CDI pantry staples: Back to basics

As part of the eleventh annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics.

Brandi Hutcheson, RN, MSN, CCM, CCDS, a remote CDI specialist at Community Health Systems in Franklin, Tennessee, answered these questions. She is a member of the 2021 ACDIS Furthering Education Committee. Hutcheson's contributions to this Q&A do not include any CHSPSC, LLC data, proprietary processes or other information. For questions about the committee or the Q&A, contact ACDIS Editor Carolyn Riel (*criel@acdis.org*)

Q **What are some of the "pantry staples" that you think every CDI department needs to have?**

A I think it's important for a CDI program to have a good orientation program so that onboarded CDI can be as proficient as possible in the beginning and moving forward. Also, I think a CDI Boot Camp is very beneficial for the facilities that can budget that option for their new CDI specialists. I was afforded the opportunity to attend a CDI Boot Camp when I was a rookie and can highly recommend that learning experience.

Next, I think it's important for a facility to have established diagnostic criteria for common or high-risk diagnoses that are based on evidence-based guidelines and medical staff input for a CDI specialist to follow. If there are no set guidelines, then a handy *ACDIS Pocket Guide* should do the trick!

Of course, CDI software helps make the CDI role a more productive one, and I know there are many options available to meet each facility's specific CDI needs. A physician advisor is a welcomed member of the CDI team and can be monumental in educating and working with providers to improve documentation. Lastly, collaboration with coders, health information management, and other departments is essential for CDI departments to succeed.

Q **What basics should a CDI specialist know when entering the field? Are there any staples of CDI you did not know when first becoming involved in CDI that you wish you had known?**

A Having a basic knowledge of common disease processes and treatments can be beneficial for a new CDI specialist. As a nurse, having that foundational knowledge made the step into CDI a smoother transition. Case management experience helped me to understand the DRG payment system and the importance of concepts of level of care, severity of illness, risk of mortality, risk-adjusted length of stay, and case-mix index.

What I had no knowledge of was the world of coding! Thankfully, I was mentored by a wonderful coder, and she educated me immensely on coding guidelines. She pointed me to [*Coding Clinic*] as well.

Q **Just over one-third of 2021 CDI Week Industry Survey respondents (37%) spend three to six months for onboarding and training of new CDI specialists. Over one-quarter (27%) allot one to two months, and 18% only train new CDI for a few weeks to a month. How long is the onboarding process in your facility? Should training and onboarding time be customized for each CDI specialist?**

A When I was first hired into the CDI role at a prior organization, I was given approximately four to six weeks of training by reviewing CDI essentials on a computer course and hands-on CDI training by consultants. As previously mentioned, I attended a CDI Boot Camp to seal the facility training I had been given. This was enough to get me going in the profession. It is my opinion, however, that CDI training should be customized if possible. There is such a diverse population of healthcare professionals that enter CDI, and each professional has their own particular strengths and weaknesses.

Q Most survey respondents (25%) said staff are assigned reviews by software protocols (such as prioritization software). Other respondents (15%–18% each) said staff are assigned reviews by service line, based on patient census patterns, or randomly. How are reviews assigned at your organization? What are the benefits of assigning reviews each of the ways noted above?

A In my role, I do consider priority scores calculated by the CDI software; however, since I am often filling in at various facilities, I am also often assigned cases by the facility CDI team based on the current needs of the day. It can vary from facility to facility. I cannot experientially speak to assigning reviews based on service line, census, or randomly. My thoughts are that reviews prioritized at a facility are related to what the CDI department is trying to achieve, whether it is quality, financial, safety outcomes, or a combination thereof.

Q According to the survey, 84% of respondents noted performing concurrent reviews for quality/nonfinancial outcomes, and 43% of respondents performed pre-bill reviews for the same impact. What are your thoughts on so many respondents performing reviews for quality/nonfinancial outcomes as part of their typical duties? Why do you think is it important to incorporate nonfinancial reviews into typical duties for CDI specialists?

A Quality matters! In this era of data transparency where many organizations tap into healthcare quality data and create hospital ratings, patients are becoming more active and involved healthcare

consumers. By focusing on quality indicators, a facility can accurately represent health and safety outcomes, readmission, and mortality rates. CDI programs can help ensure that this data is an appropriate representation of the quality care health systems provide and help identify any performance improvement initiatives they may want to undertake.

Q In terms of concurrently reviewing for quality measures, 83% of respondents review for present on admission/hospital-acquired conditions (HAC), 70% review for severity of illness (SOI)/risk of mortality (ROM) concurrent to stay, and 69% review for Patient Safety Indicators (PSI). Which quality measures does your organization review for? How was it decided that these measures would be the ones to concurrently review? What are the risks of not reviewing for certain quality measures?

A With a focus on overall documentation integrity as a best practice, we review all of the above quality measures and concurrently identify potential HACs/PSIs. I have concurrently reviewed SOI/ROM from my inception in CDI. As mentioned above, the integrity of healthcare quality data is vastly important.

Q Only 24% of respondents noted rounding with physicians on the floor as part of their typical duties. Do CDI specialists round with physicians at your organization? How does rounding fit in with CDI query and physician education/engagement duties? What is the importance of rounding with physicians?

A Earlier in my career, I did ICU rounds with the physician hospitalist team. For me, education was a two-way street: I learned from the physicians and (hopefully) they learned from me. I did find it was most helpful to review the charts in the morning before rounds to make sure I wasn't missing critical information or a documentation opportunity. Of course, CDI specialists have to balance their rounding time with review time. Currently, as a remote CDI specialist, I do not round directly with physicians, but the facility CDI specialists are encouraged to do so.

Q Respondents to the 2021 CDI Week Industry Survey listed sepsis (67%), respiratory failure

(48%), congestive heart failure (46%), and malnutrition (46%) as the top queried diagnoses. Do these align with queries you and your team are asking in your facility? Why do you think these four diagnoses tend to be the "problem diagnoses" that many organizations struggle with? What tips do you have for writing effective queries on these diagnoses?

A I have always queried for the above diagnoses. I believe these diagnoses are heavily denied by payers because of the financial impact. Also, sepsis has different definitions and can be confusing to both CDI specialists and providers alike on which criteria to use. My only tip as to prevent possible payer denials would be to be as thorough as possible with the clinical information when sending a query and encourage providers to document their decision-making process when diagnosing these high-risk conditions.

When it comes to the diagnosis of malnutrition, providers can consult a dietitian and get their input. In my practice, I have noticed that dietitians are good at including the American Society for Parenteral and Enteral Nutrition (ASPEN) indicators in their assessments when the patient indicators are evident. When ASPEN indicators are missing from provider documentation, the dietitian's notes can be a great help to providers to clinically support malnutrition diagnoses.

Q **The majority of respondents create their query templates internally with the CDI team, physicians, and/or coders. Does your facility use query templates? If so, how are those created? What are the benefits of using query templates?**

A Yes, in every CDI specialist role I have worked in, I have been able to use query templates. The templates are created and maintained internally at my current organization. I have been able to make suggestions for revisions and new templates. For me, the benefit of using a query template is time. All I have to do is plug in the clinical indicators and pertinent information.

Using encounter prioritization to solve critical CDI challenges

Whether you're in a facility or working remotely, wading through all your cases one by one is time-consuming. If you're not currently using encounter prioritization, your CDI team will use any number of ways to determine which cases to work on next. They might prioritize a particular payer or unit or focus on the cases that have been in the queue the longest or need a re-review. If your team is cherry-picking cases based on their clinical skill set, or you're not able to meet or exceed departmental key performance indicator (KPI) goals, you're probably thinking, "There's got to be a better way."

There is. As organizations look to contain costs, AI-powered encounter prioritization helps you identify the cases that will move the quality and financial needles and help you meet your CDI KPIs.

Challenge #1: Struggling to manage work volumes with available resources

To contain costs, perhaps you've been asked to reduce staff or stagger your CDI resources and you don't want to miss out on capturing the full patient story and appropriately maximizing quality and reimbursement levels for your organization. Encounter prioritization will help you identify which cases are likely to provide the opportunity for improvement given quick length of stay (LOS) turnarounds and reduced staffing levels. For example, if you don't have CDI specialists working over the weekend, you may choose to staff heavier in the first part of the week to address weekend admissions and focus on re-reviews of longer-LOS cases later in the week.

Challenge #2: Too much time spent re-reviewing cases that add no value to the patient story or bottom line

While a re-review of cases ahead of discharge is always best practice, when you're dealing with reduced staffing levels, re-reviewing every case can feel like looking for a needle in a pile of "needles." Your prioritization technology must tell you which cases have new information likely to move the quality or financial needle. If you have been asked to do more in CDI with less, you want your staff's re-reviews to refine the patient story or increase the possible reimbursement versus being done just because they were scheduled in the system.

Challenge #3: Accurately forecasting bed availability

Among other things, the pandemic highlighted the need to better forecast bed availability. With encounter prioritization, you have greater visibility into which cases are getting close to their geometric mean LOS. By sharing this detail with case managers, they can proactively interact with physicians, driving timely patient discharge.

Challenge #4: Assisting in response to denials

Anyone who has assisted in the response to a denial from a payer will tell you that the best defense is not to

have denials in the first place. While many organizations have placed moratoriums on this activity to free up resources during the pandemic, at some point the focus on denials response will return. Utilizing AI that reviews the patient documentation behind the scenes will proactively reduce your number of denials due to missing CC/MCCs or missing principal/secondary diagnoses. The technology reviews the signs and symptoms in the patient record and will highlight cases that have evidence proving medical necessity. Additionally, if certain DRGs are denied more often, you can set up a rule to identify those and move them up on the prioritization list, using both the AI and rules functionality together for your benefit.

AI-powered encounter prioritization can help you identify the cases that will capture the complete patient story and move the quality and financial needles. Whether you're trying to forecast bed availability, reduce denials, identify cases with new information, or better align your people resources, encounter prioritization will allow you to meet your CDI KPIs and make the most of the time you have with patients.