CDI collaboration with CM/UR evolves
Programs find additional opportunities to work together

While the majority of CDI programs report to the director of HIM, a good number (27%, according to the 2010 CDI Program Benchmarking Report) fall under the supervision of the director of case management (CM). CDI programs that report to CM face a number of challenges but may also take advantage of the multiple opportunities such structures present, says Joann Agin, RHIT, regional director of data quality for Carondelet Health, St. Joseph Medical Center, in Kansas City, MO, and St. Mary's Medical Center, in Blue Springs, MO.

Defining roles
Before CDI became a profession in its own right, concurrent documentation improvement duties often fell onto the CM or utilization review (UR) team’s to-do list. “These [fledgling CDI] programs started with great initiatives and enthusiasm but splitting the days between different job functions led to many program failures,” says Gail B. Marini, MM, RN, CCS, LNC, CDI manager at South Shore Hospital in Weymouth, MA.

When Agin began working in CDI, her job description included UR tasks. These efforts quickly eroded the priority of other duties, she says. “I’d be hesitant to have anyone who is performing CDI activities to also have case management or utilization on their task lists too,” she says.

UR and CM staff discussions with physicians are very different from those initiated by CDI specialists. UR focuses on patient status (whether a patient’s condition requires inpatient, outpatient, or observation care) and whether a patient’s condition meets medical necessity for inpatient admission. CM, meanwhile, typically worries about the opposite end of the spectrum: family requests, insurance phone calls, and discharge planning.

The CM team also needs to know how a particular patient’s SOI/ROM, length of stay (LOS) and when the patient will be ready for discharge or transfer to another facility (geometric LOS [GMLOS]), Marini says.

While appropriate documentation of the diagnosis affects the decisions UR and CM staff make, CDI staff typically focus on the
documentation of care provided within the hospital walls and how that documentation ends up being represented by ICD-9 codes and MS-DRG assignment.

“It can be very cumbersome for case managers to try to take on CDI efforts,” says Marini. “It is easy for them to get pulled into matters of patient care. One second you would be asking [the physician about] the type of pneumonia listed in the documentation, and then you’d be talking about discharge planning.”

Today, few CDI or CM staff find themselves in the predicament of dual roles. According to the 2010 CDI Program Benchmarking Report, only 1% of respondents now seem to integrate CM responsibilities with CDI duties.

Instead, those CDI programs reporting to CM have more clearly defined CDI roles and a program structure that’s separate from those of CM or UR. For example, while Marini started as a CDI project manager under CM, the CDI program eventually moved out onto its own. It now falls under the chief finance officer, whereas CM reports to the vice president of nursing.

Exploring opportunities

Some facilities have found ways to synergize the efforts of CDI and CM/UR. For example, the two-member CDI team at 660-bed Medical City Dallas Hospital reports to CM. There, the CM director holds a medical necessity meeting every other week to discuss issues where “CDI folks are out front and center,” says Beverly Cunningham, MS, RN, vice president of clinical performance improvement at the facility.

Cunningham’s CM team all subscribe to the e-newsletter CDI Strategies—“not so they will become experts in CDI,” she says, “but so they will be aware of items to watch for in terms of documentation improvement.”

Certain documentation requirements simply do not make sense to CM staff from a clinical perspective, notes Cunningham. “If the CDI specialists can help the case managers understand the role of documentation improvement, then [in turn case managers] can underscore the importance of CDI in their interactions with other clinicians.”

Cunningham suggests that CDI programs tailor special education sessions for the CM team by taking the top five
DRGs at the facility and walking CM through the various documentation requirements. “I don’t want my case managers to be CDI specialists or coders,” she says. “But we do all need to work together.”

For example, when looking at postoperative complication rates, Cunningham’s team discovered that rates were higher at one facility than at all the others. She gathered CM, CDI, and quality teams together to explore different scenarios and determine the root cause of the discrepancy. The group identified a particular standing order for IV fluids as the problem, got the orders changed appropriately, and kept the different departments on alert to catch any continuation of the problem. “The turnaround on this was really amazing,” Cunningham says.

Integrating UR in CDI efforts

Likewise, the CDI staff at Carondelet Health’s St. Mary’s Medical Center is invited to the CM/UR team meetings, says Agin. Monday through Friday her CDI team reviews Medicare admissions and assigns a working DRG, which is handed to the UR staff.

Marini sits on the UR committee as well. “There are plenty of questions that come up that I can help explain,” she says. For example, documentation of symptom DRGs may not support an inpatient admission. “If you have an observation patient that changed to inpatient status, having the diagnostic reason in the chart as to why that decision was made will clarify the reason for the admission and more accurately represent the medical needs of the patient,” Marini says.

Identifying the DRG/LOS connection

At South Shore Hospital, all the CDI specialists start their day at 4:30 a.m. Each team member looks at more than 25 charts per day, Marini says—generally before the time when most physicians do their rounds. That way the CDI specialists have an opportunity to read through the chart and understand the admission before they speak with the physician about a query or outstanding issue.

“In a hospital with community physicians, it can be very time consuming to page, text, or phone physicians once they return to the office,” Marini says.

Because Marini and her team share the working DRG with physicians and CM, the complexity of care and length of stay (LOS) become shared information. For example, when a physician admits a patient for a urinary infection the working DRG is 690, kidney and urinary tract infections without MCC, which has a GMLOS of 3.5. However, the patient has been in the hospital for six days. In this case, the LOS becomes a possible indicator that the patient’s illness may be more than a simple UTI. Although this is only a working DRG, it is another piece of information which can reflect SOI/ROM in acute care, says Marini.

“This can be a difficult area for people who do not understand how the DRG reflects resource use and expected LOS,” says Marini. In such situations, CDI staff can provide education on broader concerns related to LOS.

“Sometimes,” says Agin, “case management can exist in a bubble.” She recalls one CM program which used an average LOS for all its patients regardless of an individual’s principal diagnosis. “That’s flawed thinking and causes inaccuracies,” she says. “Facilities should try to open communication between CM and CDI to raise awareness about areas of overlap. Are they curious about what changes the DRG and how the DRG affects LOS? If they aren’t, they should be.”

Ann Giuli, BSN, MPH, CCDS, CDI specialist at the 305-bed Stamford (CT) Hospital, has worked under CM for the past four years. The director of CM supervises the facility’s CDI, CM, social work, and UR teams. No matter where the CDI program falls in the reporting structure, the roles and responsibilities of the staff must be well defined, Giuli says.

Although most experts agree that CDI, CM, and UR have distinctive roles to play in patient care as well as in meeting medical necessity and coding requirements, there is plenty of room for collaboration.

“CDI is connected to all these other roles,” says Marini. “It is like a Tiffany window; we are each a different part of this beautiful thing.”

Editor’s Note: Read a case study about how CDI efforts improve LOS in the article “The Problem List Project: Managing Post Acute Care Transfer DRGs,” by Michele D. Johnson, RN, BSN, documentation specialist supervisor at Wellspan Health in York, PA, on the ACDIS Blog and download a patient problem list from the ACDIS Forms & Tools Library.