As part of the fifth annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. ***Juanita Carriveau, RN, CCDS,*** *Director for Clinical Documentation Integrity for PeaceHealth, in Oregon answered the following questions regarding CDI career ladders. Contact her at JCarriveau@peacehealth.org.*

Q What, in your mind, does the "typical" CDI specialist role entail?

A Of all the different people we talk to, I really think that we have one of the most advanced programs. We look for nurses with critical care backgrounds or several years of medical/surgical experience. We also test prospective new hires for critical thinking, to see if they have the knowledge base to review cases and be able to ascertain what's really going on with this patient based on the information within the medical record.

Q As CDI programs advance, they begin to branch out into other review areas. What areas do you think programs should move into first?

A Two big areas—I think CDI programs really need to make sure they're reviewing all payers and I really think they need to start getting involved in the auditing and denials management piece. Expanding reviews to all payers really gets to the compliance of your entire program. It shows that your facility cares about each and every patient that comes through your facility's doors.

When we get denials, coding takes a look at the information first. If they determine that the record was coded appropriately, they pass it back to us to review those cases from a clinical perspective. It might be that we missed something, or something needs to be advanced to physician peers. That auditing arm then reaches out into the revenue cycle as we find patterns of behavior or difficulties. They get a hold of me if they get a new National Coverage Determination and suddenly a payer is only going to pay for inpatient services for a given diagnosis. So we're aware of those, too.

Other areas for CDI programs to advance into include patient safety indicators and working with the quality department to investigate risk adjusted methodologies. All risk adjusted methods rely, essentially, on the accurate capture of comorbid conditions and complications.

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CDI plays a tremendous role in capturing those pieces of information.

Q: It seems like the most typical career ladders for CDI fall into two categories: the step category in which individual advance based on education, time on the job, and certification; and the expertise category in which individuals advance based on their demonstrated capabilities and task sets such as CDI physician educator, or quality reviewer, or data analyst. Can you talk about what some of the pros and cons of these might be?

A: At PeaceHealth, we have varying career levels based on professional expectations but we also have steps for educational levels and certifications. So, I guess the answer for us here is that we use both of those models.

The first level is the CDI specialist on the floor. They are all nurses. Their principal role is record review and querying activities.

CDI leads are the next step up. They have greater responsibility in terms of managing the educational training for the people on the floor. The serve in a proctor-type position, managing CDI staff and ensuring they have the training they need. They also manage the CDI staff day-to-day needs and make sure the facility has enough coverage.

PeaceHealth has three [CDI] manager-level positions [to] make sure that everyone has the facility-specific data in hand, and that everyone is receiving the help they need to get their jobs done and continue the program advancement. The manager starts the new staff off with training, and stays with the new staff members for their first month or two before passing them off to the CDI lead. The manager is also the one who does the bulk of meeting organization and training within the facility departments. They attend section meetings with the different service lines; and they work with physicians, CDI staff, and coding teams to create educational tips sheets, pocket cards, PowerPoints, smart phone tips, and the like. I don't allow new staff to do any meeting with the physicians until they have at least a year's worth of experience under their belts, but the CDI leads do help the managers and support them during meetings.

PeaceHealth's CDI department also has a CDI reconciler and CDI reconciler lead, positions somewhat akin to data analysts and CDI auditors. I want to be sure that we are compliant—not over coding and not under coding. The reconciler looks at every single clarification because I want to make sure that every query is compliant and that we don't have any leading query. No one's perfect. That's why we have a process in place to evaluate and monitor and train our CDI. When they reconcile, they make comments on that query, and that goes back to the CDI specialist to understand where an opportunity might have been missed or if there's a possible leading query. It's a learning opportunity. It's a continual audit process. These individuals also pass along information to our managers on productivity, missed opportunities, leading queries, etc.

And, finally, of course, there's me, the director over all the hospital systems. I do a lot of work on expanding our CDI program's efforts and working with the upper management teams on new initiatives, as well as overseeing and maintaining our CDI program focus.

Q: How important do you think it is to develop career ladders of some sort to ensure CDI retention?

A: I think it's vital. I honestly feel bad for the small CDI programs whose administrative staff see them as an add-on. I feel badly that they just go out and do what they're told. Individuals in that situation should really spend some time researching what data elements they should track to show their CDI program's effectiveness, and work with the key stakeholders to obtain the necessary information to demonstrate success such as the case mix index, CC/MCC capture rates, DRG shifts, and overall financial impact. We know that we're not the only thing affecting the case mix index but you need to know that information and demonstrate how your program does affect important metrics.

If you can demonstrate success, you can relay the importance of your CDI staff's daily efforts to administrators. Do that, and you'll be able to argue the case for new staff

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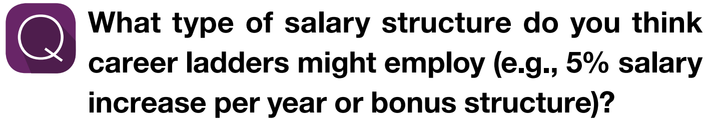
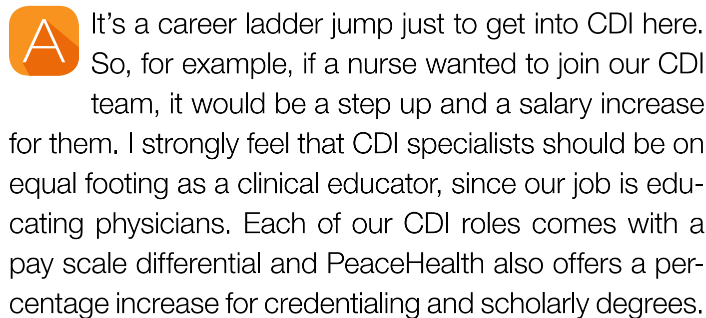
members, staff training, and even career ladders. With the expansion of CDI efforts in light of ICD-10-CM/PCS implementation, and CMS' push toward paying for quality metrics, the need for experienced CDI professionals continues to grow, too. You'll need to somehow retain the staff you just spent six months training or risk losing them to the facility down the street or the consulting firm across the country.



Q: What type of salary structure do you think career ladders might employ (e.g., 5% salary increase per year or bonus structure)?



A: It's a career ladder jump just to get into CDI here. So, for example, if a nurse wanted to join our CDI team, it would be a step up and a salary increase for them. I strongly feel that CDI specialists should be on equal footing as a clinical educator, since our job is educating physicians. Each of our CDI roles comes with a pay scale differential and PeaceHealth also offers a percentage increase for credentialing and scholarly degrees.

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