Establishing a CDI Program: How One Organization Leveraged Nursing and Coding Skills to Improve Clinical Data

By Barbara A. Lopez, BS, RHIA

Establishing a clinical documentation improvement (CDI) program is an organization-wide, transformational process that affects a hospital's culture, reaching across all disciplines and touching every colleague and the way they perform their jobs. Many factors can lead healthcare organizations to establish a CDI program, such as Recovery Audit Contractors, hospital and physician performance report cards and Centers for Medicare and Medicaid Services (CMS) public forums, and the upcoming ICD-10-CM/PCS implementation.

CDI programs require organizations evaluate their current state, including staffing, training, workflow, budget, and technology. St. Mary Medical Center in Langhorne, PA, took a methodical approach in establishing its CDI program, relying on guidance from CMS and calling on the clinical documentation expertise of coders and nurses.

Developing a CDI Blueprint

Staffing the CDI positions was the biggest challenge for St. Mary Medical Center, forcing the data integrity manager to think outside the box. Hiring experienced, credentialed coders is not an easy feat with the current shortage, and finding nurses with both coding and CDI knowledge is like finding a needle in a haystack. Waiting to hire either type of candidate was not an option for St. Mary Medical Center. Therefore, it took a step back and looked at the whole picture to come up with a staffing solution, which became its CDI blueprint that developed into a formal CDI program.

The blueprint was based on a combination of research, white papers, the November 2007 report to Congress titled "Plan to Implement a Medicare Hospital Value-Based Purchasing Program," and the CMS Quality Improvement Road Map. The report to Congress on the value-based purchasing program outlined CMS's goals, timelines, scope of work, and work components. The goal of the program is to implement pay-for-performance, with the current Core Measures as the building blocks.

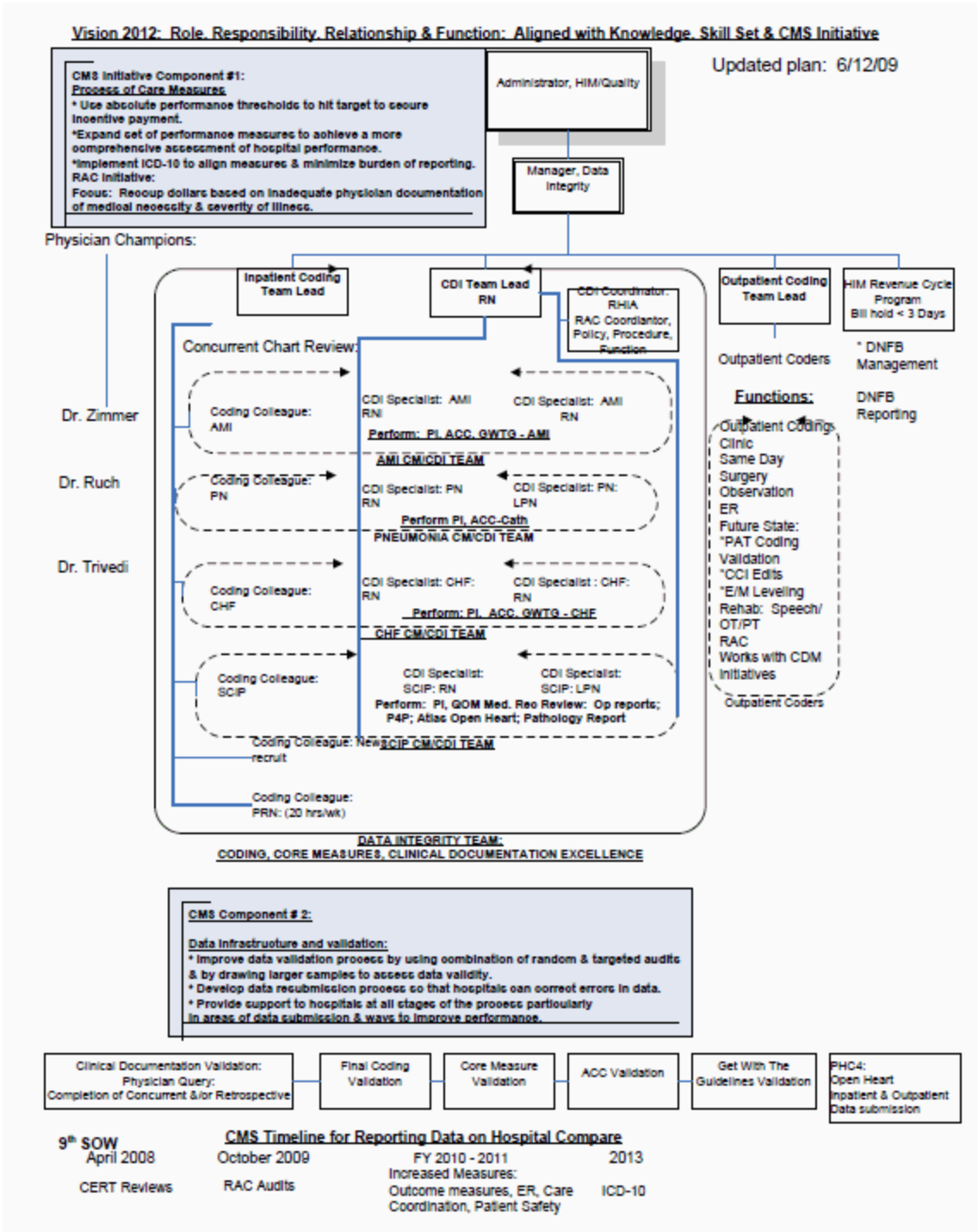
St. Mary Medical Center realized that incorporating the CDI component into the established Core Measure reviews would create less strain on physicians and reduce the number of staff inquiring about the same chart.

From a quality perspective, concurrent Core Measure review is a new concept and considered a best practice. By combining both processes, St. Mary realized improved patient safety monitoring and more accurate patient severity of illness being documented in patient charts. Other benefits included the correct alignment of patients to the appropriate diagnosis as well as the appropriate length of stay. The overall process has been instrumental in identifying and promoting patient safety.

Core Measure physician champions and a strong physician relationship were already in place, making it easy to move CDI onto the stage.

The organization determined that current Core Measure staff who evaluate the chart concurrently were the best candidates to perform CDI because they are doing part of this job already. The goal was to take the review a step further by identifying the principal diagnoses, comorbidity and complications (CCs), and major comorbidity and complications (MCCs).

St. Mary Medical Center's organizational chart [below] outlines CMS initiatives and timelines coupled with hospital-wide initiatives and colleague titles involved with the program. The model is gaining national recognition and has been posted on the National Healthcare Quality listserv and has been presented to the American Heart Association's national monthly meeting.



The CDI Workflow Process

St. Mary's second challenge was to transition the performance improvement staff into the new role of CDI specialist, which consists of nurses, and to incorporate CDI into their existing concurrent Core Measure review. Training consisted of coding, principal diagnosis selection, comorbidities and complications, secondary diagnoses, and the physician query process.

Originally CDI specialists were trained in DRG assignment. However, this caused confusion because as nurses they are skilled in assessing the patient's diagnosis and communicating that information to physicians, not assigning DRGs. They also did not have access to an encoder. The assignment of two DRGs, one from the CDI specialists during the first three days of a patient's stay and one from coders after the encounter, also created confusion.

In order to reduce this confusion St. Mary decided to educate CDI specialists on principal and secondary diagnosis selection only. The organization found training them in the concepts of ICD-9-CM, MS-DRGs, and CDI improved their understanding

and yielded great results in educating the physicians. It also resulted in an increase in capturing the correct diagnosis within the Core Measure patient population.

The CDI workflow requires patient charts be reviewed during the first three days of admission, when the required MCCs/CCs are captured or when a physician is queried to clarify the principal diagnosis and/or for the minimum capture of one MCC and one CC or two CCs. The data collected are documented on a CDI sheet and scanned into the patient's medical record, which is electronically available for coder review at the time of coding. Coders then review the CDI sheet for accuracy as well as to establish groundwork for final code assignment.

CDI Benefits

As the CDI specialists become more proficient, the organization is realizing an increase in coding turnaround time.

Together, the CDI supervisor and coding team lead foster the CDI process by communicating with the staff and explaining the results. Diagnosis discrepancies discovered by coders and CDI specialists are illustrated as case studies during staff meetings, which both coders and CDI specialists attend.

These meetings also help the coders and CDI specialists learn to speak the same language when giving coding advice. Culturally, these two teams merged and learned to exchange their knowledge with one another internally while breaking down the wall between clinicians and coders.

Transitioning coders from "authors" of the code sets to "editors" and to serve as educators is an undertaking that has resulted in considerable benefits. As experts in clinical coding, coders understand the need for high quality clinical documentation to support quality patient care, reduce potential coding compliance exposure, and receive appropriate payer reimbursement.

Coders also are invaluable in terms of initiating and sustaining the CDI program. Their extensive coding knowledge coupled with their experience and willingness to share their knowledge with the CDI specialists is what made St. Mary Medical Center's CDI program a success. The contemporary coder's role requires a consultative and educational role.

Organizations must consider multiple factors when establishing CDI programs, including the HIPAA 5010 transaction standard, ICD-10-CM/PCS, multiple external auditing initiatives, and the shortage of healthcare workers, coders, and physicians. These changes forced St. Mary Medical Center staff to come together for the first time to talk about internal hospital processes as they relate to each specific Core Measure Indicator and its respective measurements, while zeroing in on areas of weakness. St. Mary Medical Center colleagues used this opportunity to help improve documentation processes, cultivating an environment of teamwork supporting excellence in care.

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