage cannot be understated. Additionally, the steering committee will need to determine whether outside support is needed in the form of an external consulting company, software or other vendor.

The committee may assign the CDI program director/manager the task of identifying budgetary needs for program creation. Such research should include:

- CDI salaries for set number of full-time equivalency staff members
- Salaries for CDI manager/director and physician advisor (if warranted)
- Infrastructure costs
- Consultant fees (if needed), training, software, and other necessary equipment

Additionally, ongoing costs for program implementation post-year one & two should be identifies as some pre-implementation and implementation costs may be eliminated & productivity expectations may improve as the team gains in experience. However, ongoing investments in staff education, training, technical support, certification, association membership and other costs should be included to paint an accurate depiction of the overall program costs.

See the following supportive documents:

- Goals and objectives of CDI
- CDI Journal article: Mission CDI: Guiding goals, values, and principles
- CDI Salary Survey
Project plan (cont.)

The committee should also assign an individual to research effective reporting structures & examine other CDI program structural concerns, such as:

- Broad baseline data from HIM, patient financial services, & case management (i.e., case mix index, number of discharges, unpaid claims, denials from commercial payers, Recovery Auditor denials) to determine pain points
- Structure & communication process for CDI and coding (i.e., how CDI staff will communicate with coders to resolve DRG assignments)
- Medical staff responsibilities & accountability (i.e., time frame for query responses)
- Development of physician overview/education & tools *(Note: Include physician input during this process. Provide examples of slides demonstrating the value of documentation (inpatient & outpatient) and its direct correlation to hospital & physician data.)*
- Development of pre-program education plan (how to train new CDI staff, who will provide training, best ongoing teaching methods for overall organization, etc.)
- The start date of program

See the following supportive documents:

- CDI Salary Survey: Salary Survey provides insight into CDI program reporting structure
- CDI Blog: CDI Reporting Structure
According to the 2018 ACDIS CDI Week Industry Survey, 34% of more than 500 respondents say their CDI program reports up through HIM followed by 23% reporting to revenue cycle/finance & a near tie of about 11% each reporting to quality, case management, & as its own stand-alone department.

*Source: ACDIS 2018 CDI Week Industry Survey*
Baseline data

Determine which data elements the steering committee should examine. Some options include:

- Current & past year(s) case-mix index
- Current & past year number of payer denials (medical necessity, denied days, etc.)
- Governmental audit-related issues (denials, MS-DRG/APR-DRG changes, etc.)
- Current & past year number of records in deficiency status
- Accounts receivable status
- Current & past year(s) coding turnaround times (work flow chart)
- Average number & type of coding queries (pre- & post-discharge) per month, if known
- Average length of time for physicians to respond to post-discharge queries, if known
- Program for Evaluating Payment Patterns Electronic Report

See the following supportive documents:

- 2017 CDI Journal: Your CMI dropped: What is (and isn’t) in your control
- 2017 ACDIS Radio: A Matter of Principal (Diagnosis)
- 2017 ACDIS Conference Presentation: Using Metrics to Strengthen Relationships Between CDI Specialists & Physicians
- 2014 ACDIS Radio: CDI metrics & monitoring
- 2010 CDI Blog: Guest Post: Metrics ideas & thoughts
Staffing

The steering committee & CDI manager/director will need to determine the appropriate level of staffing, pay scales, productivity expectations, & training. Job descriptions need to be created & onboarding plans developed. Contact human resources to help develop job descriptions/pay scales, & internal & external postings/advertising of job openings. At a minimum these should include roles for manager/director as well as CDI record reviewer & define the basic qualifications (e.g., years experience in healthcare, educational experience, certifications/credentials, etc.), the core competencies & skill sets required (e.g., clinical &/or coding focused backgrounds, analytical abilities, interpersonal qualifications, etc.), daily duties & responsibilities, performance evaluation criteria.

Determine number of FTEs for CDI team. Total number of FTEs will depend on:
- Payer types reviewed
- Total discharges
- Accessibility of medical record
- Other documentation duties & responsibilities assigned to the CDI staff
- Skill & knowledge of incoming staff

See the following supportive documents:
- CDI supervisor job description
- CDI specialist job description
- CDI specialist performance evaluation
- CDI specialist scorecard evaluation
- CDI specialist pre-hire assessment questions
- Variables affecting staffing standards
Staffing (cont.)

In developing job descriptions consider potential opportunities for future growth as well as immediate needs. ACDIS has a number of white papers and position papers which provide guidance on essential aspects of the CDI role. According to the 2014 Position Paper "Defining the CDI specialist’s roles and responsibilities," some core duties include:

- Review inpatient medical records on a daily basis, concurrent with patient stay, to identify opportunities to clarify missing or incomplete documentation.
- Collaborate with providers, case managers, coders, and other healthcare team members to facilitate comprehensive health record documentation that reflects clinical treatment, decisions, diagnoses, and interventions.
- Use the hospital’s designated clinical documentation system to conduct reviews of the health record and identify opportunities for clarification.
- Follow-up on posted queries to ensure physician response and appropriate documentation.
- Provide education related to clinical documentation issues within the healthcare organization.

See additional ACDIS White Papers and resources:

- CDI: More than a credential
- Developing effective CDI leadership: A matter of effort and attitude
- Cornerstone of CDI success: Build a strong foundation
- Keep staff growing and engaged with a CDI career ladder
- 2017 CDI Journal, "Developing an onboarding process: Advice from the field"
Staffing (cont.)

In determining pay scales, a little research goes a long way. ACDIS publishes a yearly salary survey which provides some perspective on compensation packages for the role. Back in 2012, more than 50% of respondents reported earning $69,999 or less. In 2017, however, only 20% earned that amount. And those earning the lowest, $59,999 or less, fell by 4% year-over-year from 10% to 6%.

The largest number of respondents (20%) report earning $70,000-$79,999—the typical salary over the past three years—and those earning the next highest payment bracket of $80,000-$89,999 increased from 17% to 19%.

Be sure to check the ACDIS site for the latest data & to tailor that data as appropriate to both the geographic region & the setting type (rural, suburban, urban) as these location differences can swing salary ranges significantly.

<table>
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<th>CDI salaries</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
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<td>$59,999, or less</td>
<td>25.7%</td>
<td>18.1%</td>
<td>16.80%</td>
<td>8.6%</td>
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<td>$60,000-$69,999</td>
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</tr>
<tr>
<td>$70,000-$79,999</td>
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</tr>
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</tr>
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<tr>
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<td>14.40%</td>
</tr>
</tbody>
</table>

Source: 2017 Salary Survey: Salaries continue to grow, but participants are less optimistic than in the past
Staffing (cont.)

Hiring staff from within the hospital ranks often works well for new programs as these individuals are familiar with facility protocols & frequently have ongoing working relationships with many of the key players involved in CDI. However, those hailing from coding backgrounds could require additional training in pathophysiology & clinical concerns while those from nursing backgrounds may need coding, compliance, & query training.

In the pre-implementation phase, the program leadership team needs to address how to provide training if all CDI staff do not have the same start date.

Managers need to determine productivity levels and adjust assessment of staff who spend time helping to train newer members of the team, as well.

For example, will there be additional training provided for those who miss the initial rollout & how will record reviews be conducted in relation to the onboarding/training schedule (i.e., will staff have a week of training & then begin reviews, or will reviews be conducted during training?)

Regardless of how training is conducted (either internally or through a consultant), the program leadership needs to develop a competency assessment following completion of training tailored to the facilities specific needs & expectations for its staff to ensure new staff retain important concepts & don’t lag behind as training complexities increase.

Program leaders should also consider developing an inter-rater reliability process to ensure consistency among CDI staff & validation of their work.

Many programs implement peer-to-peer auditing of queries to identify missed opportunities & to encourage shared learning in a collaborative environment.
Staffing (cont.)

As important as those initial days on the job will be, CDI program leaders will need to identify tools that the CDI team can leverage for ongoing, on-the-job, reference to support query creation & physician engagement. CDI staff may benefit from having query forms or sticky flags to mark the record in the early days as they practice their new craft. Paper or electronic worksheets can help new staff keep track of their record reviews & help managers identify where new staff may be faltering in their learning or effectiveness.

Leaders should consider developing or purchasing reference tools such as:
- CC/MCC common diagnoses list or tip sheets
- Clinical references such as UpToDate or Epocrates subscriptions
- CMS tools (i.e., MedLearn Matters, etc.)
- Basic coding/DRG guidelines/books; &/or iPad®/laptop

For those opting to mentor &/or train new CDI professionals in-house, ACDIS recommends:
- CDI Apprenticeship or CDI Essential Skills eLearning Library
- The CDI Specialist’s Complete Training Guide, Second Edition
- CDI Workbook: Investigating Complex Cases & Formulating Queries
- Clinical Documentation Improvement Boot Camp® Online
- ACDIS membership
Physician training/program promotion

As CDI professionals aim to improve the capture of clinical information in the inpatient medical record, they need support from physicians, the ones legally responsible for patient care & the documentation thereof. Rolling out a successful CDI effort therefore requires not only support from hospital administrators but from the physician & provider staff--from the chief medical officer down to the hospitalist.

Work with the CDI & coding staff to develop high-level overview education regarding the purpose & mission of the CDI department. Also identify specific focus areas that the CDI team will review & query for, & provide targeted education to physicians specializing in those areas. Additionally:

- Ask the medical staff secretary to schedule provider/physician education meetings.
- Invite the medical staff & publicize educational sessions.
- Obtain physician CEUs to facilitate attendance.
- Solicit support of physician champions of the program in the promotion of education meetings.
- Provide one-on-one follow-up education with physicians as requested or needed.
- Consider incorporating either a CDI physician advisor or champions into the CDI team.

ACDIS also provides the following related physician training tools:
- The Physician Advisor's Role in CDI Boot Camp
- CDI Mail: Ongoing Physician Training
- Clinical Documentation Essentials for the Hospital Resident
- CDI for the Clinician Online Learning
- Clinical Documentation Essentials for the Hospital Provider

See the following supportive documents:
- CDI 101 for docs
- CDI new resident orientation presentation
- CDI physician advisor responsibilities
- MD Documentation Guide
- How to build a DRG video
PHASE 2: IMPLEMENTATION
CDI workflow

Special considerations regarding the workflow of the clinical documentation process need to be determined. Undoubtedly, the steering committee will need to consult with its coding & HIM members, work with the IT department to understand EHR capabilities, & shadow physicians as they document to determine the best method(s) for query & education practices.

More specifically, programs need to determine when to conduct:
- Initial health record reviews
- Follow-up reviews
- Post-discharge pre-bill reviews
- Retrospective reviews

Additionally, programs need to determine program priorities as it is often impractical to set high productivity goals for reviews of all hospital discharges early in a program's life-cycle.

Specifically, programs need to determine:
- Which payers to review (Medicare, Medicaid, private payers, principal payers within a system, etc.), if a comprehensive review of all payers is not possible
- What service lines will be reviewed, if a comprehensive review of all services is not possible
- How to assign CDI staff reviewers (by unit, specialty, or physician)
CDI workflow (cont.)

Certain coding related functions & interactions need to be addressed when further defining CDI workflows such as whether CDI staff will establish a preliminary (pre-review) MS-DRGs, a working (any DRG changes due to query efforts) DRG, & post-discharge DRG assignment reconciliation. Although concurrent coding models haven't traditionally had much traction in CDI programs, some facilities may wish to research this & determine whether such efforts may prove fruitful.

50% percent of 2013 respondents do some concurrent coding, primarily in order to assign a working MS-DRG, but coders perform coding retrospectively.

"Concurrent coding efforts are limited in CDI practices," *CDI Journal*, vol. 7, issue 1
You definitely have to do your research & get your key players involved. [You] want to get everybody to agree on one thing [policy and process]. Historically, we’ve included lots of people on decisions, & I think we’ll continue doing that. [You] need to formalize procedures & processes so everyone knows what to expect.

Jeff Morris, RN, BSN, CCDS
ACDIS Advisory Board member
"The buck stops here: CDI escalation policies," CDI Journal, vol. 12, issue 2
Policies & procedures (cont.)

Once the steering committee & the CDI team have developed their workflow, they can begin to draft policies & procedures around that workflow, integrating these documents with the program's mission, vision & overarching focus.

Doing so provides concrete support to the CDI team regarding their efforts & ensures that each member of the team remains steadfast to the same standardized best practices. It bears repeating that physician involvement in policy & procedure creation helps ensure their support in CDI efforts.

At a minimum CDI programs should consider creating policies regarding:

- Standard operating procedures (typical workflow concerns)
- Query compliance (in adherence with ACDIS and the American Health Information Management Association [AHIMA] best practice recommendations)
- Query retention
- Unanswered queries & query escalation
- CDI/coding MS-DRG reconciliation
- Conflict resolution
- Ongoing team auditing & process monitoring

See the following supportive documents:
- CDI query policy
- CDI unanswered query escalation policy
- Standard operating procedures for queries

See the following additional materials from ACDIS:
- 2016 update ACDIS/AHIMA "Guidelines for Achieving a Compliant Query Practice"
- 2016 ACDIS Radio: "Implementing a policy and procedure"
- Procedure: Overall CDI program processes
- 2013 ACDIS Journal, "Escalation policy addendum added to new AHIMA/ACDIS query practice brief"
- 2013 ACDIS Journal, "Conduct peer audits to provide query practice insight"
75%

The amount of programs which use facility-wide query policies for all query types—written, electronic, and verbal.

2017 Physician Queries Benchmarking Survey

Policies & procedures (cont.)

If you make a query process that the physicians can understand, you don’t have to spend every moment explaining how to read & understand the query.

Mark Dominesey, MBA, RN, CCDS, CDIP, CHTS-CP, the manager of excellence in clinical documentation at Children’s National Medical Center in Washington, D.C.

Does your facility have standard query policies & procedures?

Yes, for all types 74.52%
Yes, but they only apply to written queries 6.93%
Yes, but they only apply to coding staff 2.22%
No 9.70%
Don’t know 6.65%
Policies & procedures (cont.)

The most important of these policies & procedures during the implementation phase of CDI efforts is the query policy. Consider the following components in your policy:

- Integration of ACDIS/AHIMA query guidance
- Criteria of when it is appropriate to issue a query
- How queries will be presented to the medical staff (i.e., paper, electronic, verbal)
- Query follow-up process (i.e., how quickly queries must be answered/resolved)
- When to assign “no response” versus when to follow up on an unanswered query

The steering committee (or by this point the CDI department leadership) will need to define the relationship between CDI & coding departments to ensure both teams follow compliant practices & are not duplicating or complicating query efforts. Determine:

- Will coding also issue queries?
- Who will follow up on open queries following discharge?
- Who will issue queries that arise from the coding process?
- How will coding/CDI resolve MS-DRG contradictions?
- How will coding/CDI escalate questionable coding/documentation situations?
- How will coding/CDI handle lack of physician query response?

See the following supportive documents:

- Unanswered query & query conflict escalation policy
- Escalation policy: Unanswered queries

See the following materials from ACDIS:

- 2017 CDI Strategies, "Note from the Instructor: Be wary of verbal query compliance"
- 2015 CDI Journal, "Note from the Advisory Board: Create a CDI/coding reconciliation process"
- 2015 CDI Journal, "Ask ACDIS: Escalation policies and clinical validation queries"
- 2010 Conference, "The clinical/coding reconciliation process"
Programs need to develop baseline expectations regarding staff productivity, return on investment, & alignment with core objectives & program mission with an understanding that these measurements may shift as the program staff gains in proficiency & review targets change.

At a minimum, programs should track:

- Number of records reviewed
- Number of records with query opportunities
- Number of queries issued
- Type of query (i.e., yes/no, open-ended, multiple-choice, etc.)
- Reason for query (i.e., clinical indicators without diagnosis)
- Physician response to query (agree with query & provided documentation, disagree with query, no response)
- Timeliness of physician response (in relation to established policy on the matter)
- MS-DRG shift (from initial to working to final coded)
- Severity of illness/risk of mortality shifts
- Educational hours (for both internal CDI staff learning & time required for building & delivering physician education)
Measuring Program Efforts (cont.)

- Determining acceptable levels of productivity for CDI staff can be an overwhelming task. Although many organizations prefer a single national standard for calculating CDI productivity (e.g., a set number of new reviews & re-reviews per CDI specialist per day), frequent regulatory changes & broad diversity within the industry prohibit a one-size-fits-all approach.
- CDI productivity is influenced by a number of intrinsic & extrinsic variables such as the review focus or mission of the CDI department, the defined role of the CDI staff within the organization & their experience with the tasks, how much data each CDI specialist must track & enter during chart reviews, the complexity of the assigned patient population, availability of supplemental resources (i.e., technology), & the format of the health record (i.e., electronic or hybrid).
- As industry demands evolve & responsibilities change, CDI managers will need to adjust their productivity expectations & will be challenged in setting both qualitative and quantitative productivity goals.

Source: ACDIS White Paper: Set CDI productivity expectations
Miles to go...

Phase 1 & 2
Summary
Mission & Vision

The Association of Clinical Documentation Improvement Specialist has as its mission "to serve as the premier healthcare community for clinical documentation specialists, providing a medium for education, professional growth, program recognition, and networking."

To that end, those working in the CDI field have graciously provided ACDIS with a wide variety of sample tools and materials in order to help facilitate the growth of CDI programs throughout the nation. ACDIS abides by the sentiment that a rising tide carries all boats and together we can elevate the profession and better serve the underlying goal of ensure the most appropriate documentation is captured in the medical record.

ACDIS will continue to solicit and curate materials from the CDI community and it encourages donations to its resources section. To donate materials or to serve on one of its volunteer boards please contact, the ACDIS leadership team.
Roadmap reminder

Presently, the Roadmap includes guidance relevant to pre-CDI program implementation & implementation phases. Phases for ongoing maintenance & advanced CDI/program expansion will be added at a later date. The original Roadmap documents were reviewed & approved by the ACDIS Advisory Board. The Roadmap was updated by the CDI Practice Guidelines Committee in 2018. Please note that these are only sample documents & policies. They are intended to be tailored to fit the individual culture and processes of a given hospital.
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