cdi*Journal*

CRYSTAL BALL:
The year ahead in CDI

CDI fortune telling: Looking to the future in the new year

By Melissa Varnavas

Last year, in the January/February edition of the *Journal*, we suggested CDI professionals focus on growth for the "year of the rooster." (In case you're wondering, 2018 is the year of the dog according to the Chinese zodiac.) And that's what it seemed like everyone did. Not because of our urging, but rather out of a sense of *urgency*.

As ACDIS celebrated its 10th anniversary, many CDI programs also celebrated their own decades–long effort proving the worth of this clinical documentation improvement experiment. So many CDI professionals have invested so much energy to ensure the continued expansion and value of CDI even as the focus of CDI shifts, the scope of CDI practice changes, and the components of effective programs advance.

This growth became evident over the past year as the largest and most diverse gathering of professionals within our 10-year history headed to Las Vegas to participate in the ACDIS Conference.

It could be seen within the education and networking offerings organized by local chapter leaders across the country and illustrated by the new volunteers seeking to promote CDI in locations such as the eastern Mediterranean, Bahamas, and United Arab Emirates. It came to fruition as more programs emerged on pediatric floors and in children's hospitals, as the pediatric ACDIS networking group (APDIS) formed, as after-hours sessions offered post-conference opportunities, and as a book addressing pediatric concerns was published. And it was on display as the first ACDIS Symposium to focus on outpatient CDI gathered nearly 300 vested professionals, sold out, and spurred the creation of additional virtual workshops on the topic.

But we have so much further to go.

In the article "Crystal Ball: Gazing into the profession's future" on p. 8, the *Journal* explores concerns to watch for in 2018. One big push relates to the ongoing assessment and implementation of CDI for outpatient efforts as it relates not only to risk adjustment payments, but also technological integration, regulatory changes, and education and staffing expansion, as further explained in the article "Outpatient CDI: Getting up and running," on p. 15.

Other top concerns cited in the "Crystal ball" article turn back time and ask CDI programs to pay attention to the core items of clinical criteria and coding

requirements. A host of changes in these two areas could be on the horizon in 2018, and CDI programs need to ensure they're prepared should these fortunes come to pass. To review clinical and coding concerns related to malnutrition, for example, see the article on p. 27.

The new year also represents a perfect time to take the proverbial plunge and join the CDI ranks, get a CDI program started at your facility, or obtain the Certified Clinical Documentation Specialist (CCDS) credential. (Read how ACDIS members tackled these challenges on pp. 36–38.)

Finally, with the turn of the calendar comes an opportunity to review your policies and procedures, reassess your metrics, and determine what assessments can be leveraged to advance the CDI mission. In his "Note from the Instructor," **Allen Frady, RN-BSN, CCDS, CCS, CRC,** offers some key performance metrics to watch for, and in a case study on p. 20, Ohio Health CDI System Director **Tonya Motsinger, MBA, BSN, RN,** shares how her team successfully argued to obtain an informaticist role to augment its data analysis efforts.

So, what are your priorities for the coming year? I asked a few ACDIS Advisory Board members for theirs.

At southern California Kaiser Permanente in Pasadena, **Susan Schmitz, JD, RN, CCS, CCDS, CDIP,** CDI regional director, plans to add observation cases to her team's CDI worklist due to a recent report illustrating a rise in such cases with lengths of stay lasting three days or longer. She also plans to investigate documentation related to homecare services.

Over in Frisco, Texas, **Angie Curry, RN, BSN, CCDS**, CDI director at Conifer Health, will push on with quality-focused concerns, increasing her CDI team's efforts with second-level reviews on a post-discharge/pre-bill basis in all markets. She also points to her team's expanded efforts related to patient safety indicators, hospital–acquired conditions, and all mortality cases with a risk of mortality/severity of illness score less than 4/4, as well as reviews of any records with signs or symptom MS-DRGs without additional specificity or diagnoses captured.

Such cases, Curry says, get reviewed by an experienced member of the CDI staff, and the team also works through opportunities with ancillary departments such as coding, quality, case management, and utilization review.

"I love the idea of having a second pair of eyes on these cases," she says. "This is our big project for the coming year."

For **Robin Jones, BSN, MHA/Ed, CCDS,** division CDI director at Adventist Health Care Florida Hospital West division, 2018 represents a new start both professionally and personally. After having lived her whole life in Cincinnati, Jones is moving 900 miles and taking on a new team, restructuring the existing program, and developing collaborative efforts between HIM, quality, case management as well as new physician groups, and site-based and corporate administrators.

"In my new role, I will be learning a new way of looking at metrics and what a successful program looks like," she says. "2018 will be filled with many challenges, but the adventure will be fun."

Let the adventure begin!

Melissa O. Varnavas

Take Time to Return to Basic CDI Training

by Paul Evans, RHIA, CCDS, CCS, CCS-P

We have seen our industry grow increasingly complicated each year. With that increased complexity, we also see greater sophistication among our colleagues' skill levels.

CDI professionals now specialize in quality reviews for hospital–acquired conditions (HAC) and patient safety indicators (PSI). Some CDI staff function as CDI trainers, some as educational specialists. All serving in the role probably do much more than confirm that the proper MS-DRG is assigned and supported with precise documentation. Inpatient reviews are much more sophisticated now than even just a few years ago.

Polls (on the ACDIS website and elsewhere) indicate many CDI professionals also concurrently review for APR-DRG assignments as well as a multitude of risk factors that affect an increasing number of metrics and quality measurements.

> **The proper formation of a query represents the most important task for a CDI professional. Without that skill, a CDI team cannot achieve long-term success nor work in a compliant fashion.**
> *– Paul Evans, RHIA, CCDS, CCS, CCS-P*

In addition to increasing the sophistication of its inpatient reviews, the industry is widening its scope of practice. Some CDI teams now review various outpatient encounters, such as the ED, ambulatory surgery, skilled nursing facilities, and rehabilitation, in which different coding languages and tools are used as compared to those employed for inpatient claim review. Some of these languages and tools include evaluation and management (E/M) coding, Current Procedural Terminology (CPT®) coding, hierarchical condition category (HCC) assignment, and revenue codes.

It is with this increasing scope and complexity of CDI practice in mind that I wish to revisit what I think is the most important function within the profession—the elements of a compliant query.

I believe that the written query is the foundation of any CDI program. While all portions of any program, such as education and metrics, are important, the proper formulation of a query represents *the* most important task for a CDI professional. Without that skill, a CDI team cannot achieve long-term success nor work in a compliant fashion.

Are the rules the same for all?

Some have stated that a clinician (i.e., physician, physician assistant, nurse practitioner, registered nurse, etc.) can operate in a particular manner when issuing a query because clinicians can have a direct (clinical) conversation with the physician.

Hence, a fundamental question one may ask would be: Do the published query and coding rules apply to all?

The answer can be found in extracted portions of the following guidelines. A review of these published guidelines, which are deemed industry best practice, makes it clear the same rules apply to anyone and everyone issuing a query.

According to the 2016 ACDIS/AHIMA update of *Guidelines for Achieving a Compliant Query Practice*:

> "All professionals are encouraged to adhere to these compliant querying guidelines regardless of credential, role, title, or use of any technological tools involved in the query process."

The Ethical Standards for Clinical Documentation Improvement (CDI) Professionals published by AHIMA in 2016 state that the published guidelines:

> "…are relevant to all clinical documentation improvement professionals and to those who manage the clinical documentation improvement (CDI) function, regardless of the healthcare setting in which they work, or whether they are AHIMA members or nonmembers."

In addition, AHIMA's 2017 *Standards of Ethical Coding* state that the guidelines:

> "are intended to assist and guide coding professionals whether credentialed or not; including but not limited to coding staff, coding auditors, coding educators, clinical documentation improvement (CDI) professionals, and managers responsible for decision-making processes and operations as well as HIM/coding students.
>
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These references make it very clear that there no exceptions. A query is a query, and all CDI specialists are bound and constrained by a common set of best–practice guidelines.

What is the role of evidence-based medicine?

It has become industry standard for those issuing queries to use established guidelines and clinical indicators that have been cited and approved by the medical staff,

CDI teams, HIM leaders, and compliance officials. These definitions are not meant to restrict the licensed diagnostician; rather, they are intended to ensure CDI teams use these indicators in a consistent and compliant way—so as to determine whether a threshold of evidence is present within the health record to support the query in question.

> **A query is a query, and all CDI specialists are bound and constrained by a common set of best-practice guidelines.**
> *– Paul Evans, RHIA, CCDS, CCS, CCS-P*

Has your team recently revisited the clinical criteria your facility references in the CDI process? Every CDI program needs to regularly review the clinical criteria it uses, updating as needed to ensure compliance in dealing with problematic clinical topics such as sepsis, malnutrition, encephalopathy, and acute respiratory failure.

Desirable query characteristics

Revisiting best practice, the ACDIS/AHIMA *Guidelines for Achieving a Compliant Query Practice* (2016 Update) make a few salient points, such as the following statements:

"To support why a query was initiated, all queries must be accompanied by the relevant clinical indicator(s) that show why a more complete or accurate diagnosis or procedure is requested. …**A leading query is one that is not supported by the clinical elements** in the health record and/or directs a provider to a specific diagnosis or procedure." **(emphasis added)**

"Multiple choice query formats should include clinically significant and reasonable options as **supported by clinical indicators** in the health record, recognizing that there may be only one reasonable option.

"As such, providing a new diagnosis as an option in a multiple choice list—as supported and substantiated by referenced clinical indicators from the health record—is not introducing new information. Multiple choice query formats should also include additional options such as

"clinically undetermined" and "other" that would allow the provider to add free text. Additional options such as "not clinically significant" and "integral to" may be included on the query form if appropriate." **(emphasis added)**

Taking into account the guidance above, I advocate for the following characteristics/elements in a query—what I call the "four C's":

- Conciseness
- Context
- Clinical support
- Compliant responses offered

Review elements of the theoretical queries below, both on the same topic, and compare them to the list above.

Example 1

Dr. X:

History and physical (H&P) and progress notes document "acute renal insufficiency."

Creatinine (Cr) is 2.1 at admit, 1.4 on day 2, 1.0 on day 3.

Please indicate your intended classification

1. Acute Kidney Failure/Injury
2. Acute Tubular Necrosis (ATN)
3. Acute Renal Insufficiency
4. Other
5. Unable to Determine

Example 2

Dr. X:

H&P documents a patient admitted with pneumonia with dehydration and acute renal insufficiency.

Progress notes repeatedly state: "acute renal insufficiency—follow Cr and consider renal consult if no improvement; provide IV fluids to improve renal function."

Cr is monitored serially and is 2.1 on day 1, improving to 1.4 on day 2, declining to 1.0 thereafter.

Please indicate your intended classification

1. Acute Kidney Failure/injury
2. Acute Renal Insufficiency

3. Other
4. Unable to Determine

While both examples are concise, there are differences:

- **Context:** How and when was "acute renal insufficiency" documented and by whom? How was the renal function evaluated and treated?

- **Clinical support and compliant choices:** For example 1, there is no clinical support for ATN; as such, it should not be offered to the physician as a response to the query.

What is the value of peer reviews?

I have the pleasure of working with an abundance of advanced CDI professionals, and I learn a lot by reviewing their work.

Consider implementing a collaborative (not punitive) review process for the CDI team so that best practice can be recognized and good work shared with all.

The article "Note from the Associate Editorial Director: Consider the peer audit" provides an excellent discussion and resources regarding peer review. ACDIS also recently published a book on the topic, an excerpt of which can be found here.

As our world and work becomes more complicated, take a moment to reflect back on the query basics. I encourage everyone to consider the fundamental elements and desired characteristics of a compliant query.

Take time to examine your clinical definitions and perform an inventory of the query forms used by your institution to ensure they are concise, contain proper context and clinical support, and offer compliant responses. 🌱

CDI crystal ball: Gazing into the profession's future

Outpatient. Hierarchical Condition Categories (HCC). Quality. Value-based purchasing. Pediatric. Interdisciplinary, integrated CDI response and analysis. Such topics have been the buzzwords of the industry for many years, and for good reason.

Regulatory shifts associated with the 2010 Patient Protection and Affordable Care Act put reimbursement penalties and benefits in place in exchange for meeting certain quality measures. CMS has further defined these measures within its various payment systems over the past several years—making the capture of documentation related to patient safety indicators, hospital acquired conditions, readmissions, and so forth ever more important.

Similarly, in an attempt to reduce expensive hospital costs CMS put bundled payments and accountable care organization programs into play. It also increased scrutiny of the medical necessity of inpatient admissions—all of which has been pushing a larger volume of patient care to the outpatient setting.

Many believe these previously emerging topics hit a critical mass of interest in 2017, with more CDI programs expressing an interest in, or expanding to, these areas. No doubt this trend will continue to contribute to the CDI discussion in 2018 and beyond.

And yet, just as these regulatory shifts have had a profound effect on CDI focus and expansion, CDI professionals need to annually reassess their program priorities in light of the expected shifts in the healthcare landscape for the coming year.

Coding terrain

"CDI [originally] defined its value in the CC/MCC, case–mix index, etc. world because there is a direct financial demonstrated impact," explains ACDIS Advisory Board member **James P. Fee, MD, CCS, CCDS,** vice president of Enjoin, based in Collierville, Tennessee. That impact became calcified after the implementaation of MS-DRGs and ICD-10-CM/PCS, he says.

Successful programs need to consistently provide evidence of meeting (if not exceeding) CDI expectations in these core competencies, but they also need to keep an eye on how code assignment may shift and the effect of those shifts on MS-DRGs

and their relative weights. And, in turn, programs must consider what education might be needed for CDI staff, physicians, and coders.

"We have been coding with the ICD-10-CM/PCS code set for more than two years now," says **Laurie Prescott, MSN, RN, CCDS, CDIP, CRC,** CDI education director, for HCPro/ACDIS, based in Middleton, Massachusetts. "I think in 2018 the [inpatient prospective payment system (IPPS)] Final Rule is going to bring huge changes."

Armed with years' worth of statistics from ICD-10-CM/PCS implementation to the present, CMS can leverage that data to analyze resource consumption and evaluate it against the MS-DRG system, she says.

That could mean dramatic shifts in determining what conditions qualify for a CC/MCC. For example, the National Institutes of Health Stroke Scale may affect the value of a cerebrovascular accident; the depth of a non-pressure chronic ulcer may determine whether the condition qualifies as a CC or MCC; so too might the Gustilo–Anderson scale for open fractures affect CC/MCC assignment, Prescott says.

"The increased specificity we see with the ICD-10 codes will affect which diagnoses will provide more value or severity," Prescott says.

Clinical constructs

Similarly, CDI Education Specialist **Allen Frady, RN-BSN, CCDS, CCS, CRC**, encourages CDI professionals to stay abreast of changing clinical literature. Principal clinical criteria for a number of high-volume/high-cost conditions get updated roughly every four or five years, he says.

For example, the American Society for Patental and Enteral Nutrition (ASPEN) criteria for malnutrition, the Kidney Disease: Improving Global Outcomes (KDIGO) Clinical Practice Guideline, and the Third Universal Definition of Myocardial Infarction were last updated in 2012, he says, with the Surviving Sepsis clinical criteria updated in 2016 (also previously updated in 2012).

"If I had to predict right now, I would say we should be on the lookout for some major updates in the coming years to some of these standardized clinical definitions/criteria which deeply impact the CDI practice," Frady says.

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The recent sepsis criteria change, for example, led to much confusion over which guidelines to follow as code assignment rules failed to mirror clinical changes, and the elemental approaches "to improve health—administrative and clinical—are not always in sync, [which has] led to unintended consequences," according to an ACDIS White Paper *"Where are we now with sepsis?"*

written by Advisory Board member **Sam Antonios, MD, FACP, SFHM, CPE, CCDS**.

For CDI specialists, changes principally led to the need for increased communication and collaboration with internal stakeholders such as specialty physicians, coders, quality, and even ED staff to determine facility-based policies defining the medical staff's preferred uniform definitions for sepsis and its related conditions. It also meant CDI staff needed to amend queries to reflect those changes and be ready to defend the facility's efforts in the face of audits or claim denials.

Furthermore, changes in clinical criteria often require in-depth research and collaboration from a variety of specialty-specific societies and international associations, as was the case with malnutrition criteria published in a consensus statement of the American Academy of Nutrition and Dietetics and ASPEN. As another example, a specific set of criteria for sepsis garnered the support of dozens of medical authorities including the American Association of Critical Care Nurses and the American Thoracic Society.

CDI teams need to keep up with medical literature and stay connected with their specialty-related physicians and physician champions, as well as publications related to coding and documentation such as AHA's *Coding Clinic for ICD-10-CM/PCS*, *Journal of AHIMA*, and the *CDI Journal,* as these frequently include advice on how to handle any conflicting coding/clinical conundrums.

Typically, as CDI professionals well know, the recommendation is often to query for clarification.

Regulatory movement

With the White House administration aimed at governmental deregulation, including within the healthcare sector, CDI programs may want to consider pivoting back to core, financially focused incentives. After all, the 2018 IPPS Final Rule included relatively few changes to value-based purchasing or other quality-related measures. Perhaps future changes could be few as well.

> **We are in a world of transition where organizations have to look to the future but pay for today.**
> – *James P. Fee, MD, CCS, CCDS*

"We are in a world of transition where organizations have to look to the future but pay for today," Fee says, suggesting that CMS will "learn more from the successful pay-for-performance business models of payers such as [BlueCross BlueShield], United, Humana, etc., and continue to modify programs to yield better patient outcomes as well as financial incentives for providers."

This will continue to push CDI programs into the outpatient/physician practice setting, but "like everything in healthcare, limitations are set because of resources," Fee says.

So, while CDI efforts will need to "focus on providers in the near future," program managers will also need to do a better job of understanding the "value" of that effort "in this space and translate that to [hospital] leadership," he says.

Too many in the field are "speaking in buzzwords but do not truly understand the intricacies of alternative payment models or the direct impact on finance and quality that CDI plays. Those who run these programs can see the holes and lack of understanding in those who are trying to apply old CDI concepts," says Fee.

Further, Fee says, "organizations will not deploy resources for CDI in these spaces until the value proposition can be clearly identified and aligned with the organization's risk models."

But, Fee says, there is good news for those ready to do the research.

"You will see innovative leaders step out in front of the rest in the CDI profession. And you will see the inpatient CDI playground change drastically with unified technology across the continuum," notes Fee.

"I think this is a great learning time for CDI professions, trailblazing the future of CDI dynamically as healthcare is revolutionized," he says. "We will define the future of CDI and not let others define it for us. Unifying technology with people and process allow for efficiency, consistency, and growth. CDI is fundamental to a provider's measurable success. It's my prediction that we will see interesting things in 2018."

CC/MCCS FOR CDI:
CLINICAL INDICATORS
& QUERY OPPORTUNITIES

JOIN WILLIAM HAIK, MD, FCCP, CDIP

01.25.18 / 1-2:30 P.M.

Starting from scratch: Tales from building a CDI program

Though larger facilities may have had CDI programs for years—some for over a decade—others are only starting now. When the first CDI departments formed, they focused on CC/MCC capture and DRG assignment for accurate reimbursement, but over the years, things like value-based purchasing and quality measures have changed the course of CDI significantly. So, what does a CDI program starting up in 2017 look like? To gain some perspective, ACDIS spoke to a couple of CDI specialists during the very first week of their CDI department's existence.

St. Mary's Healthcare is a relatively small, 100-bed facility in Amsterdam, New York, and a part of Ascension Healthcare. Though other facilities within Ascension Health,

the largest non-profit health system in the United States, had ventured into CDI before, St. Mary's started exploring the CDI space in the fall of 2016. **Julie Fenton, RN, BSN,** and **Brittany Gillen, RN**, were the first two CDI specialists selected to pilot the program.

Different backgrounds, similar goals

Fenton and Gillen came from different nursing backgrounds (though they had crossed paths in the small St. Mary's environment before). Fenton came from utilization review and case management; Gillen came from quality. Because of these backgrounds, the two brought a definite quality focus to the new department.

"I had been working on physicians' profiles and saw where the documentation needed improving,"

says Gillen. "Improving the profile of our hospital through documentation was really exciting to me."

"I'm most excited about the quality side of it. Doing the denials on the back end in conjunction with HIM, I was really aware of where our documentation needed improving," says Fenton. "We want to keep the quality patient care at the center of it all."

First steps

As admirable as their goals are, the duo nevertheless faced a daunting task. Before the program could "go live," so to speak, Fenton and Gillen had several steps to complete.

Last year, the administration employed a consulting team to perform some background education, including 10 one-on-one training

sessions with the physicians and the specialists, Fenton says.

The two new CDI specialists then took off on their own, providing their own brand of physician education, joining ACDIS, and reaching out to other CDI team leaders within Ascension Health. "We attended some seminars and aligned ourselves in the hospital with the dietitian, wound care nurse, infection control, clinical resource management, quality, and HIM/coding," Fenton says.

Fenton also had a secret tool—her mother works as a CDI specialist in a nearby facility. "They've been really a wonderful resource in driving our initial steps."

Medical staff education

In addition to providing space for the education, the time between exploring St. Mary's CDI opportunities and actually implementing CDI efforts allowed for more educational outreach to physicians.

"We've been working slowly to get ourselves out there and make [the physicians] aware of our mission. We didn't just show up one day on the unit—we ensured that our goals were aligned with the utmost quality of care for the patients we serve," says Fenton.

She and Gillen made themselves visible by creating a newsletter and tip cards for physicians. Fenton had developed a denials management newsletter in her previous role, so she used the same template to keep the format familiar to providers. The first newsletter covered the basics— who the CDI team is, what they do,

and their goal—and went to all the physicians and leaders in the facility.

The tip cards, though, stay with Fenton and Gillen. "We carry the tip cards with us and attend multidisciplinary rounds. Whenever we have a physician interaction with an opportunity for education, we can provide it to them," says Fenton.

And it wasn't only the physicians getting education in the ramp up to the program's launch. Fenton and Gillen have also provided education to new RNs, the clinical resources management team, critical care nurses, and the clinical care managers. The last group even attended an ACDIS/HCPro Boot Camp taught by Laurie L. Prescott, MSN, RN, CCDS, CDIP, CRC**,** along with the CDI specialists and HIM/coding staff.

Though many CDI specialists— including Fenton and Gillen—shy away from discussing CDI programs' financial effect during education, Gillen found that ancillary staff actually respond well to the information.

"When we were educating the critical care nurses, they really responded to the changes in the DRG with assigning different present on admission statuses," says Gillen. It empowered the nurses to know that their assessment and documentation made a difference

Even as they transitioned to their new roles, Fenton and Gillen continued serving in their previous positions for continuity's sake until replacements could be hired, meaning they wore their regular quality and case management/UR hats as

well as new hats for physician education and CDI self-education.

"Being a small hospital, we were doing two roles at once until we were officially done training," says Gillen.

Technology hiccups

Even though the physicians use an EHR system, the system doesn't yet have querying capabilities, so the process will be hands–on for the time being, Fenton says. "We don't have a consistent monitoring tracking tool. We're monitoring and tracking by hand, which is very time–consuming," she says.

"Eventually our goal is to have an electronic tracking tool. That is very exciting to me because it will demonstrate the difference we know we're making," says Gillen.

Even without that electronic tool, however, both Gillen and Fenton are hopeful about the promise of their new CDI department. They've spent a lot of time and energy building relationships with the physicians and offering education, so being able to officially launch their program feels like a triumph in and of itself.

"I look forward to the challenges ahead," says Fenton. "We're a small community hospital that truly reflects a spirit of teamwork. I'm so very grateful for the dedication of the administration, HIM, and the physicians to the success of this program. I can't wait to see how far we can grow!" 🖐
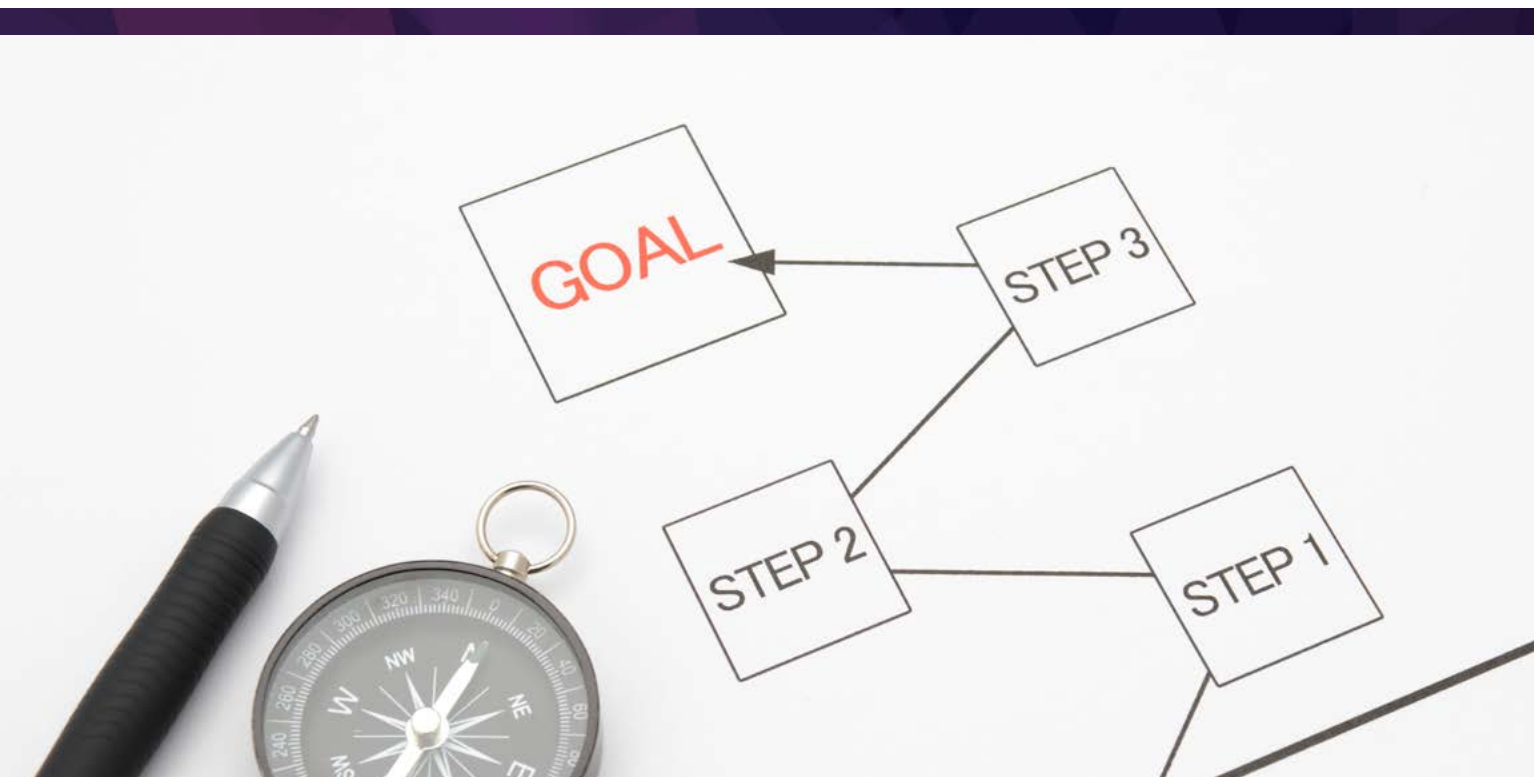
Becoming a CDI professional: Tips for getting started

Starting a new job can be intimidating, no matter the profession. Whether you're coming from a clinical or coding background, the CDI role will present new challenges and come with a steep learning curve. Between coding rules and guidelines, query composition and compliance, physician engagement, keeping up with the current medical literature, and the ever-changing world of healthcare reimbursement and regulations, it's enough to make any newbie's head spin.

So, if you're new to the CDI table, this article is for you. The ACDIS team spent time brainstorming and chatting with seasoned CDI specialists to bring you some top-notch tips

and ease your transition to this exciting role.

Tip 1: Collaborate with other departments in your facility

New CDI professionals need to ask for, and accept, help and education from others—both inside and outside the CDI department.

"Work together with the coders," says **Amy S. Sterner, CCS, CCDS, CDIP,** CDI specialist at Hanover Hospital in Hanover, Pennsylvania. "There is a wealth of knowledge within them, and it is not a competition."

"Learn to collaborate with others in your facility—coders, case managers, the quality team," agrees **Jennifer Cooper, MHIIM, RHIA, CDIP, CCS,** a CDI specialist at Hunt Regional Medical Center in Greenville, Texas. "Although we have different roles, the goal is the same—quality documentation for more efficient care, regardless of the financial impact."

As you get your feet under you, remember that you don't have to go it alone. Other departments have valuable information to share with you—you just have to ask.

> **Work together with the coders. There is a wealth of knowledge within them and it is not a competition.**
> *– Amy S. Sterner, CCS, CCDS, CDIP*

Tip 2: Gather your resources

Though others at your facility are a great resource as you get comfortable with your new role, individual education can also be beneficial.

"Use every possible minute of orientation," says **Tracy Pitts, RN, BSN, CCDS,** CDI specialist at St. Luke's Hospital in Chesterfield, Missouri. "Explore the references available in your particular program, reviewing diagnoses, associated conditions/complications, decision trees, and coding guidelines."

Of course, don't just limit your search for resources to your own organization.

"The first piece of advice I would offer is to join ACDIS and use the numerous resources they offer us," says **Jeff Morris, RN, BSN, CCDS,** CDI supervisor at the University of South Alabama Health System. "There are also a ton of free resources available on the internet for new CDI specialists to take advantage of, including from ACDIS if you are unable to join."

Shannon Huth, MSN, RN, CCDS, CDI specialist at San Francisco General Hospital, reminds new CDI specialists that they need not understand everything right away. "That's impossible," she says. "Just take the time to understand your resources: people, books, ACDIS, *Coding Clinic,* etc."

Getting buried in books and articles trying to piece it all together could result in frustration, so if you have questions after independent reading, take them to others: your CDI manager, mentor, or co-workers.

Tip 3: Collaborate and network

Reaching outside facility walls can be equally helpful. While different programs may have slightly different focuses, much of the daily CDI work will be consistent between facilities. Knowing what others do daily will help give you a broader perspective on the how and the why of CDI.

"Network, network, network," says Morris. "Whether you're two miles or 2,000 miles from another CDI professional, we are all working toward the same goal: attaining accurate documentation reflective of the patient's severity of illness/risk of mortality and resource consumption. I've made so many connections via the ACDIS Forum and the national conference, most of whom I speak with at least weekly to bounce ideas off each other—it's great to have that support."

Further, ACDIS local chapters can help you build a network nearby. By attending, you'll open opportunities for mentorship and networking. (To visit the Local Chapter page, *click here*.)

"Keep networking," says **Penny Souder, RN, MS, CPC,** a CDI specialist at Maui Memorial Medical Center in Hawaii. "Our success depends in part on our ability to network. You are going to encounter some difficulties, but don't let that encumber you. Each sunrise brings a new journey."

Tip 4: Give yourself time

You can't learn everything overnight. As you embark on your new career as a CDI professional, give yourself some time and don't get frustrated.

"Be patient with yourself!" says **Christi Drum, RN, BSN, CCDS,** a CDI specialist at Lee Health in Fort Myers, Florida. "CDI is very different from bedside nursing [or coding]. It takes time and exposure to learn and remember the many different facets, rules, regulations, requirements, guidelines, *Coding Clinic,* etc."

While on a good day it's easy to cut yourself some slack, the hard days deserve just as much grace, says **Claudine Close, BSN, RN,** a CDI specialist at Children's Hospital at Saint Francis in Tulsa, Oklahoma.

"Don't take things personally," she says. "We all have our good days and bad days. Try to remember that the same goes for physicians and residents. Try to start each day with a clean slate."

Though it's not always easy, CDI is an exciting field to join, says **Diane Smith, RN, CCDS,** a CDI specialist at Pen Bay Medical Center in Rockport, Maine.

"Hang in there!" she says. "There's always something to learn, people to learn from, and conferences to attend. CDI is expanding as we speak, and your opportunities are endless."

Outpatient CDI: Getting up and running

More than 30% of respondents to the *2017 CDI Industry Survey* plan to expand to some sort of outpatient service in the near future. But, with fairly flexible definitions of the term "outpatient," those planning to expand are left without direction.

As with any new frontier for CDI, those looking to venture out into the great unknown of outpatient CDI need to rely on those who went before. Though those on the forefront of outpatient expansion are learning as they go, they're nevertheless valuable resources.

Following the first ever ACDIS Symposium: Outpatient CDI, ACDIS wanted to help with some of those connections by chatting with a couple of people in the trenches of outpatient CDI expansion.

"Utilize every resource out there," says **Dawn Diven, BSN, RN, CCDS, CDIP,** a documentation specialist at West Virginia University Hospital in Morgantown. "ACDIS has great resources, and you can connect with other people who have similar programs. Find your resources and connect."

Choosing a focus

"When I was asked to start the program, no one knew where to start—including me," says Diven. "It was sort of like Pandora's box. Once you start looking, you're going to find a lot of issues to fix all over the place."

As most CDI specialists know, without adequate planning or staffing it's easy to let the CDI mission creep into other areas as a program

matures. When moving into new spaces, though, the creep can happen at the onset. If the new outpatient program is forced into tackling more areas than it can handle, it will fail. So, instead, a clear focus area needs to be defined. (To read about possible focus areas for outpatient CDI, *read ACDIS' White Paper on the topic*.)

"We decided eventually that the best plan would be to start with the easiest—the thing that had the least to fix. But we still wanted to have an impact, so we went with HCCs [Hierarchical Condition Categories]," says Diven.

To tackle the issue of HCCs, Diven and her coworker, **Cathy Glover, RHIT**, focused on one of the small family practices within their system that had poor risk adjustment

factor (RAF) scores. From there, they started educating the lead physician at the practice, then moved on to each physician within the practice systematically.

Though HCCs broadly represent a fairly common area for outpatient CDI focus, the team at Asante Health System in Medford, Oregon, decided to narrow their focus to a specific patient population. Oregon (along with Arkansas, Colorado, Hawaii, Michigan, Montana, New Jersey, and Ohio, plus select areas of Kentucky, Missouri, and New York) is part of CMS' Comprehensive Primary Care Plus (CPC+) pilot program. The program discounts the fee-for-service payment for the providers in participating areas, but adds a care management payment.

"We narrowed our focus down to our CPC+ patients as a place to start, which gives us a more manageably sized patient population. Eventually, we hope to expand to all payers, though," says **Ellen Jantzer, RN,** the CDI coordinator at Asante.

Staffing the program

Following focus, identifying appropriate staffing levels and qualifications for outpatient efforts represents the next challenge. Like the inpatient CDI world, outpatient CDI specialists can come from a variety of backgrounds, the most common of which are nursing and coding. In many cases (though not exclusively), outpatient CDI specialists transition from an already established inpatient CDI program, as was the case at West Virginia University Medicine. Diven pulled from the existing

inpatient program and opted for the best of both worlds when it came to professional background and experiences: She has a nursing background, and the program's other member has coding experience, she says.

"My other team member is an RHIT and has been in CDI for eight years now. She's a very strong coder with a lot of experience, and she has the clinical knowledge, too. I feel pretty strong in coding myself, but I always love to have a coder with me," she says.

Asante also pulled inpatient CDI specialists over to its outpatient program partly because of the geography of the project. Medford, Oregon is pretty rural— "We're a small health system, but we're the biggest in the area," says Jantzer—so Asante's decision to keep things local was partly driven by self-preservation.

"If I bring in someone with CDI experience but no ties to the area, are they even going to stay?" says Jantzer.

But now, as the outpatient program is getting its sea legs, Jantzer has other staffing concerns to consider. Asante recently hired two more staff for outpatient, neither of whom have previous CDI experience.

"We're still figuring out how to go about training them. Productivity and efficiency always take a hit during training," she says. "Right now, we see something we don't know and then we talk about it—a lot. It's sort of like little kids playing soccer. We're not playing the field

very well right now; we're just chasing the ball around."

Of course, starting a new CDI program in any setting requires facing some challenges. The important thing, says Diven, is remembering that everyone's on the same team.

"You can use all coders or all RNs, but you need to have strong people either way," she says.

Physician engagement and education

Record review timeframes also differ between the inpatient and outpatient setting. The average patient spends just under 16 minutes at a primary care office visit, according to *a 2007 study by Health Services Research*. Compared to an inpatient stay stretched over several days, CDI specialists may quickly feel overwhelmed by the scope of the effort.

Because of the extremely fast paced nature of outpatient encounters, CDI specialists in this setting need to rely more on education than queries to gain physician engagement.

"We've done a little bit of everything. We've done education through the query process and also through group education. We also do individual, face-to-face education and ask the providers what they need," says Diven. "We want to do something that works best for them. What they really want are face-to-face interactions, tip sheets, and the query process, so that's what we do."

Diven and her coworker have taken a personal approach to physician engagement through

one-on-one education sessions with the providers to individually win them over and answer their questions. Sometimes, though, it simply takes an escalation policy to start the ball rolling, according to Jantzer.

"On the inpatient side, I'll go to educate the hospitalists and our physician leaders will come with me. It's hard to wiggle out of something if your boss is there too," she says. "We're pulling that same idea into our ambulatory program."

By finding and recruiting a few physician champions to help spread the good news of CDI, Jantzer and her team hope to limit the physician engagement struggle on the outpatient side.

"We're having really good conversations already with select providers. And, actually, I even appreciate the people who are a little more resistant and ask more questions because they help keep us accountable," says Jantzer.

Despite the occasional bout of uncooperativeness, working with physicians to meet their needs, creating some an accountability system, and finding champions helps illustrate the importance of the program to providers.

"We try to tailor the education to the department and what works for them," says Diven. "The CDI specialists become a patient care team member in a sense rather than someone who's just annoying the physicians."

Measuring success

Measuring the success and effect of an outpatient CDI program represents another challenge. This is partly due to the dearth of adequate tracking software available for the outpatient space. While 99.14% of the respondents to *the 2017 CDI Industry Survey* said they use either a completely EHR system or a hybrid, the outpatient world is a bit behind this curve. And, of course, the lack of software means that everything has to be tracked by hand.

"Everyone's using shared Excel spreadsheets again, which can be really difficult when the CDI team grows. It just takes one mistake to wreck all the data," says Jantzer. "It also makes it very hard for me to prove a return on investment because I'm just in an Excel sheet doing it by hand. It's much better when the data's pulled from a report."

Even though neither Jantzer nor Diven have technology solutions just yet, they're both tracking the same metrics themselves.

"The main thing we're going to look at is our HCC capture rate, but we're also going to monitor the RAF scores of the physicians and the patients, and we're going to look at our query response rate and the number of reviews we're doing," says Diven.

"CDI's not production oriented, but we are also monitoring the number of reviews because as we put processes in place and gain knowledge, our review numbers should go up," says Jantzer.

Despite monitoring the CDI productivity numbers (along with HCC capture rates and RAF scores), Diven and Jantzer say there aren't many benchmarks available for outpatient CDI because of how new it is. As more and more CDI programs branch out, those metrics will emerge, but CDI specialists need to communicate with each other across facility lines, according to Diven and Jantzer.

"I think we're all either going to sink or swim together," says Jantzer. "We need to be talking to each other."

CDI Leadership and KPIs: Long live metrics

By Allen Frady, RN-BSN, CCDS, CCS, CRC

If you mention analytics or key performance indicators (KPI) in relation to thought leaders on social media, you may be treated as though you've just suggested the world is flat and the earth is the center of the solar system.

While a number of people may not have realized the sun is in fact bigger than the earth, there has been an awakening of sorts about the unintentional consequences of metrics that are applied dogmatically and without an appropriate understanding of what they portray. Certain complaints have basically become a war cry with catch phrases such as "no more analytics without insight."

Yet there's an identifiable cause behind the inappropriate use of metrics. Sometimes, those with little experience suddenly find themselves in charge of CDI efforts. Directors of case management, quality, or finance, for example, might take over the program due to consolidation or other factors and yet receive little training on the import of their new role.

What is someone with no CDI experience, no coding expertise, and no real understanding of healthcare revenue to do when told, "Oh, by the way, you are now in charge of the CDI program?"

To add insult to injury, these poor managers receive very detailed and confusing analytics (expensive ones, too, if they come from a consulting firm or software product) that suggest areas of performance improvement without any real insight as to how and why that performance improvement happens.

Understanding the value of such data, requires years if not decades of experience working within the healthcare revenue, Medicare, coding, and regulatory circles.

But because embattled managers often lack this experience, they frequently draw incorrect conclusions from the data, with unintended consequences. Imagine a consultant tells a new CDI manager that a higher query rate could improve diagnosis capture for non-ST-elevation myocardial infarction (NSTEMI), thereby increasing case-mix index, revenue, and severity. The unsuspecting manager, who is essentially at the consultant's mercy, orders the CDI staff to focus on NSTEMI diagnoses.

CDI staff follow orders and begin dropping queries even on potentially inappropriate cases. The cardiologists then reject the diagnosis of NSTEMI and stop responding to queries, leaving the CDI staff with an increase in both non-response rate and disagreed queries.

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>
> *– Allen Frady, RN-BSN, CCDS, CCS, CRC*

The unintended consequence is that no performance gains occur, and the CDI staff end up with a lower annual review.

In this not-so-hypothetical example, no one thought to actually look at the NSTEMI criteria or have a conversation with cardiology to determine if they even should be querying on the matter.

Even worse, no one realized a new code had come out that specifically captures a type 2 MI and acknowledges that an NSTEMI can (in theory) be represented with or without ST elevation—or, perhaps more likely, that a type 1 MI can sometimes manifest with or without ST elevation. In the end, initiatives that attempt to fully leverage ICD-10-CM coding for clinical accuracy often end up as an exercise in futility.

For the queries that received a positive response, meaning the physician added unspecified MI as a

diagnosis, there are still more unintentional negative consequences: The data now seems to show that hospital-acquired MIs not present on admission have increased, or that quality measures for addressing MI on admission were not followed.

Queries answered with partial answers and/or improper coding further result in the addition of codes triggering the expectation of protocols that were actually not indicated. And to top it all off, poorly supported diagnoses end up as chum in the water for auditors, who end up issuing massive chart requests for MI records.

It doesn't have to be this way. What if the CDI manager understood that the facility had a lower MI capture rate because such patients were regularly routed to a cardiac care center by ambulance services? With this knowledge, the manager could conclude that the analytics are showing results completely within expectations—meaning he or she could shrug off the consultant's advice to increase the query rate.

And what if the manager understood that type 2 MIs are highly likely in patients admitted for shock, respiratory compromise, severe sepsis, severe dehydration, rapid cardiac arrhythmias, and certain types of drug overdose? He or she would know that those populations with higher numbers of type 2 MI do not indicate poor care on the part of the hospital or overly aggressive CDI tactics, but simply show that genuine documentation improvement has occurred.

In many cases, the audience making the rules or leading the program does not understand even basic information like the above. Conversations about interpreting analytics and CDI policymaking are not for the uninitiated, and overly simplified KPIs do not always mean what they appear to mean.

A CDI specialist with a high query rate isn't necessarily doing a better job than one with a low query rate if the first specialist is asking a lot of unnecessary questions. A physician with a high agree rate doesn't necessarily have better documentation than one with a low agree rate if the queries being posted are bad queries. A physician with a high complication rate isn't necessarily giving subpar care if he or she is accepting more high-risk patients. And a low case-mix index does not necessarily mean

that the documentation is poor or that the patients at the facility are not very ill—it could mean either of these things, but there's no way to know without context.

I am a very data-driven CDI practitioner; I like analytics and find them useful. That's because I understand the nuances involved in correctly interpreting the data, asking the right questions to help make an accurate root cause determination, and judiciously (not broadly) applying policy change to test that determination.

Given the right context and interpretation, KPIs/analytics are incredibly useful tools. Data is not inherently flawed or evil. Where the train goes off the tracks is usually with the methodology used to obtain the analytics (a subject I haven't even gotten into here) or with the interpretation of the meaning of the data and response to that data.

So, who is at fault for all the confusion? The vendor of the data? The consultant who brings it to the facility? The CDI leadership who underestimated the skills, education, and experience required to put the information to proper use? The salesperson who sold the data as the answer to all of the facility's problems?

To be honest, I would say all of these parties bear some of the responsibility—and all are accountable for fixing the problem. CDI needs direction and a way to measure its outcomes; we cannot run an industry on goodwill and hope alone.

Healthcare data is based on proper coding, which in turn is based on documentation that must be stated in a very specific way lest it be lost in translation. Revenue, quality, mortality, and efficiency are predicated on specifically defined criteria that are indeed measurable and actionable. I am deeply concerned with the trend I see on social media of moving away from forward-thinking concepts and plunging into the tenets of "just document good." We need measurements, not mysticism.

Case Study: CDI informaticist eases data woes

Any CDI manager knows how important reliable CDI data is for benchmarking, goal setting, and proving a return on investment. Getting your hands on that data, though, can be much more difficult than you might hope. Between the intricacies of working with different EHR systems and busy workloads, it can be challenging for a CDI manager or director to juggle applications, let alone validate data, run reports, and further the CDI department's scope.

To mitigate this issue, the CDI team at OhioHealth in Columbus formed an unusual role within the department—a CDI informaticist—dedicated to managing the CDI systems, generating reports, analyzing available data, and providing support for department expansion.

As the facility increased its EHR use, **Tonya Motsinger, MBA, BSN, RN,** system director of CDI at OhioHealth, found herself spending an ever–increasing amount of time dealing with CDI application issues, EHR integration, and addressing the data analysis needs of her department. "It became a real imperative to find someone who could manage that data for me," she says. "Also, navigating the complexity and problems within CDI tools and EHRs became increasingly important to minimize productivity loss."

Of course, in order to hire the right candidate, Motsinger had to establish the parameters of this new position.

Job parameters

When OhioHealth implemented a new CDI application across six facilities, it enlisted a information systems (IS) project manager. Motsinger leveraged that project manager in developing the informaticist job description and ultimately hired her for the role.

"After we implemented the new CDI application, I could see they needed an analyst," says **Tricia Ramey, PMP,** clinical informaticist administrator at OhioHealth. "About a year after that, [Motsinger] called me and said they were looking for someone and needed help with the description. I thought to myself, 'I can't wait till this job opens because it's so exciting.' "

The right candidate needed some measure of clinical knowledge as well as IT and informatics skills due to the complexity of data reporting and analysis required.

"It's a little bit of project management, some IT skills, and analytics, says Ramey. "I think great communication skills are also a requirement. It's not really a programming role, but a little bit of understanding does help. Really, just a diverse background in healthcare and IS brings a lot to the table."

Motsinger found Ramey was actually the perfect candidate: They were already familiar with each other, and both knew the exact expectations for the role, which eased the transition tremendously.

"I already knew this team, and I was excited to help put even more value into this department," says Ramey.

Daily duties

Though the goal of adding value is a lofty one, making that goal a reality is multifaceted.

Much of the role focuses on system support and data analytics. Managing the CDI application that interfaces three EHR systems takes up most of Ramey's time. Working with the software vendor and other departments ensures everything runs smoothly. Ramey also creates monthly scorecards that are distributed to facility and physician leadership and individual CDI specialists. "[Those reports] show us how we're doing individually, as a system, and as individual hospitals. Plus, I validate that data too. I have to ask, 'is it telling us what we really think it's telling us?'" she says.

Because of her IT background, Ramey also has the foresight to see what the department needs from a technical perspective. "She's done a lot of work on our CDI intranet page—she's actually the chair of our [intranet] committee. We know that all of our materials are available system-wide now, which is very beneficial," Motsinger says.

Recently, Ramey also designed an internal audit tool that the senior CDI team members use. She also assists with physician tip sheets and new query formatting, as well as other application testing and communications. She also assesses upcoming changes for impact to the CDI workflow and manages access to systems for the CDI department and outside audit consultants.

As new ideas develop, Ramey's expertise is often called upon to formulate application processes. "When we bring up a new problem, there's a lot of IS management involved. We're able to move faster on our projects with her help," says Motsinger. For instance, Ramey managed the integration of a children's hospital's EHR system into OhioHealth's CDI application so the cases could be reviewed.

The CDI program at OhioHealth is always developing new ideas and strategies. "I've learned to bring my notebook with me when I meet with [Motsinger]," says Ramey of her evolving duties.

Of course, some duties of the job weren't planned in advance. "A CDI specialist might call with a computer issue and I can help them. It's not really what I was hired for, but it's really added value to our department," says Ramey. "My job is really to make their jobs easier."

Benefits to the department

It can be a huge challenge to implement a consistent CDI program across facilities and hold CDI specialists systemwide to the same standards.

"All the hospitals in our system are different sizes and therefore the cultures are all very different. [The data Ramey finds] gives us a better idea of how to set targets and goals," says Motsinger. "The same benchmarking doesn't work for all types of facilities. We do deep dives into the data in order to set appropriate targets."

The increased data and analysis not only allow for better goals at each facility, but also help identify education opportunities and progress. "Being able to produce reports to the physician on how their department or specialty is doing has been invaluable," says Motsinger.

"You really need someone to run and validate the data. You need someone to bring things to the forefront that aren't readily available in the CDI application or EHR," says Motsinger. "With more data to work with, you can drive your program effectively and efficiently because you clearly understand which direction you are trying to go and you can anticipate the bumps in the road."

Minimizing traumatic experiences in trauma reviews

"The cases can be anything from a simple pneumothorax to someone who's been crushed from head to toe," says **Kristie Perry, RN, MHSA, CCDS, CCS,** CDI specialist at Erlanger Health System, a Level 1 trauma center in Chattanooga, Tennessee.

EDs at designated trauma centers encounter some of the most complex patients—and with them, a complicated documentation web that's difficult for even the most experienced CDI specialists to untangle.

While that difficulty is due partly to the complexity of the patients' conditions, communicating with physicians in a high-pressure situation where every moment could literally be a life or death presents additional challenges, says **Patricia Swierczynski, BSN, RN, CCDS, CRC,** CDI specialist II at Cooper University Health, a Level 1 trauma center in Camden, New Jersey.

Working with physicians in their environment allows the CDI specialist not only to gain an appreciation of the grueling intensity of a trauma surgeon's day, but also to formulate better teaching strategies that are more conducive to the physicians' workflow.

"Be ready to be flexible and creative when rounding with these physicians," says Swierczynski. "We are there to alleviate the tedious rules of documentation and allow our physicians to focus on patient care."

Why review trauma cases

When Cooper University Health started reviewing its trauma cases, the CDI team discovered a lack of documentation led to reduction of resources needed for treatment of such critical cases, says **Rebecca Willcutt, RN, BSN. CCDS, CCS,** director of CDI at Cooper University Health.

"Our CDI specialists always review the admit type and source code

because these codes need to be accurate for proper billing, patient safety indicator (PSI) allocation, type, and priority of inpatient admission, as well as the very important reason: The trauma activation fee," says Willcutt. All designated/verified trauma centers, such as Cooper, can receive a one–time (per encounter) trauma activation fee to offset the costs of the trauma team response, according to Willcutt.

"Trauma cases are an admit type 5, and if this is incorrect on the UB-04, the fee cannot be charged," she says. "When reviewing the admit types, we noticed that admit type 5 was not being used on the majority of trauma cases, which resulted in us losing that fee. We quickly initiated a six sigma workout that involved multiple departments (CDI, HIM, admissions, billing, and ED), and developed a process to capture 100% of these cases," Willcutt says.

"During the course of this," she adds, "We also realized that Cooper's activation fee had not been updated in years and undertook additional measures to remedy that. This led to a significant increase in revenue to the trauma department, which in turn helped Cooper neutralize some of the costs of caring for those high–acuity patients and maintain specialty staff and equipment 24/7."

Furthermore, trauma physicians often leave information out of the documentation because they consider it an automatic assumption, adds Perry.

"Think about brain injuries," she says. "Yes, nine out of 10 have cerebral edema and often it involves a compression, but we still need that data documented. The trauma registry needs it, too."

That trauma registry, in turn, helps the facility understand its patient population, track resource expenditure, and ultimately provide better care for its patients.

Establishing conditions as present on admission (POA) and integral to other injuries also prevents the hospital from taking a hit on quality scores and reimbursement, says Swierczynski.

"A lot of the time, a patient will have simple lacerations with a truly horrific abdomen, but because the physician didn't document the POA status, we're getting dinged for it," she says.

Complex patients and complex documentation concerns

Everyone working in CDI likely has some common query opportunities they could rattle off fairly quickly—whether they be the "low-hanging fruit" diagnoses, those which require precise documentation to capture the correct ICD-10-CM/PCS code, or facility-specific concerns.

For trauma centers, most of the documentation insufficiencies stem from the high level of specificity needed for these patients coupled with physicians' time constraints. Given the choice between saving a patient's life or documenting the patient's injuries, physicians will choose the former option. That

means CDI specialists have to be smart about following up on cases after the patient is stabilized.

"If there's something like a pneumothorax documented on day 3 of the admission for the first time, you can't assume that was due to the trauma. You have to query it," says Swierczynski.

Though that pneumothorax may have been present since day 1 and the physicians are caring for every injury present, very often the physicians tend to document the most prominent life–threatening injuries first when prioritizing their care. Coding cannot assume any relationship.

Because of coders can't assume, CDI specialists reviewing trauma cases need to be prepared to query for a POA status when they notice new conditions cropping up in the documentation several days into an admission.

Swierczynski often finds some of the greatest opportunities associated with some of the shortest lengths of stay—though those are often the records for patients who expire soon after admission. Sometimes, she says, "the sicker they are, the less the physician says."

Physicians caring for extremely complex patients with multiple traumatic injuries tend to assume that their limited documentation using "doctor language" or "medical speak" is sufficient to capture the acuity of these patients.

Some examples of this are "profound hypotension" instead of hemorrhagic shock and "vent dependent" rather than acute hypoxic

respiratory failure, Swierczynski says.

"Translation is key in this physician population," she says.

Whether or not the patient expired, however, tracking down trauma physicians to get queries answered can be difficult.

On many cases, Perry says, many physicians will be caring for a single patient with multiple traumatic injuries.

Trauma cases often require insight from a wide variety of specialists such as cardiothoracic surgeons, neurosurgeons, gastroenterologists, and orthopedists.

"When you have five consultants on a chart and they're all going to the operating room as soon as the patient's admitted, it can get a little overwhelming," says Perry.

"Reading through all those op notes and keeping your head clear and focused enough can be really difficult."

Tips for overcoming challenges

With so many providers working on a single patient, it's important to have strategies to deal with the documentation deluge.

"I always start by looking at the trauma nurse's notes and the clinical criteria," says Swierczynski.

"I look at the pertinent scans and labs and see if the physician progress notes are congruent with the evidence. Once I'm done, I usually have some query opportunities to follow up on."

Even after combing through the charts, the scans, and the notes, both Perry and Swierczynski tout the benefit of face-to-face conversations with the trauma physicians.

"I think if you were to poll the residents I work with, they would tell you that me being out there while they're

> **"Take it slowly. Piece by piece, diagnosis by diagnosis, and familiarize yourself with the nuances of that diagnosis. Even still, there may be scenarios where you have to call for help."**
>
> *Kristie Perry, RN, MHSA, CCDS, CCS*

rounding is more beneficial than a written query. They understand what I'm asking better, and it sticks a little better when you discuss it verbally," says Perry.

Go into those conversations well prepared, Swierczynski cautions. "I always go through the chart and then go down to the unit to round so that I already know what's missing and am prepared with the clinical evidence," she says.

"Trauma physicians usually talk in symptoms and in treatments—for example, 'shift' instead of vasogenic edema or brain compression and 'pressor dependent' instead of hypovolemic shock. So, you have to look for what they're not saying and again assist in narrowing that translational gap by teaching physicians

to supplement their language with diagnoses."

Spend time with the code book, says Perry. Knowing how the documentation will be coded can help you identify what might be missing from the chart.

"When ICD-10 was implemented with all that specificity, I had to sit down with the code book and figure out what things coded to," Perry says. "A lot of that knowledge just comes from sitting and studying, and there's no real way around that."

Walking through some coding examples may also illuminate places for additional education and physician collaboration, says Perry.

When ICD-10 was implemented, Perry and her team sat down with one of the trauma surgeons and actually walked through the code book to develop coding crosswalks for things such as a grade 2 spleen laceration.

"Then, I compiled the document that gave the coders a crosswalk, and all the trauma surgeons signed off on it. Now, our HIM/coding supervisor provides it to all the new coders."

Even armed with tips and tricks for reviewing complex trauma cases, Perry says, the main thing CDI specialists need is time.

"Take it slowly," she says, "Piece by piece, diagnosis by diagnosis, and familiarize yourself with the nuances of that diagnosis. Even still, there may be scenarios where you have to call for help."

Coding POA pressure ulcer after debridement

Q: I understand the *Official Guidelines for Coding and Reporting* related to pressure injuries and present on admission (POA) status. For example, I know that if a decubitus ulcer is a stage 1 on admission and progresses to stage 4 during the stay, we are to code stage 1 POA-yes and stage 4 POA-no.

However, the *Official Guidelines for Coding and Reporting* do not specifically address the deep tissue injury and unstageable pressure injuries as related to them being unstageable until the wound bed can be seen.

I understand that unfortunately the *Guidelines* are not always up to date with the clinical advice.

If an unstageable pressure injury that was POA was immediately debrided and was found to be a stage 3, then it would be a stage 3 POA-yes.

However, it may be some time before the wound is debrided to reveal the stage 3. The documentation would appear to be a progression of the injury.

For example: On the day of admission: November 1, the physician documents, an unstageable sacral pressure injury.

Then, on November 5, the physician documents s/p sacral debridement of decubitus ulcer stage 3.

In the above scenario per the *Guidelines*, it appears one would code the unstageable sacral pressure injury as POA-yes and the stage 3 sacral pressure injury as POA-no. Is that correct?

I have discussed this concern with several wound care nurses. Some are comfortable documenting "unstageable, likely to be a stage 3 or 4 POA," and others are not.

Would that documentation be clinically accurate and ethically coded as POA-yes?

Any thoughts on how to make this coding and clinical situation correspond?

A: Let's start by looking at the *Guidelines* as well as AHA *Coding Clinic* instruction related to the code assignment for pressure ulcers.

Section 1.C.12.a.2

Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on the clinical documentation. These codes are used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma. This code should not be confused with the codes for unspecified stage (L89.--9). When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage (L89.--9).

This instruction tells me that the codes classifying a pressure ulcer as unstageable should be assigned when the wound bed of the ulcer cannot be visualized to accurately apply staging.

This can be a wound covered with a thick eschar covering, one with a thick covering of slough and necrotic tissue, or one that has been treated with a skin or muscle graft. We cannot stage the wound because we clinically cannot see the depth or extent of the tissue damage.

I am not a wound specialist, but from my years of nursing experience, I can say that those wounds

with a thick covering of eschar are likely a stage 3 or 4. But since I cannot see how deep the wound is, I must describe it as unstageable.

This *Guideline* also reinforces that a deep tissue injury not due to trauma is classified as an unstageable pressure ulcer as well. Clinically this makes sense as this type of injury describes damage to the subcutaneous tissue.

Let's compare that to the definition of a stage 3 pressure ulcer—an ulcer that extends into the underlying subcutaneous tissue layer, but not all the way to the bone.

Most nurses have seen the patient who presents with intact skin, but with a deep tissue injury that when bumped or irritated can instantaneously open up, and when cleaned or debrided demonstrates a stage 3 or 4 ulcer.

Section 1.C.12.a.6

If a patient is admitted to an inpatient hospital with a pressure ulcer at one stage and it progresses to a higher stage, two separate codes should be assigned: one code for the site and stage of the ulcer on admission and a second code for the same ulcer site and the highest stage reported during the stay.

This *Guideline* introduced last year also makes sense and was devised to more accurately capture quality measures related to the care of pressure ulcers.

It also stresses the importance of accurate and timely skin assessments to be completed on admission, and throughout a patient's stay.

When introduced, however, it prompted many questions as to how it pertains to ulcers we cannot stage, because likely these wounds are stage 3 or 4 ulcers and we simply could not assess them on admission.

This led to the following advice in *AHA Coding Clinic,* Fourth Quarter 2017:

Question: What are the correct ICD-10-CM codes and POA indicator for an unstageable pressure ulcer in which an eschar is removed during the patient's stay to reveal either stage III or stage IV pressure ulcer?

Answer: If a patient is admitted with an unstageable pressure ulcer, and the eschar is removed to reveal the stage of the ulcer, assign the code for the ulcer site with the highest stage reported during the stay with a POA indicator of "Y." Do not assign a code for unstageable pressure ulcer, as the true stage of an unstageable ulcer cannot be determined until the slough/eschar is removed. The opening of the wound does not indicate a progression to a higher stage. The code for unstageable pressure ulcer should only be assigned

when it is not possible to stage the ulcer during the current encounter.

Now let's apply this *Coding Clinic* advice to your scenario.

There is no timeline guidance in this *Coding Clinic*, meaning that even if there is a delay of several days after admission, the unstageable pressure ulcer on admission would be coded with only one code of a stage 3, POA after the debridement or unroofing was complete.

Clinically, the fact that the wound was opened does not indicate a progression in the wound—the wound was a stage 3 on admission. There is no need for the clinician to state "unstageable pressure ulcer, likely a stage 3 on admission."

No pun intended, but the AHA *Coding Clinic* has this situation "covered." (OK, well maybe the pun was intended.)

I encourage you to continue to work with the wound care nurses so they understand the importance of capturing these wounds accurately on admission as well as throughout the stay. Their documentation is so important in your efforts to ensure accurate code capture.

The malnutrition dilemma continues

By Lynelle A. Clausen, RN, BSN

I started working as a CDI specialist in May 2014, and was assigned to oncology, intensive care and the step–down unit (SDU) to complete reviews. I have a seasoned clinical background in these areas and knew what to look for in the medical record. After working as a CDI specialist for a few months, I was looking for MCCs (e.g., acute respiratory failure, acute tubular necrosis, and even severe protein–calorie malnutrition), and for CCs, e.g., acute blood loss anemia, chronic respiratory failure with hypoxia, and even mild or moderate malnutrition. I started to realize how often I was querying for malnutrition and wondered why the licensed independent practitioners (LIP) were not documenting it.

The LIPs described weight loss of so many pounds in a short period as "muscle wasting, loss of subcutaneous fat, cachectic" (instead of cachexia), and "underweight" with a body mass index (BMI) of 16. There were orders for registered dietitian (RD) and speech language (SL) consultations, along with occupational therapy (OT) and physical therapy (PT) evaluations and treatment plans. They also noted laboratory work orders and monitored an insertion of feeding tubes, plus initiated and/or continued tube feedings.

The LIPs were clearly treating a condition but not documenting it. Queries were sent and contacts made with the LIPs and the registered dietitians.

After reviewing the literature, I learned the shocking statistics: Malnutrition is present on admission up to 50% of the time and another 30% of hospitalized patients will develop it, according to (*"Coding for Malnutrition in the Adult Patient: What the Physician Needs to Know" by Wendy Phillips, MS, RD, CNSC, CLE*). If these statistics are accurate, then under documentation of malnutrition is definitely occurring in our medical records.

Another *recent study published in Public Library of Science ONE online journal*, states the U.S. spends upwards of $15.5 billion per year in direct medical costs on malnutrition associated with eight diseases. The total economic burden of disease-associated malnutrition in the U.S., including direct medical care and indirect care, poses a $157 billion burden each year, according to *an article in the September 2014 Journal of Parenteral and Enteral Nutrition*. Malnutrition will always be a major consideration in patient care determinations, reimbursement, and other risk factors/medical conditions due to the malnutrition.

> **"If [the] statistics are accurate, then under documentation of malnutrition is definitely occurring in our medical records."**
>
> *– Lynelle A. Clausen, RN, BSN*

Considering the scope of the problem, our CDI program decided to review *the American Society for Parenteral and Enteral Nutrition (ASPEN) criteria* and make a clinical documentation tip sheet for malnutrition. (See the malnutrition tip sheet on p. 29.) Consequently, I learned more about malnutrition and clinical documentation concerns:

1. There are no nationally recognized standards, according to HCPro Boot Camp Instructor Allen Frady, RN-BSN, CCDS, CCS, CRC, who spoke on *the September 2017 ACDIS Radio*.

2. The ASPEN criteria are subjective, as they estimate energy intakes and do not include social and environmental risk factors or loss of muscle mass. Subcutaneous fat determination is also subjective as mild, moderate, and severe without detailed guidance for fluid accumulation and edema and how such conditions may mask weight loss (See the *CDI Pocket Guide* by Richard D. Pinson, MD, FACP, CCS, and Cynthia L. Tang, RHIA, CCS)

3. There are variable pre-existing factors associated with malnutrition, such as chronic illness

of malignancy disorders; HIV; end-stage liver, heart, or renal diseases; eating disorders; elderly (frail, weakness, easily fatigued, and deconditioning); COPD; dementia/Alzheimer; Parkinson's; depression; and other psychiatric disorders. (See the white paper from the National Association of Clinical Nurse Specialists, "Malnutrition in Hospitalized Adult Patients"). At admission, the provider needs to add the secondary diagnosis of malnutrition with type, severity, and present on admission status.

4. Acute variables include sepsis and/or systemic inflammatory response syndrome, trauma, other acute inflammatory conditions, such as pancreatitis and prolonged NPO status (e.g., small bowle obstruction with nasogastric suction, prolonged intubation with ventilator periods, enteral feedings, and/or total parenteral nutrition).

5. There are also social–environmental risk factors (e.g., homelessness, poor dentition, isolated and unable to procure food, unable to feed self, food not appetizing or unfamiliar, prolonged fasting/starvation and/or polypharmacy).

6. During medical school, very little is taught about nutrition. Dr. Mary Newport stated that she received about three hours' class time on nutrition.

In 2016, The Joint Commission required a nutritional screen be completed within 24 hours of admission. If there is even one "yes" response on the nutritional screen, the registered dietitian is alerted to complete a further assessment within 48 hours. The dietitian writes a progress note to the principal care provider that includes a diagnosis and treatment plans. Coders are not allowed to code from the dietitian's progress notes, and the medical diagnosis must be determined and documented by the physician in the medical record (See Phillips). The problem here is that the principal care provider has so many areas of the chart to review that he or she may overlook the dietitian's progress notes. Sometimes the electronic medical record is a barrier in communication as there are so many areas to collect information from. This is a good time for the CDI specialist to query using this information.

Do you see how complicated it is to get to the diagnosis of malnutrition? According to Robert S. Gold, MD, in *ICD-10 Documentation Strategies to Support Severity of Illness*, "The complexity of physicians' medical decision–making reflects the complexity of the patient, and terms that the physicians use in the medical record lead to code assignments that either do, or do not, inform the database that they know their patient. … All [this] occurs through analysis of ICD codes and how the physician's documentation justifies assignment of the correct ICD-10 code." By improving the clinical documentation of malnutrition, the use of resources (RN, RD, OT, PT, SL, etc.) and the severity of illness (SOI) and risk of mortality (ROM) all more accurately reflect the patient care, patient outcomes, and patient safety.

> ❝ **"Sometimes the electronic medical record is a barrier in communication as there are so many areas to collect information from."**
> *– Lynelle A. Clausen, RN, BSN*

Pinson states that "since coding and documentation impacts the pay-for-performance outcome measures and rates based on comorbid conditions and whether a condition is classified as a hospital-acquired condition, it is important to incorporate pay-for-performance initiatives into your existing CDI program. … The five categories with the greatest impact on risk adjustment are metastatic cancer, lung and other severe cancers, quadriplegia, paraplegia, and malnutrition" (*See the article "Hungry for Accuracy on Malnutrition" by Rachel Mack, RN, MSN, CCDS, CDIP*).

In ICD-10, the malnutrition codes are E40–E46. There are four malnutrition diagnoses that are MCCs, but only one MCC that should be used in the U.S. healthcare system: E43 (unspecified severe protein-calorie malnutrition), E40 (kwashiorkor), E41 (nutritional marasmus), and

E42 (marasmus kwashiorkor) are most often found in developing countries.

The rest of the malnutrition codes are CCs. E440 and E441 are moderate and mild protein-calorie malnutrition, respectively, and E46 is unspecified protein-calorie malnutrition.

Get the word out to your LIPs with malnutrition tip sheets, educational opportunities, queries, article sharing, and your own facility research. At Centura Health in Colorado and Kansas, we have developed the Malnutrition Partnership Initiative: Collaborative Process with Registered Dietitians and CDIS Associates. So far, four of the 18 hospitals have initiated the partnership process to improve clinical documentation of malnutrition, and presently we are compiling the results of the collaboration and how it affects the DRG, SOI, ROM, and reimbursement. Eventually, all 18 hospitals will redefine their process and incorporate the partnership.

Malnutrition is something all healthcare team members need to be cognizant of in order to see the patient's total healthcare needs. 🌿

Editor's note: Clausen is a CDI specialist at Porter Adventist Hospital, Centura Health, in Denver, Colorado. The opinions expressed are hers alone and do not represent a consensus agreement of ACDIS or its Advisory Board. Contact her at *LynelleClausen@Centura.org*.

See why Pinson & Tang's CDI Pocket Guide is the go-to resource for so many CDI professionals.

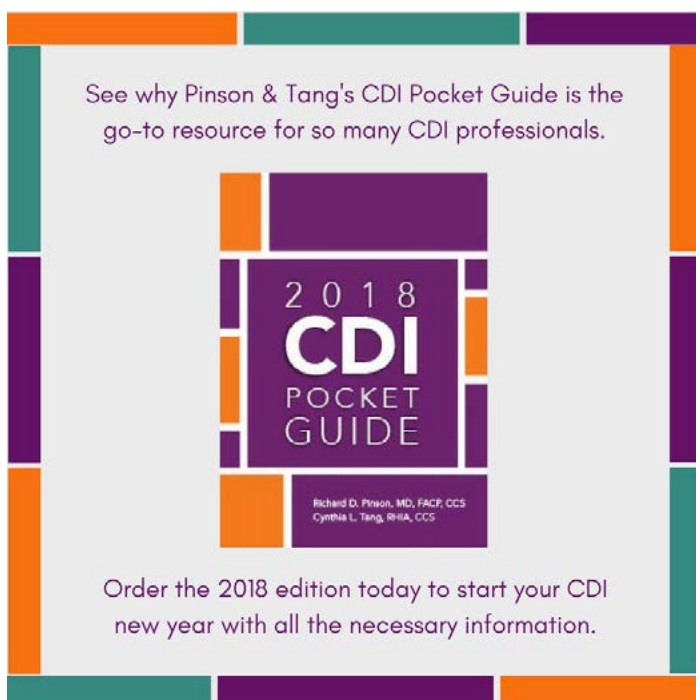2018 CDI POCKET GUIDE

Richard D. Pinson, MD, FACP, CCS
Cynthia L. Tang, RHIA, CCS

Order the 2018 edition today to start your CDI new year with all the necessary information.

DOCUMENTING MALNUTRITION TIP SHEET

To meet the criteria for a reportable secondary diagnosis, malnutrition must have bearing or relevance in terms of patient care. This means it must prompt clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, and/or increased nursing care and/or monitoring.

ASPEN Criteria for Malnutrition

(Must have a minimum of two characteristics; numbers 2 and 5 are mutually exclusive.)

1. Insufficient energy intake
2. Weight loss
3. Loss of Muscle
4. Loss of Subcutaneous fat
5. Localized or generalized fluid accumulation that may sometimes mask weight loss
6. Diminished functional status as measured by hand grip strength.

Source: Pinson R, & Tang C. (2017). *2017 CDI Pocket Guide.* HCPro.

Three contents

1. Chronic illness of three months or more: Metastatic cancer, HIV, end-stage liver disease, end-stage renal disease, end-stage heart disease, etc.
2. Social and environmental circumstances: Severe disability, elderly living alone without social support or lack of care, homeless, etc.
3. Acute Illness or injury, with a duration of less than three months: Multisystem trauma, intubation, prolonged ventilation, or limited food intake.

Diagnostic criteria include physical findings (e.g. cachexia, wasting of muscle, or loss of subcutaneous fat); risk factors; biochemical markers (not due to other causes); and BMI less than 19; low body weight relative to ideal or usual weight; and recent or progressive unintentional weight loss.

Editor's note: This tip sheet was provided by Lynelle Clausen, RN, BSN, a CDI specialist at Porter Adventist Hospital, Centura Health, in Denver, Colorado, in conjunction with her article. The opinions expressed are hers alone and do not represent a consensus agreement of ACDIS or its Advisory Board. Contact her at *LynelleClausen@Centura.org*.

Welcome to the incoming Chapter Advisory Board

ACDIS currently has more than 40 state and local chapters as well as networking interest in the Eastern Mediterranean, Australia, the Bahamas, and elsewhere. In addition to these geographically based educational offerings, ACDIS also supports topic-focused efforts such as the CDI educators' network, and the Association of Pediatric Documentation Specialists (APDIS); in 2018, it also plans to create a network for directors and managers, as well as one for physician advisors.

Each local chapter or networking group is required to have three official volunteer liaisons who work directly with the ACDIS national administration to ensure events provide valuable information related to the work professionals perform. Most hold events quarterly, and some groups have more formal structures than others. Some collect dues; some don't. Some hold large, full-day events that gather more than 100 attendees. Others host after-hours events at a host facility or nearby restaurant where they exchange ideas on hot topics and commiserate over common difficulties.

To support the efforts of the hundreds of volunteers across the country and internationally, another group of volunteers regularly joins the ACDIS administration—the Chapter Advisory Board (CAB). This committee has met regularly over the past five years, and this year it will enter a new phase of work with a new set of volunteers. Its core duties and responsibilities include:

- Monthly teleconference calls with CAB members and ACDIS administration
- Quarterly webinar panel discussion with CAB, ACDIS, and the chapter leadership community
- Annual review of leadership resources/toolkit
- Contribution of policies and procedures and best practices for inclusion in the toolkit
- Annual review of the formal local chapter agreement form
- Abiding by and advocating for ethical adherence to the agreement form
- Occasional mentorship to the chapter leadership community
- Contributing to the *CDI Journal* or ACDIS website

Members of the CAB represent the most dedicated of this association. Not only have they stepped forward to assist CDI professionals in their local communities, but they are taking on these additional

responsibilities for the benefit of the national organization and their chapter counterparts around the country and the globe. It goes without saying that these generous individuals do so on top of their daily work and home lives.

Please take a minute to get to know them. If you are a local chapter leader or participate in local chapter events you've no doubt benefited from their efforts, so why not take a moment and shoot them an email to share your thoughts?

Incoming Chapter Advisory Board:

- Debra Dallos, Florida
- Lillian Dickey, Washington
- Lori Ganote, Kentucky
- Lori LaFaver, Pennsylvania
- Kerry Seekircher, New York
- Molly Seibert, Oregon
- Aimee Van Balen, Massachusetts
- Alma Yap, Arizona

Honorary past-chairs:

- Katherina Burleson, North Carolina treasurer
- Sherri Clark, current Tennessee co-lead
- Emily Emmons, current California president
- Bonnie Epps, past Georgia leader

Debra Dallos, CDIP, RN
Supervisor of CDI program
Sarasota (Florida) Memorial Hospital
Deb-Dallos@smh.com

When did you join CDI and how did you get here?

I am a registered nurse with 28 years in the profession. My career for the first 22 years was in the critical care arena—ICU, open heart recovery, PACU, and ER. I have served as chair on unit-based practice councils and was selected to be chair of the hospitalwide practice council. I was the EXCEL Award winner at Sarasota Memorial Hospital after being nominated by my peers.

The last six years of my nursing career have been spent in CDI with two years as a CDI specialist and four as supervisor of CDI team at Sarasota Memorial Hospital. I have hosted two Florida ACDIS meetings at my facility (with a little help from my friends) and have been board president of Florida ACDIS for the past two years.

Lillian M. Dickey, BSN, RN, BSBA
Clinical Documentation Specialist
Providence Regional Medical Center, Everett, Washington
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When did you join CDI and how did you get here?

I became a CDI specialist on December 28, 2015. Prior to that, I'd been a bedside nurse for eight years, mostly in ED/trauma, but also pediatric ICU and various specialties. I spent much of my life moving around. I've lived primarily in Hawaii, Nevada, Georgia, and now Washington with shorter stints as a travel nurse in Texas and Massachusetts. My travel nurse experiences pushed me further and further away from the bedside. At nine patients to one nurse in a busy Level I trauma center, I was finally tapped out and ready to try something new.

I discovered CDI by accident after having applied for a utilization management position. When calling about my application, my director suggested I interview for a CDI position first. I did some research and thought she might be right. (Serendipity, anyone?)

What made you volunteer for the local chapter?

About six months into my position, my team went to a chapter meeting. Our event hostess shared information with us about becoming an "official" ACDIS chapter and asked for volunteers to both sign the agreement form and, ideally, be more involved. I'd grown increasingly interested in learning more about my new specialty, but I wasn't sure how useful I'd be, as a new CDI staff person. After having participated in many groups throughout college, though, I knew I'd have something to offer. My team lead encouraged me to chase my interest, so I did!

Prior to joining our chapter leadership team, I wasn't involved much at all in local chapter activities. Now that I am, however, it has opened plenty of new opportunities for me to be involved.

What excites you most about local chapter events?

I've been involved with all the Washington events since joining the chapter leadership team a little more than a year ago. The most exciting part for me is the planning: coordinating with the other members of our leadership team, communicating with members, and preparing materials.

Lori J. Ganote, MSN, RN, CCDS
System Clinical Documentation Integrity Auditor/Educator
Baptist Health System,
Louisville, Kentucky
lori.ganote@bhsi.com

When did you join CDI and how did you get here?

I joined the ranks of CDI in October of 2013. Prior to this transition I'd been a bedside nurse for eight years, in different venues. I did most of my direct care in outpatient settings, including home and long-term care. My favorite specialties are pediatrics and geriatrics.

My husband and I are blessed with five children, and as they aged we recognized their needs changed. It was during this time I began to expand my horizons. I transitioned away from direct care to a position that would accommodate busy schedules for our teenagers and young adults. It was with great excitement and a whole lot of anticipation when I began my CDI career. I honestly could not be happier with the change in course. I still feel a strong sense of advocacy to our patients, providers, and staff and strive to serve our community through education. The mutual benefit, of course, is being able to be there for my family and their needs. (Editor's note: Ganote just welcomed a new grandbaby into the world, Emma June, born December 6, 2017.)

What made you volunteer for the local chapter?

The sense of community and sharing is very strong at our local chapter. Teamwork, encouragement, and support is offered to one and all. This atmosphere is very conducive to learning and sharing of challenges, success, and strengths. This environment made it easy to volunteer to help with planning the upcoming annual meeting, presenting educational topics, and outreach, and I have been very grateful for the opportunity to participate in our local chapter.

What excites you most about local chapter events?

I am excited about outreaching to other programs that are not participating with the local chapter. I feel a strong sense of community and shared learning within our group, and the opportunity to extend this to others is amazing. I am eagerly anticipating planning for the events, coordinating with the other members of our leadership team, communicating with new members, and preparing education materials.

Lori LaFaver, BSN, RN, CCDS
Clinical Documentation Specialist Manager
Reading (Pennsylvania) Hospital, Tower Health System
Lori.LaFaver@towerhealth.org

When did you join CDI and how did you get here?

I started my CDI career in December of 2005 at Reading Hospital and obtained my CCDS in June 2012. My background prior to becoming a CDI was as a bedside nurse for 10 years in the areas of telemetry, ICU, and hemodialysis. In 2005, Reading Hospital started a CDI program through the HIM department. I was intrigued by the job description and what the vision was for the program. It was exciting to be part of a new program at the hospital. The growth in the area of CDI that I have experienced since 2005 has been a tremendous journey, and I look forward to continuing the journey to advance in new areas of healthcare.

How did you first get involved in local chapter activities?

I have watched CDI progress many ways since I first started in 2005. One of the ways is the networking possibilities and different venues of growth within our profession. Years ago, I was part of a group of CDI specialists who tried to get together to network and learn from each other. It was a great concept that just could not be sustained at the time. I attended a meeting at a local hospital and started discussing the role and the profession with the CDI manager, and we discussed what we could do to help create a local chapter and become more organized as a group. We progressed into being co-leaders and have been working together to educate and promote the progress of the CDI profession with the help of our peers.

What excites you most about local chapter events?

I enjoy seeing the more seasoned CDI members encouraging and helping the newer CDI members. There are different levels of experience that attend the local chapter

events, and the ability to support our peers and profession has been wonderful to experience.

Kerry Seekircher, RN, BSN, CCDS, CDIP
Director, Clinical Documentation Improvement
Northern Westchester Hospital/Northwell Health, Mount Kisco, New York

kseekircher@northwellhealth.com

When did you join CDI and how did you get here?

I was hired in March 2010 to help start up the CDI program. Being brand new to CDI, I relied heavily on all the resources made available by ACDIS, including webinars, the ACDIS Forum, forms, policies, education tools, and the conferences. Over the years, I have been fortunate to see the progression of the program shift from a CC/MCC-driven focus to a focus on quality documentation and collaboration with a multidisciplinary team.

What made you volunteer for the local chapter?

As an active member of ACDIS, I was looking for another opportunity to network with other CDI professionals. Starting up a local chapter just seemed like the logical next step, and with guidance from ACDIS and help from a group of amazing volunteers, our chapter has grown to approximately 30 members from several counties in Hudson Valley, New York.

What excites you most about local chapter events?

Being a part of ACDIS at the local level has been rewarding in that it helps me connect with my peers, learn about best practice, and hear about what others are doing to bring their programs to the next level. Knowing that we are filling a gap by offering networking and educational opportunities is a bonus, and I look forward to watching the chapter and all its members grow in the years to come.

Molly M. Siebert, RHIA, CCDS
Clinical Documentation Specialist
Legacy Health, Portland, Oregon

msiebert@lhs.org; molly@thrivenet.com

When did you join CDI and how did you get here?

I was hired by Legacy Health as a CDI specialist October 15, 2013. I became a CCDS on June 8, 2016. Prior to that, I have been in HIM since 1975 working for a QIO Medicare reviewer for seven years and three hospitals performing quality, trauma registry, cancer registry, systemwide EMR development, and assistance in HIM operations management.

I have always known, based on my QIO and quality experience, there was an opportunity to work with physicians on documentation improvement. After a temporary EMR development position was completed, I discovered a job opening at Legacy Health. The CDI director and I talked for more than an hour about documentation issues and some AHIMA best-practice publications, notably the Best Practice for the Problem List (since updated).

What made you volunteer for the local chapter?

I have always been active in associations and civic organizations. I was on the OrHIMA board, off and on, for a grand total of five years. I was involved in two different AHIMA workgroups in 2007–2009. Civic duties included Soroptimist International, several arts councils in Alabama, the Junior Women's League, and currently the Al Siebert Resiliency Center.

How did you first get involved in local chapter activities?

I was raised to be civic minded. With my experience, I saw an opportunity to perhaps enhance ACDIS NW of Oregon to a higher level of functionality. Plus, my mentor encouraged me to volunteer to be on the board.

What excites you most about local chapter events?

Connecting with other members is my favorite part of local chapter events. Also, I see opportunities to enrich and assist members through these events so that members can make a difference in the delivery of healthcare.

Aimee Van Balen, RN, BSN, CCDS
Certified Senior Clinical Documentation Specialist
Lifespan Corporation in Providence, Rhode Island

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When did you join CDI and how did you get here?

I currently work at Lifespan Corporation in Providence, Rhode Island, as a senior CDI specialist. I am coming up to almost nine years in the role and truly could not have imagined

how much the CDI industry would change within that time frame.

Since entering the CDI field, I joined the Massachusetts ACDIS leadership team, served on the ACDIS Chapter Advisory Board, spoke at the 2017 ACDIS national conference, and have been lucky enough to join the ACDIS staff on ACDIS Radio twice. I received my CCDS certification in 2011.

In my current role, I not only review charts and educate providers but also serve as a resource to my peers and often train new staff on the day-to-day aspects of our job. I also review charts concurrently for HACs/PSIs, mortality and length of stay risk adjustment, and pre-bill retrospective mortality charts for risk adjustment optimization.

What made you volunteer for the local chapter?

I was looking for a new way to get more involved within the CDI profession and felt that I had much to offer our local chapter. My co-leads and I have been busy since the initiation of our tenure creating bylaws, building our membership, and incorporating a strong emphasis on education for our events. We have also collaborated with the MA AHIMA for an all-day Northeast CDI and Coding Symposium, which had its third successful event this past summer.

Chapter leadership involvement has reignited my energy for the CDI profession. It is so rewarding to plan and execute a successful event that is meaningful to our members. I have been so fortunate to get to know many of my CDI peers on a more personal basis as a result, and it has enhanced my leadership, communication, and networking skills.

Alma Yap, RN, BSN, CCDS, CDIP
Clinical Documentation Improvement Specialist
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When you joined CDI and how did you get here?

I was a bedside RN in a cardiac-neuro progressive care specialty for more than five years prior to my transition to CDI. When I was in my RN to BSN degree program, I became interested in exploring other nursing areas such as Informatics, case management, quality, and CDI. As I was considering the different non-bedside specialties, a CDI position opened at another affiliated hospital where I was working. I did my own research about the CDI specialist's responsibilities before I finally applied for a transfer! I transitioned to the position in June 2013; and I felt blessed to be starting in the inpatient setting at a teaching hospital as I gained more skills and experience through collaboration with providers and interdisciplinary healthcare teams in maintaining clinical documentation integrity.

I've been an active ACDIS member since 2015 and I received my CCDS certification in the same year. I took my CDIP certification in 2016.

What made you volunteer for the local chapter?

Volunteering has opened several new opportunities for me to be involved and make a positive impact in both professional and local communities. Prior to joining our AZACDIS leadership team, I joined the Arizona Nurses Association leaders as one of the delegates at the *ANA Lobby Day* held at Washington, DC (July 2015). Additionally, at the hospital where I first worked as a CDI specialist, I also love helping in the facility's events at my own time.

Back in 2015, it was my first time attending a chapter meeting at Mayo Hospital in Scottsdale, Arizona. Our AZACDIS chapter president at that time was encouraging members to step up and volunteer for local activities. I took the opportunity!

How did you first get involved in local chapter activities?

I first joined the local leadership as a chapter officer/educator in early 2016. Currently, I am happy to be co-leading the AZACDIS chapter with my truly supportive co-officers (Lee Anne, Debra, and Melissa) from three other organizations.

What excites you most about local chapter events?

I'm always looking forward to meeting new members, connecting with CDI colleagues and guest speakers, and learning from others' best practices or compliance strategies. The most exciting part for me is coordinating with my co-leaders on planning chapter meetings, preparing event agenda, creating the meeting invite flyer, and bouncing off ideas that would benefit the whole AZACDIS memberships.

ACDIS
LOCAL CHAPTERS & NETWORKING GROUPS
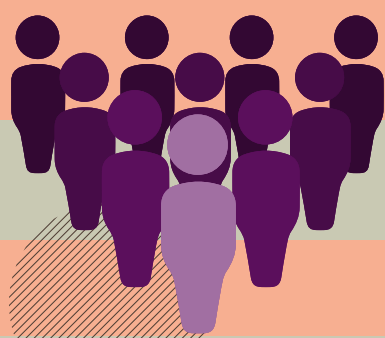
DISCOUNTS FOR LOCAL CHAPTER MEMBERS

Local chapter members receive a discount off national membership. To obtain this discount, members must complete the online membership roster on a regular basis.

DISCOUNTS FOR LOCAL CHAPTER LEADERS

Leaders who successfully volunteer for a full calendar year are eligible for a 50% discount off national membership through ACDIS. Each chapter needs three core volunteers from three different facilities who are current ACDIS members to serve on the leadership team.

NATIONAL SUPPORT FOR LOCAL ENDEAVORS

ACDIS publishes event information & wants to be an active member of chapter and networking leadership teams. Leadership should include ACDIS on their planning calls & communications to their local chapter members.

PRODUCTS & MATERIALS

ACDIS donates two free products (a book or a webinar) to help facilitate local chapter activities every calendar year.
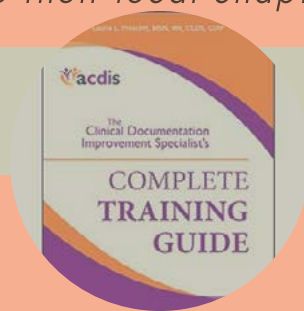
CONTINUING EDUCATION

Local chapters can apply for continuing education credits for the CCDS credential free of charge. Only a member of the core leadership team may complete & submit the form. The form must be completed at least 30 days prior to the event.

FOR MORE TIPS, CHECK OUT ACDIS.ORG/CHAPTERS/NEW

acdis.org/chapters/new
www.keysurvey.com/f/617822/c7f0/
acdis.org/sites/acdis/files/Chapter-
Agreement-Contract-12117-LA_BM.doc

Learning from those who've gone before: CCDS holders share stories of triumph

While not every facility requires CDI staff to earn the Certified Clinical Documentation Specialist (CCDS) credential, roughly 3,500 CDI professionals now hold the certification. For many, obtaining the credential illustrates that they've reached a career milestone and a level of expertise related to their experience in the CDI field.

While the CCDS marks a new level in a CDI specialist's career, the path there isn't always a straightforward one. In order to help those still preparing for the exam (or wondering if they can or should sit), ACDIS spoke with several CCDS holders about their studying and test-taking experiences. (For some quick facts about the CCDS, see the sidebar on p. 38.)

The first-ever CCDS exam

The first CCDS test was offered as a paper-and-pencil exam in Las Vegas after the second national ACDIS conference in 2009. And **Jeanne Bradbury, RN, ACM-RN, CCDS,** CDI specialist, HIM, at Baylor Scott & White Health in Dallas, was among those present to prove their CDI knowledge.

"I remember everything from that day," she says. "I can even remember exactly where I was sitting."

Bradbury wasn't alone that day; she was accompanied by two coworkers. The team attended conference sessions during the day and then headed back to their hotel room to "study and study and study" in the evening. And while she remembers where she sat, the actual conference content fell away in a fog of "studying late every night," says Bradbury.

All three team members passed—but it took a little longer for Bradbury to get the good news. "When the mailroom received my results, they read DRG [the name of the department was DRG Coordination at the

time] and thought it meant 'drug.' My results were sitting in the pharmacy."

Those wishing to earn certification need at least two years' experience working in concurrent CDI, but Bradbury already had significantly more experience at the time she sat for the exam. Her facility's CDI program started as a pilot in 2000. "Really, I'm still working on the pilot. We're constantly evolving," Bradbury says.

The department was still finding out what it could do and learning about information available from ACDIS, Bradbury says. "Our HIM manager told us about CDI Strategies. This was our first introduction to ACDIS. By the time of the second ACDIS Conference, though, we were determined to take the first exam," she says.

> "Don't overestimate your knowledge on the subjects you think you know. I only spent about two weeks reviewing and I really should have taken about a month."
>
> – Danielle Wirth, RN, BSN, CCDS

Bradbury recommends committing to study hard. "It'll all be worth it when you pass," she says. "I was quite proud to have passed and have the certification."

A lifelong learner pursues certification for herself

For **Karen Asquith, RN, CCDS,** a CDI specialist at the Carle Foundation Hospital in Urbana, Illinois,

sitting for the CCDS exam in 2015 was a self-improvement choice.

"I had a professor in nursing school who said it's important to get credentialing even if it's not required," says Asquith. "I'm the only one who's credentialed in my group. I wanted to do it for myself."

When she started in CDI, everything was an unknown. "It was crazy when we first started," she says. "I was totally clueless."

As a lifelong learner, Asquith chipped away at the concepts she struggled with and expanded her frame of reference.

"I always encourage people, even if your facility doesn't cover it, try to go to training sessions and conferences as a refresher," she says. "Plus, a lot of stuff can be done online now, so it's even easier."

Asquith attended in-person training, which spurred her on to take the exam. She also purchased the CCDS Exam Study Guide and found it useful, but she suggests candidates also have familiarity with the DRG Expert and leverage the knowledge and experience of their facility's coworkers.

"Having a good working relationship with your coders and some clinical experience are real pluses, too," she says. If you came to CDI from a HIM/coding background, conversely, make friends with the clinical members of the staff—nurses, physicians, etc.—to expand your knowledge base, she says.

Once you have the experience under your belt, commit yourself

to studying, says Asquith, echoing Bradbury's sentiments. There's no reason not to pursue certification, she says. "I would definitely advise anyone doing CDI to get the certification," she says. "It's important to keep up on your education. Keep up with your CEUs, all of that. And when you come to recertification, do not wait till the last minute."

Job requirements spur on personal growth

When **Danielle Wirth, RN, BSN, CCDS,** senior CDI specialist and educator at Spectrum Health Hospital Group in Grand Rapids, Michigan, sat for the CCDS exam in 2016, she did so to fulfill her job requirements. "Certification is a requirement for our position," she says. "We have to wait the two years, and then we have to sit for it."

Because her facility requires certification, it also provides training materials to help CDI specialists prepare. Namely, Wirth and her coworkers were provided with the CCDS Exam Study Guide and were encouraged to take practice exams. "The practice exams were extremely helpful because I hadn't really had much exposure to the regulatory side—PEPPER, etc. The practice tests show you exactly where you need to focus," she says.

Nevertheless, Wirth warns against sitting for the exam unprepared—or underestimating its difficulty or the time needed to take it.

"I felt a lot of angst that day," she says. "I didn't use quite the whole

time for the exam, but I probably used about three hours. I really didn't expect to take nearly the whole time."

Wirth also suggests spending time studying the areas you're comfortable with, too.

"Don't overestimate your knowledge on the subjects you think you know," she says. "I only spent about two weeks reviewing, and I really should have taken about a month."

In addition, like Asquith, Wirth recommends spending some quality time with the DRG Expert. CDI specialists may not use the book regularly, but they should be familiar with how code assignment translates to MS-DRGs. "You can bring the DRG Expert into the exam with you, but since we don't use it too much, I was really stressed by it on the day of the exam."

An unconventional path leads to CCDS success

Unlike the majority of CCDS holders, **Suzanne Dennis, CTRS, CCDS,** director of clinical services/documentation specialist at Acadia Healthcare Company Inc., in Franklin, Tennessee, didn't come from a nursing or coding background to CDI. Instead, she had worked in the behavior health sphere for her entire career (since 1988). In 2000, however, she transitioned into administrative roles in quality and risk management for a large private behavior health hospital. That led to her current role at Acadia Healthcare in March 2014.

"Because I decided I needed to take the CCDS Exam Prep Boot Camp, I went to a CDI Boot Camp," she says. "I knew I wanted the credential to support my current position, and I knew I needed some background first. There were about 50 of us in the room [at the CDI Boot Camp], and I was the only person who wasn't an RN, MD, or an advanced CDI professional. People

> **"It's a shame to limit yourself that way. I'm a believer that you should always learn and always challenge yourself. Always push yourself to learn a little bit more."**
> – *Suzanne Dennis, CTRS, CCDS*

I spoke with at the class thought I was nuts."

But Dennis didn't give up. "Because I didn't know the medical side of things well, I committed myself to a year to learn it. I figured I had invested a lot of time so I studied a lot. I figured, 'I'm in this deep, so I should at least try.' And as I studied, my team members said it was helping me in my job."

Just as Wirth does, Dennis touts the benefits of the practice CCDS exams. "The practice exam available online is phenomenal," she says. "It let me know where I needed to study and where I could narrow my flash cards down some."

Despite her unconventional background and the long hours of studying required, Dennis says certification was a goal for her as soon as

she learned about it. "I probably needed more time to prepare than a nurse would have, but it's definitely worth taking the time," she says.

Dennis encourages those who aren't required to take the exam to sit for it, too. "I talked to someone who said they weren't going to take the exam because it wasn't required. It's a shame to limit yourself that way," she says. "I'm a believer that you should always learn and always challenge yourself. Always push yourself to learn a little bit more. That was my attitude."

CCDS QUICK TIPS

Q: How many years of experience are required?
A: Two years or more as a CDI specialist.

Q: Do I need certain credentials?
A: An RN, RHIA, RHIT, MD, or DO is required with the two years of experience. More experience is required with other credentials/backgrounds.

Q: What's the exam fee?
A: $255 for ACDIS members, $355 for non-members.

Q: When do I need to recertify my CCDS?
A: Every two years, starting at the date you passed the exam.

Q: What's the recertification fee?
A: $100 for ACDIS members, $200 for non-members.

Q: Can I earn CCDS CEUs through ACDIS membership?
A: Yes! For a full list, visit the ACDIS website.

for the full details, visit acdis.org/certification

From auditor, to CDI specialist, to doctor of nursing

Steven L. Griffin, MSN, RN, CCM, CCDS, is the director of CDI at Baycare Health System in Clearwater, Florida, and he's soon to be a doctor of nursing practice too.

CDI Journal: How long have you been in the CDI field?

Griffin: I've been in formal CDI since 2008, but I've been involved in some form of documentation review since 2001.

CDI Journal: What did you do before entering CDI?

Griffin: Over the years, I've worked in acute care, home health, rehabilitation, commercial insurance, a Medicare Fiscal Intermediary, consulting, and then full circle back to acute care.

As a clinical auditor for BlueCross BlueShield of Tennessee (BCBST), I reviewed medical records to determine if the documentation supported the submitted claim.

Shortly after transferring into BCBST's Medicare division, Riverbend Government Benefits Administrator, I was promoted to be the supervisor of the appeals department.

Both jobs were similar to CDI, except I was taking money from providers rather than making it for them.

CDI Journal: Why did you get into this line of work?

Griffin: When Medicare replaced the Part A Fiscal Intermediaries with A/B Medicare Administrative Contractors, Riverbend lost its bid for the contract and 450 people lost their jobs, including me.

This coincided with the introduction of MS-DRGs, which really put CDI into the spotlight. Because of my prior auditing experience, I was hired to start a program at a 400-bed hospital in Texas in 2008.

CDI Journal: What has been your biggest challenge?

Griffin: Implementing the CDI program in my current system, which included performing a current state assessment, soliciting requests for proposals, selecting a CDI vendor, hiring 20 CDI specialists, and coordinating the actual implementation in 10 hospitals all within a 14-month period.

CDI Journal: What has been your biggest reward?

Griffin: Getting our Nursing Certification Board to acknowledge that CDI has a direct impact on patient outcomes. Allowing my team the opportunity to earn this bonus has been my greatest reward! CDI is much more than just "show me the money!"

CDI Journal: How has the field changed since you began working in CDI?

Griffin: The biggest change has been the electronic health record (EHR). In my first facility, we were physically located in the nursing units because that's where the chart was.

There were some advantages because it was like the watering hole in the savannah and the doctors were the gazelles waiting for the lions (nurses, case managers, CDI specialists) to pounce. The EHR has made it much more difficult to find face-to-face time with the doctor and build relationships. Efficiency, though. is the tradeoff.

CDI Journal: Can you mention a few of the "gold nuggets" of information you've received from colleagues on The Forum or through ACDIS?

Griffin: One of the CDI specialists wrote a clarification asking the physician to document acute Congestive Heart Failure (CHF) because he had documented fluid overload and the patient had a brain natriuretic peptide over 3800.

Unfortunately, there was no history of CHF, and the patient's ejection fraction was 65, but the patient did have end-stage renal disease and hemodialysis. The Ask ACDIS article "*Query appropriately for fluid overload vs. CHF*" provided some helpful advice in educating the CDI specialist.

In another case, the patient had a sodium level of 134 and the

physician thought the CDI special-ist was being too aggressive even though the patient had a fall, history of ethyl alcohol abuse, received a bolus of 2700 cc NS, NS at 125 cc/hour, and follow–up labs. An "Ask ACDIS: Advisory Board" article was helpful in supporting the legitimacy of the CDI specialist's clarification.

CDI Journal: If you have attended, how many ACDIS conferences have you been to? What are your favorite memories?

Griffin: I have attended three of the national conferences. My favorite memory is being selected as a presenter!

CDI Journal: What piece of advice would you offer to a new CDI specialist?

Griffin: To remain relevant and to write credible clarifications, a good CDI specialist must be a lifelong learner.

CDI Journal: If you could have any other job, what would it be?

Griffin: I would love to write evidence-based medical policies that could positively impact the lives of patients on a national or international basis.

CDI Journal: What was your first job (what you did while in high school)?

Griffin: I worked in my dad's restaurant—washing dishes, waiting on tables, and working the grill.

A few of your favorite things:

Vacation spots: My favorite vacation so far has been a Mediterranean cruise from Barcelona to Athens.

Hobby: My favorite hobby is collecting and maintaining antique watches.

Non-alcoholic beverage: Virgin Mary.

Foods: Homemade banana pudding.

Activity: Home improvement—installing hardwood floors, stone veneer, tile. Anything with my hands.

My wife, also a nurse, and I have been married for more than 30 years. We have two grown children: a daughter who teaches English in Japan, and a son who manages a restaurant in Nashville.

No grandchildren yet, so we are enjoying the empty nest. Biggest raise in time and money you'll ever get!