ROSALIND FRANKLIN UNIVERSITY of MEDICINE AND SCIENCE
INTERPROFESSIONAL HEALTHCARE WORKFORCE INSTITUTE

CDI profession presents opportunities, obstacles to international workforce

By Brian Murphy; Director, Association of Clinical Documentation Improvement Specialists (ACDIS)

Abstract
The clinical documentation improvement (CDI) industry has experienced tremendous growth over the last decade, creating a need for trained and credentialed CDI professionals in the U.S. and internationally. But differing care delivery and payment modalities and cultural differences point toward a need for standardized training. This commentary serves as an introduction to the clinical documentation improvement (CDI) profession in the U.S. and its international growth and development. Focused interviews with Foreign Medical Graduates working as CDI specialists in the U.S. highlights opportunities for viable career pathways and progression in this healthcare field.

Clinical Documentation Improvement (CDI) is a growing profession in healthcare, both in the U.S. and overseas.[1] CDI specialists review patient medical records and assess whether all conditions and treatments are documented. This documentation helps paint an accurate picture of the severity of a patient's illnesses and the extent of the care required. When the documentation is unclear or deficient, CDI specialists prompt (also known as "query") physicians to provide clarification. CDI specialists serve as the bridge between health information management (HIM) and clinical staff. They must comply with Medicare and/or private payer rules and regulations. CDI specialists include a variety of licensed healthcare providers across multiple disciplines. The hallmark of a CDI specialist is clinical knowledge, since they must decipher complex medical records and need to be able to recognize treatments and diagnoses that may not be clearly documented. They also need to be comfortable educating busy physicians on documentation requirements. The majority of CDI specialists are RNs, but also include HIM/coding professionals, physicians, and quality improvement staff.

The growth of the CDI profession has mirrored the healthcare industry's increased focus on compliance with regulations, managed care profiles, payment for services rendered, quality of care improvement measurements, and liability exposure. All these factors increasingly depend on the integrity of complete and specific clinical documentation in the medical record. Although CDI is relevant to any country—accurate documentation leads to appropriate capture of ICD-10 codes, which are a world-wide disease classification system—CDI as a dedicated profession has experienced the greatest adoption in countries that use ICD-10 codes for reimbursement, such as the United States. For example, the Association of Clinical Documentation Improvement Specialists (ACDIS) has chapters in operation in Australia and Saudi Arabia—countries that use ICD-10 for reimbursement—and 98% of its members are U.S. based.[i] [2]

CDI is now widely penetrated into hospitals. According to a 2015 survey issued by the Advisory Board,[3] some 90% of U.S. based hospitals today possess some form of CDI department or program (81% reported possessing a CDI program in 2015, with an additional 12% reporting they planned to start one in 2016). With an estimated 5,000 eligible hospitals nationwide (5,564 according to a 2017 survey of the American Hospital Association,[4] then subtracting

approximately 500 psychiatric, long-term care, and other hospitals less likely to possess a CDI department) and 90% penetration, ACDIS estimates that 4,500 hospitals have some form of CDI department. Assuming an average of 6.5 FTEs based on the ACDIS 2017 *CDI Week Industry Overview Survey*,[5] the size of the CDI universe, in the United States/employed by U.S. hospitals, is about 29,000 CDI specialists/professionals with some degree of CDI responsibility. It is a large and growing profession and finding qualified staff can be challenging.

CDI in the U.S. has benefitted from an influx of foreign medical graduates (FMGs). These professionals hold a clinical degree from their country of origin, and while they are often not licensed to practice medicine in the U.S. their clinical acumen often makes them a good fit for CDI.

The following is a series of four interview questions conducted with four Foreign Medical School Graduates (FMGs) and members of the Association of Clinical Documentation Improvement Specialists (ACDIS) who have made the successful transition to U.S.-based CDI. It includes their perceptions of the U.S. healthcare system in general as compared to their country of origin. Also included are their insights on how the next generation of healthcare professionals needs to be trained in order to provide employment opportunities for FMGs both stateside and abroad, and to develop a strong global workforce. The CDI profession provided a successful, alternative pathway for these FMGs due to challenges with obtaining U.S. licensure.

Question 1. *As a physician who was educated and raised outside the country, what are your perceptions regarding the U.S. healthcare system and how care is delivered, and its clinical and business opportunities?*

Overall, the four respondents noted several strengths of the U.S. healthcare system, particularly with technology and evidence-based medicine. But all cited a lack of empathy for patients as well as an inordinate focus on the business of medicine as downfalls/areas in need of improvement.

"Back when I first came to this country, as an outsider, I thought the US healthcare system was very advanced when it came to interventional technology, such surgical procedures, available drugs, etc. However, coming from a third-world country, I never thought that I would encounter so many patients who had had their disease burden increase just because of lack of access to healthcare due to financial constraints," wrote one respondent. "We spend a disproportionately high amount of money on prolonging final few months of life, instead of focusing on improving the overall health of our younger population. Moreover, historically, we haven't rewarded our best providers, thus, leaving not enough financial incentives for providers to go the extra mile for their patients. Just doing H&P, reviewing labs, and prescribing medicine doesn't translate in to good quality healthcare. Some of it is beginning to change, but we still have a long way to go."

Another wrote, "The U.S healthcare system 'quality of care' provided is excellent but the cost of care and access to care is concerning compared to my native country. There are some areas that India can learn from the US such as importance of use of evidence-base medicine/research, data analytics, and patient satisfaction. But the US can also learn from India in areas such as less over-dependence on expensive technology which increase costs and insurance companies determining access to care."

A third added, “I’ve always had a positive perception of the US healthcare system, although now I can see that it’s more of a business oriented system compared to what I’m used to way back in the Philippines. Compared to when I was still practicing in the Philippines, we often rely on our ‘clinical eye,’ and use of highly sophisticated diagnostic tests are minimal.’
“The US healthcare system is extremely advanced compared to the developing world which is where I came from,” added a fourth, who believes that the U.S. needs to improve on the compassion of healthcare delivery. “The opportunities I see is the diminishing human touch seen in the U.S. healthcare system because of the deployment and or reliance on technology to provide care for patient. That lack of human touch takes away the basic empathy expected of healthcare workers. Considering the amount of resources invested in the US healthcare system and healthcare outcomes obtained compared to other developed countries, one cannot help but say there is an opportunity to improve on such outcomes.”

Question 2. *What are your perceptions of the healthcare system of your country of origin?*
Each of the four respondents noted significant healthcare shortcomings in their native countries, including a lack of funding for healthcare, poverty and wealth inequalities, and a lack of data-driven research and rigor. “Healthcare and education have always been on back burner, with major funding going to military expenses to fund the never-ending feud with next door neighbors, India. The level of poverty that exists there is unconscionable. On the other hand, we have the elites who are very rich, and so out of touch with reality that they can’t even empathize with the problems and challenges faced by the masses,” said one respondent. “There is no concept of health insurance there, and everything is paid out of pocket. Even though it does help keep administrative costs low, there are millions that are denied care, including acute healthcare, due to lack of funds. There are government hospitals scattered all over the country, but they are woefully short staffed, and are overburdened, and overwhelmed. Doing any kind of retrospective research for any kind of population health study is very hard, since there are no claims, and no coded data, which can be utilized for data mining. Researchers rely on data abstraction via chart review, which is very hard to conduct due to almost non-existent infrastructure for electronic health.”

“India has made significant progress in healthcare over the last decade. The rise in medical tourism and the return of many U.S based Indian physicians back to India (reverse brain-drain) has helped,” noted a second source. “However, there is still opportunity to improve the healthcare practices in many areas such as quality of care, patient satisfaction and data analytics.”

A third respondent wrote, “The healthcare system of Ghana (my country of origin) is still in its developing phase. There is a significant shortage of healthcare workers to take care of the citizenry. For instance, one doctor currently attends to about 10,450 patients, which is a very unhealthy ratio compared to the Commonwealth recommended ratio of one doctor to 5000 patients or 1 doctor to 1,320 patients recommended by the World Health Organization. To top it off, most of the common diseases seen are still those resulting from infection or infestation including malaria. Although there has been some improvement in the use of investigational tools in the healthcare system including CT scan, MRIs, etc., it is still a luxury to most community hospitals.”

Question 3. *How does the next generation of international healthcare professionals need to be developed, fostered, and trained, in CDI and more broadly for healthcare? What needs aren't currently being met?*
Respondents to this question cited a strong need for documentation training and improvement in their counties of origin. They noted some key differences and nuances as obstacles to adoption, including payment differences that make CDI less of a priority, as well as the difficulty of keeping medical graduates working in their home country due to the allure of greater financial opportunity and job stability in the U.S. The key to making it work is training and development of international standardized skill-sets, respondents say.

"The biggest challenge in my opinion is holding on to the best minds in healthcare in developing countries," one respondent noted. "Most of the brightest international healthcare professionals move to developed western countries in pursuit of better life, and more opportunities. The lack of any real research infrastructure makes the CDI look not as appealing, since there is not much data collection taking place to begin with. The next generation of healthcare professionals need to be trained to look deeper, and question traditionally accepted practices in favor of evidence-based medicine. Until we have that mindset, we won't have the desire for research, good data collection, and CDI as a profession."

"There may be limited scope for CDI in India for now, as the dependency on insurance/reimbursement based on documentation specificity is not yet advanced, and quality is not determined and driven by coding but physician name recognition/care provided/outcomes," added a second.

"Changing the mindset of international healthcare professionals when they first come here to work is necessary," added a third. "Learning to adopt to their new job in a new environment (new country) doesn't really require going through a rigid training, as long as they have the right skillset that's required for the job, training should be easy and smooth. I've trained a lot of foreign medical graduates to become good and successful CDI specialists, these folks have the clinical knowledge needed for the role, it's just a matter of teaching them another skill where they can apply that knowledge."

"Sharing experiences and building the human manpower base internationally may be one way to go," a fourth respondent said. "Very often the exchange of information and training becomes only a one-time event rather than making it a process. A process that will ensure that such training and sharing of skill set is continuously nurtured over a prolonged period supported by the needed resources so that there can be a significant impact to the human race at large."

Question 4. *What can ACDIS and other entities in the broader healthcare system (i.e., hospitals, schools, employers) do to foster the international development of the CDI profession? Are there any skill-based trainings, employability skills development, education, etc. that could be offered or tailored to these audiences?*

Respondents to this question noted that leadership—whether by associations, schools, or privately-held businesses—are what is needed to help develop an international workforce in

CDI. Creating a general awareness through onboarding programs, education, dissemination of information, and networking at conferences were noted as possible first steps.

"Comparing and contrasting how the healthcare delivery and reimbursement differs from our country will be a great start," said one respondent. "I feel giving more opportunities to similar international applicants, and inviting international attendees (to conferences), will create an intrigue and interest in CDI outside of US. We can partner with prominent international teaching healthcare institutions, as they may already have some healthcare research infrastructure. Once there is enough need and demand for CDI, the skills development and education for CDI can follow a similar blueprint to the one we have here in US. I feel skills development would not be as hard, as getting the initial buy-in, and creating the awareness would be."

A second source added, "There is an opportunity to recruit foreign trained physicians to fill the shortage of CDI professionals in the US. Making them aware of this career opportunity (for those that may not want to pursue the USMLE medical residency path or not get accepted) would address the US needs but visa issues still would be an issue in the current political environment. And in the future there may an opportunity to develop CDI in India. Creating awareness of CDI in medical school and/or via local state chapters of medical associations would be a good start." "I always believe in getting the right resources whether for individual professional development or for teaching a team," said a third source. "Education sessions in whatever format (webinar, conferences, calls, and even published CDI books) always help. Hospitals/employers, likewise should also have good and effective trainers for new staff."

A fourth source stated, "I believe we need to prepare the ground work to help foster the international development of the CDI profession. This ground work could take the form of public advocacy on the need for documentation improvement which may help pass legislations and or enforce such legislations that will address the relevance of documentation improvement. Alternatively, training, education etc. could first be focused in countries that have the framework for the CDI profession to thrive."

Conclusion

Developing a global CDI workforce requires standardization of processes, procedures, and training. The CDI profession centers on accurate capture of International Classification of Diseases (ICD) codes, a foundation which applies to all nations using ICD-10. But the practice of clarifying diagnostic information with busy physicians including the timing and language used in the delivery of the query is an important foundational skill that must be learned by learning the culture of care of the country in which CDI is practiced. CDI specialists must also acclimate to the unique interfaces of a hospitals' electronic health record. They also must learn the basics of compliant physician queries and the basics of the *Official Guidelines for Coding and Reporting*. These are skills which must be taught with targeted training. As one interviewee stated above, "these folks (FMGs) have the clinical knowledge needed for the role, it's just a matter of teaching them another skill where they can apply that knowledge." Such feedback highlights an emphasis on needed precision skills training to facilitate an individual's successful progression into alternate occupational roles with aligned knowledge, skills, and abilities. The FMGs

presented within this commentary, transitioned into CDI from the "foreign medical physician" field, clearly lending support to alignment of skills training and Skill Pathways.

Finally, there also exists a need to develop a greater international awareness of what is still a relatively niche profession. Schools, hospitals, and professional associations are good candidates to better position CDI as a viable career option for FMGs and others in healthcare roles who possess the necessary clinical foundation for success.

[i] Note that Australia uses the AR-DRG classification system; Saudi Arabia a similar model. Diagnosis-Related Groups (DRGs) are groupings of ICD codes used to capture resource intensity for the purposes of payment

References

1. Association of Clinical Documentation Improvement Specialists. "AHIMA study shows growth in CDI industry." Accessed January 28, 2018: http://www.hcpro.com/HIM-299427-5707/News-AHIMA-study-shows-growth-in-CDI-industry.html
2. Arab News. "KSA inks deal with Australia on health codification, DRG systems."". Accessed January 30, 2018: http://www.arabnews.com/node/952966/saudi-arabia
3. Advisory Board. "Survey Results: A Picture of Today's CDI Programs." Accessed January 30, 2018: https://www.advisory.com/research/financial-leadership-council/at-the-margins/2015/01/cdi-benchmarks
4. American Hospital Association. "Fast Facts on U.S. Hospitals, 2018". Accessed January 30, 2018: https://aha.org/statistics/fast-facts-us-hospitals
5. Association of Clinical Documentation Improvement Specialists. "2017 CDI Week Industry Overview Survey". Accessed January 30, 2018: https://acdis.org/cdi-week/2017-cdi-week-industry-overview-survey

Suggested Citation: Murphy, B. CDI profession presents opportunities, obstacles to international workforce. Journal of Interprofessional Workforce Research and Development. Volume 1:Issue 1, 2018.