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

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

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

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

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

CDI and quality

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

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

LeBlanc says his CDI department took on PSI review due to some poor outcomes data and immediately found opportunities where CDI could help. “Sometimes ‘elective’ hadn’t been updated to ‘emergent’ when it should have been—a burn victim through the ED didn’t elect to come in, but due to an EHR documentation
error they were reported as emergent,” he says. “A PSI excludes all emergent admit types, so you have to make sure you get that right. We were able to turn those around and resubmit the data.”

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

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

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

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

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

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

### Program monitoring

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

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

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

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

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

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

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

### ICD-10 delay and preparedness

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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**Physician engagement**

Most survey respondents (60.8%) have a physician advisor to CDI. 45.7% are employed in a part-time capacity, while only 15.1% are full time.
is different from the model presented in the survey, which asked respondents if they had an escalation policy backed by the medical executive committee.

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

Electronic health records

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

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

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

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

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

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

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

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

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

Career advancement

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

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

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

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

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

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

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

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

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

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About the Clinical Documentation Improvement Week survey advisor

Mark LeBlanc, RN, MBA, CCDS

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

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

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