Case management or HIM?

The right home for CDI

In a recent “CDI Talk” discussion, ACDIS members shared reporting structure details, describing the pros and cons of their situations. Of those participating in the discussion, three reported to quality, one reported to the chief financial officer, and one reported to the chief medical information officer (information technology).

Most discussion participants reported to either case management or HIM—five to six respectively. Their anecdotal results were similar to those illustrated in the 2010 CDI Staffing Survey (www.hcpro.com/acdis/details.cfm?topic=WS_ACD_JNL&content_id=251560).

In that study, when asked “To which hospital department do your CDI specialists report?” the responses were as follows:

- HIM/coding: 33%
- Case management: 23%
- Quality/performance improvement: 19%
- Dedicated CDI department: 14%
- Other: 7%
- Finance: 5%

A related survey, the 2010 CDI Program Benchmarking Report (www.hcpro.com/content/254481.pdf, see p. 35), found that CDI staff report to the following departments:

- HIM: 45%
- Case management: 27%
- Quality: 15%
- Finance: 3%

Despite HIM generally taking the lead as the CDI program’s home base, many facilities struggle to determine which structure works best.

Housed under case management

When CDI first began to emerge as a profession, programs were frequently housed under case management, says Angela Worden, managing director of clinical documentation and coding integrity for FTI Consulting in Atlanta. “I think we are seeing it move away from case management and shifting to HIM,” she says.

Sheri Blanchard, RN, CCDS, CDI specialist at Wexner Medical Center at The Ohio State University in Columbus, has experience with both models. In 2006, while employed at Arthur G. James Cancer Hospital and Richard J. Solove Research Institute the CDI program reported to HIM, Blanchard says. After several years the administration pulled the CDI department over to case management.

Often the decision to move a CDI program is based on placing the team in a department that
will facilitate collaboration of the CDI staff, coders, and physicians. The other important factor is ensuring the CDI program manager has the time to monitor the program, paying close attention to both workflow and outcome metrics, says Worden.

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—Sherri Blanchard, RN, CCDS

Although she believes CDI programs can be successful regardless of their reporting structure they need to have sufficient support and the appropriate tools to monitor and manage the program.

“A challenge of integrating the CDI specialist’s role with the case management role comes to prioritizing tasks,” Worden says. “A majority of the time, managing the patient’s hospital stay/course of care overrides the CDI specialist’s duties leading to a decrease in record reviews from a ‘documentation improvement’ perspective. If the CDI staff maintains their role and reports to the case management director while case managers continue in their traditional roles, the model works out well.”

Blanchard agrees. At her previous facility the CDI component essentially dissolved as it became incorporated into other case management activities.

“They didn’t understand the total benefit of the CDI program,” Blanchard says. Case management leadership was not well versed in coding-related regulations and guidelines, and did not fully understand the need for ongoing educational efforts regarding those changes, she says.

“Case managers typically are not taught the methodology of ICD-9-CM and MS-DRG assignment,” Worden says. “When offered a training session that reviews the methodology and nuances of assigning a principal diagnosis and working MS-DRG they are astounded by the rules that determine sequencing and principal diagnosis assignment,” she says.
CDI programs that do integrate with case management should provide in-depth education for all staff regarding rules for assigning DRGs, Worden says. She believes even non-integrated case management programs should receive a basic overview of DRG assignment best practices and rules and regulations from either the coding team or CDI staff on an annual basis.

Doing so helps case managers understand how DRG assignment affects the expected length of stay, severity of illness, and medical necessity.

On the positive side, CDI specialists under case management can work collaboratively on concerns that affect the entire hospital, such as medical necessity, Blanchard agrees.

A home in HIM

Blanchard now reports to HIM at Wexner and performs CDI activities for trauma and orthopedic services for the 1,600-bed facility along with seven other CDI specialists. The center plans to add five more full-time staff.

Lisa Stephens, RN, CDI specialist at Self Regional Healthcare in Greenwood, S.C., faced a dilemma similar to Blanchard’s previous experience.

Stephens’ CDI program began under case management leadership. In the early days it “grew and grew,” she says but administration felt the “CDI program wasn’t getting the attention it needed,” and moved it under HIM. Three years later, administrators floated the idea of moving the CDI program back under case management’s guidance.

The proposal pushed Stephens to poll her fellow South Carolina ACDIS Chapter members (Stephens is secretary for the group) to see where their reporting structure fell. She received a slew of comments and some sage advice, but most responses echoed the results of previous ACDIS national surveys—most CDI programs report to HIM, followed closely by those reporting to case management.

“When the CDI program reports to HIM, the beauty of the situation is, if they truly abide by the philosophy of creating a collaborative program, the coders and CDI professionals can really learn from one another for the benefit of the organization and the patients,” Stephens says.

However, when CDI duties are either not clearly delineated or communicated within the HIM/coding department, an “adversarial relationship can develop and eventually lead to the demise or restructuring of the program,” Worden says.

All under one roof

With the margin of those reporting to case management and HIM relatively close, how can administrators know which is the best fit for their CDI program?

“I’ve been doing this for about 15 years and firmly believe that the CDI program must report to the department that can devote the time and the energy to its success, whether that is HIM or case management or finance or the quality team,” Worden says.

First and foremost, Worden suggests administration determine which leadership team is best able to:

- Monitor, review, and analyze the metrics
- Establish query policies and procedures
- Escalate query processes as needed
- Work with medical staff on documentation improvement
- Understand and support the entire CDI process, including prospective, concurrent, and retrospective record review
- Demonstrate how CDI efforts affect compliance, quality, and hospital and physician quality scores; severity of illness and risk of mortality; and denial prevention and management

“In my opinion, no matter where the CDI program lands, the effort is truly a collaborative one,” says Worden. To ensure that collaboration, a few things need to be in place:

- Executive leadership needs to understand and support the underlying mission of the CDI program
- Physician training needs to be provided and their responses to queries must be monitored on an ongoing basis
- A physician advisor needs to be assigned to support the program and maintain physician involvement
- Coders, CDI specialists, and physicians need to collaborate
- Coding and CDI specialists productivity and effectiveness must be tracked and evaluated regularly

“In my experience, when a CDI program fails typically finance spurs the CDI program’s rebirth,” says Blanchard. “Regardless of how the program gets to be reenergized, regardless of to whom the program reports, the combination of changes in healthcare have caused the light to come on for people. CDI used to be a department in a hidden room. Now it’s front and center.”