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2021 MASTERMIND HOT TOPIC GUIDE: PART 1

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CDI leaders' responsibilities are varied and far reaching. Rather than going the journey alone, leaders can gain valuable insight by connecting with peers outside their organizations to collaborate, trade advice, and share challenges and successes. The ACDIS CDI Leadership Council serves the purpose of connecting leaders across the country for conversations about the hot topics and industry trends in CDI. But a smaller subset of the Council, the Mastermind group, provides participants with an opportunity for focused brainstorming and problem-solving.

This multi-topic report, produced in partnership with 3M Health Information Systems, shares takeaways from the first half of the 2020/2021 CDI Leadership Council Mastermind term. These conversations cover a range of leadership topics, from the perennially popular topic of CDI/coding relationship building, to the key management concern of quality assurance, to new frontiers with outpatient CDI expansions.

In the lead-up to the ICD-10 implementation, **Carrie Willmer, RN, CCDS, CDIP,** CDI director at SCL Health in Broomfield, Colorado, found her team in a tense situation. On the one hand, the coding team was under major stress to continue hitting their productivity expectations while also getting ready for the upheaval of ICD-10. On the other hand, the CDI team had recently been put under new and ambitious financial impact expectations thanks to a consultant evaluation. It was a recipe for an explosion, Willmer says.

"Both teams ended up in this pressure cooker situation," she says. "It was at that time that our relationship really snapped and fragmented. A decision was made that there would be absolutely no contact, no communication between coders and CDI specialists during this time. No meetings, no emails, nothing. As you can imagine, losing the reconciliation piece was huge."

Traditionally, CDI has functioned as the bridge between the clinical and coding worlds, ensuring that the clinical language and expertise employed by providers clearly and cleanly translates into codes. With half of the bridge severed, Willmer's team needed to find ways to connect with the coding team—particularly around the process of DRG reconciliation—that wouldn't disrupt their productivity or hinder CDI metrics. Rather than reopening full lines of communication, the SCL Health team decided to direct all their communications down to one person, keeping the process clean.

"We ended up hiring a CDI-coding liaison role," Willmer says. "They were the point person to help begin to bridge and to even funnel the communication and messaging, so we weren't having to tax the coding department with questions, education, and needs."

While the liaison role worked to get SCL Health through the initial ICD-10 implementation in 2015, it couldn't sustain the increasing number of cases needing reconciliation over time. As the job expanded, the liaison had to work with the coding team more frequently post-discharge. Willmer realized they needed a more permanent and advanced solution: a formal escalation process for DRG reconciliation to keep things running smoothly and professionally.

"In 2017, we were able to initiate a small pilot, to gain enough leadership support to open the door a bit," she says. "We built an escalation team. We limited the communication to 1–2 emails back and forth before it needs to be escalated. We don't want to get stuck in the tit-for-tat, so we

were really structured in that communication. […] It's been very successful."

As their program evolved, the coding team ended up hiring a liaison role in their department as well so that both CDI and coding had point people "in their corners," so to speak. The whole escalation team now meets weekly to discuss any difficult cases face to face (whether in person or virtually).

"After years of rebuilding, the working relationship between CDI and coding is now stronger than before the separation," Willmer says. "Having a strong partnership with shared goals remains essential to the success of both programs."

Whether you have a designated escalation team or not, it's important to take the escalation process to someone outside of the initial CDI/coder disagreement. This person can keep a cooler head because they weren't personally involved in the disagreement, according to **Lee Anne Landon, CCM, CCDS,** CDI manager at HonorHealth in Scottsdale, Arizona.

"If [the CDI specialist and coder] don't agree, it goes to a second-level auditor who looks at it. If it gets resolved, that's fine, but if the CDI specialist still isn't happy, it gets escalated to me and I'll deal with it with the coding supervisors," she says. "The two people involved in it feel a personal responsibility toward it. It takes that personal complication out of the equation."

When you allow the initial disagreement to go on too long, it can breed bad blood between the CDI and coding teams—or at least between the two staff members involved. Because the CDI staff works to bridge the clinical and coding worlds, they need good professional working relationships with staff on both teams. An escalation policy protects that relationship, Landon says.

"We tend to do better when we escalate it up and take it away from the people closely involved," she says. "You don't want them going back and forth with each other arguing for a long time. That's how you build bad relationships."

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Beyond a formal escalation policy, lean on less formal relationship building activities too, suggests **Jo Brautigam, RN, CCDS,** CDI manager at Roper St. Francis Healthcare in Charleston, South Carolina. If you're able to meet in person with both groups, save time for fun alongside the business talk. This will allow the staff members on both teams to see each other on a personal level and help to keep any disagreements civil.

As an example, Brautigam explains a game Roper St. Francis played with its CDI and coding team members. "Everyone got an index card. One card had a code on it and the other had a definition. You had to go find whoever had your matching card, and they became coding buddies," she says. "You had somebody you could rely on."

Whether you're employing formal policies or team building activities, leadership support and backing is the biggest factor to ensuring a good relationship between the CDI and coding teams. If the leaders of the two groups can't see eye to eye, it's very unlikely that the staff members will.

"I'm trying not to do the 'us versus them' thing," says Brautigam. "Even leadership can fall into that."

One of the biggest components of a CDI leader's job is to ensure that their staff are meeting expectations. While this often takes the form of monitoring and evaluating key performance indicators, many CDI programs also employ an internal quality assurance program through staff audits. This process generally involves a CDI leader, a peer, or an educator reviewing a set number of charts per CDI specialist each month and then meeting with the CDI staff member in question to review the results of the audit.

The audit process can feel subjective because it's based on the viewpoint of the auditor, so using a concrete scoring system can help guide the post-audit conversation with staff members. For example, the CDI educator at West Virginia Medicine in Morgantown uses a point deduction system for scoring her audits, says **Dawn Diven, RN, CCDS, CCDS-O, CDIP,** West Virginia Medicine's CDI director. The deductions are assigned based on:

- Placing a leading query
- Placing an unnecessary query
- Missing query opportunities
- Failing to follow up on the query process
- Missing an opportunity to validate or confirm a diagnosis
- Missing query opportunities for alternate DRGs
- Missing quality measure opportunities
- Missing a diagnosis that was pulled from existing documentation
- Incorrectly formatting note content
- Missing DRG optimization opportunities

The resulting score then guides the next step in the process: "95 to 100 is considered a master level; 89 to 94 is proficient, and that's where there's education specific to missed opportunities; 83 to 88 means somebody's going to get some one-on-one training; and then if it's equal or less than 82, then there's going to be a more concerted effort for education," says Diven.

If your CDI team doesn't include an educator role, the weight of quality audits may be too much to add to a leader's already-full plate. In these cases, Landon suggests leveraging peer-to-peer reviews instead. Once the initial audit is done, the CDI leader should review the audit to ensure that the comments/feedback are clear and professional before passing it along to the audited staff member. Keeping things anonymous will also ensure feelings aren't hurt during the process, Landon says.

"They don't know who did their audit. I try to have them review people that work at another facility, so it's their peer, but it's not their direct peer," she says. "They actually have all had really positive responses to it. I think primarily that's because it is anonymous, so they feel comfortable."

When meeting with staff members to review audit findings, CDI leaders should

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give them the opportunity to provide feedback, ask questions, and even bring up concerns. Staff members will be much more willing to receive feedback and correction if they feel the process is focused on education, not punishment.

"We allow them to rebut any of the findings that they don't agree with. There are times when we certainly will change the scoring based on those conversations," says **Allison Bowlick, RN, MHA, CCDS,** AVP of CDI at Ensemble Health Partners in Blue Ash, Ohio. "We are held accountable to our many different measures, and quality is one of them."

Assigning scores can feel punitive to some CDI staff members, causing them to close down to feedback. Thus **Colleen Gianatasio, CPC, CCS, CCDS,** lead, field programs (director, outpatient CDI) at Devoted Health in Waltham, Massachusetts, suggests moving some conversations away from the formal audit process. Instead, she favors less structured regular conversations with staff about their process and any missed opportunities. Plus, since those conversations aren't scored and aren't part of staff evaluations, they can be used later to educate other staff members.

"One thing that's been really successful for us is just having monthly calibrations. It's not a scored conversation," she says. "It's a safe space to discuss. [...] We've gotten more consistency throughout the team, but it also brings new staff up quickly. We've recorded those sessions so that when new staff comes on, if we've already had these discussions, they can go ahead and listen to them and get the feel for what our approach is."

Some of the most common audit findings, according to **Michael Rant, RHIA,** manager, industry relations U.S. and Canada, at 3M Health Information Systems in Murray, Utah, aren't even related to missed opportunities that could be easily scored. Instead, the audit process often reveals workflow improvements that could improve key metrics, such as review productivity.

"I've seen coders reviewing charts in 3M™ 360 Encompass™ System, but they were still using a legal pad and writing down all their diagnoses on a sheet of paper. Then they had to go into the 3M 360 Encompass tool and do it all again," he says. "You have to find a way to work with them and improve that process."

Having some sort of quality assurance audit process, whether that be a scored quality assurance process or a less formal conversation model for education purposes, ensures that a CDI program performs to its highest ability and continues to benefit the organization.

"Because our role is so important, I think we need to have a tool that pushes the staff to achieve more and better results," says **Patty King-Musser, RN, DNP, CCDS,** CDI director at Geisinger in Danville, Pennsylvania. "We don't want mediocre. We need high quality."

OUTPATIENT CDI EXPANSION

Gone are the days when CDI programs were confined to the walls of an acute care hospital. Now that CDI programs have proved their worth on the inpatient side, organizations are increasingly expanding their programs to the outpatient space. That arena, however, requires tactics that are much different from "traditional" CDI practices. As with any expansion, the first step is to choose where to focus your initial efforts.

Hierarchical Condition Category (HCC) capture for accurate risk adjustment offers a natural entry point for many burgeoning outpatient programs, according to Diven. If a program selects this focus, CDI leaders will need to get ahold of the data surrounding their current risk adjustment factor (RAF) scores to establish a baseline. This often requires collaboration with the organization's biggest third-party payers and any internal population health departments that may have access to the organization's data. Because this is such a new area, however, that data may be difficult to attain, Diven says.

"Humana is the one company that had data for us. We did not have any internal data at the time as far as RAF scores and HCC capture rates and things like that. It was all brand new," she says. "As a matter of fact, the people in the population health space, when I asked them for our HCC data, they wanted to know what an HCC was. So, I was starting from nowhere."

With the benchmarking RAF score data in hand, ideally leaders could effectively show their CDI teams' progress over time by tracking changes to the score. That prospect, however, is easier said than done because of the nature of outpatient payment structures, according to **Karen DiMeglio, RN, CCDS, CPC,** CDI director at Lifespan in Providence, Rhode Island. Documentation from one calendar year doesn't affect the prospective payment determinations until the next calendar year, so CDI leaders are left flying blind for much longer than they would be on the inpatient side of things.

"[Leadership] really wanted to make sure that the RAF score was where it should be, but the RAF score doesn't change for a while. So, we couldn't say we improved something like we could on the inpatient side," she says.

Since the return on investment (ROI) piece may take longer to pin down than on the inpatient side, DiMeglio suggests CDI leaders instead focus on population health

and on the continuum of care when making a case for their outpatient expansion.

"We need to know who we're caring for, and not every patient gets admitted," DiMeglio says. "Every hospital has practices. Well, who are those practices caring for? How sick are they? What are the resources that they're utilizing?"

Not only will an outpatient CDI program ensure complete and accurate documentation for all patients the health system cares for, but that documentation will help physicians care for those patients if they are admitted to the hospital, says Rant.

"If the patient does become an inpatient, you need to be able to have the documentation there for the inpatient physicians as well. A lot of patients that go see their family practitioner hopefully don't end up in hospitals," he says. "You've got to be able to collect that data still so you can make sure the RAF score's correct."

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ROI isn't the only sticking point for outpatient CDI programs either. When a patient is admitted to the hospital, they generally stay for several days, giving CDI professionals time to review the documentation and query concurrently. On the outpatient side, patients typically see their physician for just 15 minutes, making concurrent review nearly impossible. While technology can help by sending real-time prompts based on existing documentation while physicians write in the patient's chart, many CDI teams opt to conduct pre-visit prospective reviews and query physicians before they see the patient at all.

"Our CDI specialists go in pre-encounter, whether that be virtually or face to face," says Diven. "They take a look at who's coming in the next several days. They'll go and look and see what kind of RAF score they had, see if anything is being left out that needs to be redocumented this year. And then, they send a query."

Diven's team also focuses on the annual wellness visits as a way to clean up the notoriously problematic problem lists, leveraging the nursing staff's help to avoid cluttering physicians' already busy schedules. A clean problem list ensures that only relevant diagnoses are listed, making it easier for physicians to address chronic conditions and capture HCCs annually. This will in turn result in a more accurate RAF score in the long run. Plus, in Diven's model, physicians get a bit of their time freed up since the annual wellness nurses take care of the problem list cleanup for them.

According to Rant, focusing efforts on helping free up physicians' time to focus on patient care will engender support for a new CDI program.

"Years ago, when you went to the doctor, your pediatrician, your family physician may work from 9 to 5, no Fridays. Now they're working longer hours because of all the added documentation we're giving to them and all the new requirements that come out," he says. "Creating time to care is not just about making time in their office or in the hospital, but also to give them their home life balance too." ■