Hybrid engagement model: Orlando Health, NYU Langone offer flexible approaches

ACDIS
Association of Clinical Documentation
Integrity Specialists

CASE STUDY 2

Provider Engagement Series

Series introduction: Provider engagement is a core function of the CDI profession. In addition to record review, CDI specialists also teach the why behind the need for accurate, complete, and specific documentation, and assist providers in their day-to-day charting and EHR workflow. But there is no one-size-fits-all model. This series provides case studies of organizations at all ranges of the engagement spectrum, including full clinical integration, remote CDI, and hybrid models. Its objective is to offer models of success from which ACDIS members can consider new ideas to implement, and to supply best practices for provider engagement that work regardless of organizational size, type, or budget.

Orlando Health

Florida-based Orlando Health has developed a CDI career ladder ranging from CDI 1 (newest) through CDI 4 (most experienced), with positions stratified based on certification status and experience. Its CDI staff is comprised of nurses, foreign-trained physicians, and two RHIA-credentialed HIM professionals. Provider engagement is expected of all CDI staff, new or veteran.

Staff members develop and present educational sessions to providers, as well as round in specific units three days per week (Monday-Wednesday-Friday). They spend time sitting up on the units in designated areas, where they provide documentation tip cards, follow up on clarifications, and build relationships.

For **Sheri Blanchard, RN, MSN, FNP-BC, CCDS, CCS,** corporate director of clinical documentation excellence for the organization, visible presence and relationship building are an integral part of the CDI role. "[Providers] get to know who we are, we get to educate them on key general documentation opportunities, and we've also seen a large volume of opportunities for queries," she explains. "From our perspective, we look at this job as a relationship, almost a marketing job. And what you're selling is proper documentation. At the end of the day when we send the clarification out, the physician will know, 'Oh yeah, that was Sheri; let me make sure I get that answered.' "

After starting its rounding efforts with a dedicated CDI staffer in the ICU, Orlando Health now plans to expand CDI rounds to neurosurgery and trauma, which Blanchard views as an area of opportunity for both education and queries.

Despite the high expectations of them, new CDI staff aren't thrown to the wolves; Blanchard assesses each employee's level of expertise and comfort as a presenter before easing the person into assignments. "Some need a little bit of encouragement and a team member to go with them. Our goal is for every single person to feel comfortable and confident. We try to avoid putting them in positions where they're going to fail," she says. "If you're going to go on an ICU round, you don't want to be a brand-new CDI going into that space."

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Orlando Health supplements its on-site presence by developing educational trifold boards and electronic billboards, displayed in the physician lounge, on a topic of the month (it recently featured hemorrhage and hematoma). It also coordinates with its quality team on diagnosis topics of the month for IBM Watson. Clinical documentation excellence tablecloths are provided for each hospital, which lend a professional appearance to the documentation tip cards (and the treats that are put out with them). "The team enjoys this, and it gives us the opportunity to share our knowledge with our providers, nurses, and hospital staff," Blanchard says.

All CDI staff are also allowed to work remotely, with the number of allotted days based on their career ladder position. CDI 3s, for example, work three days remotely and two days on-site. Rounding is built around these schedules and meshes with other team members. So if a CDI 3 rounds in the ICU Monday-Wednesday-Friday, but Wednesday is one of that staffer's remote days, a colleague will take the Wednesday rounding shift. When working remotely, staff review the same patients' charts that they see during their on-site rounds to ensure continuity of coverage.

"The team loves it; it gives work-life balance," Blanchard says. "But we still have to maintain productivity even while at home."

The organization's hybrid approach includes close work with more than just providers. For example, CDI staff are currently working to assist case management in reviewing patients with longer than expected lengths of stay, and in turn share DRG assignments. The department has also embarked on a pilot project in which CDI and case management work together to improve documentation in the ED. Additionally, CDI staff collaborate on denials prevention, with a particular focus on patients who flip from inpatient to observation.

"The ED and case management is future state," Blanchard says. "Our goal is not to do medical necessity reviews, but to collaborate with care management regarding potential documentation opportunities that may support inpatient status by talking with providers in a compliant manner for missing diagnoses."

NYU Langone Health

NYU Langone Health recently made the switch to a partially remote model. Its CDI staff used to work four days a week, but they were longer days (8.75 hours) and all on-site. Now they work five days, three of which are remote.

NYU Langone has a main campus in Manhattan and a second location in Brooklyn. The CDI workforce is split into two teams—Team A and Team B. Everyone works from home on Monday, which is generally a busy review day due to a high volume of weekend admissions. Team A then comes on-site Tuesday and Thursday, and Team B takes on-site duty Wednesday and Friday.

On-site staff occasionally round with providers; they also go out on the floors for face-to-face provider discussions. Staff deliver presentations in front of provider service lines and have the flexibility to adjust their on-site schedules accordingly (for example, a Team A member could bump his or her on-site day from Tuesday to Wednesday to accommodate an on-site presentation the staffer is giving to clinicians).

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NYU Langone has two separate CDI job descriptions: CDI specialist and coding/CDI liaison. The latter is for professionals with a CDI and coding background and involves more complex reviews, including secondary reviews of HACs and PSIs, mortality reviews, and special projects. Four CDI staff presently serve in this capacity.

Irina Zusman, RHIA, CCS, CCDS, director of HIM coding and CDI initiatives for NYU Langone Health, encourages her staff to get involved in clinical initiatives. Two CDI specialists participate on a pediatric sepsis committee, for example, while a third serves on an intensive care oversight group. "The CDI team is a permanent collaborator in a wide range of hospital initiatives—quality, value-based management, and more," she says.

CDI staff have enjoyed the change from all on-site to the hybrid approach, and response rates and provider buy-in have not dropped. It helps that the program has been in existence for 10 years and has built a strong relationship with the medical staff. "When your doctors come to know you, you don't need to be on-site to get an answer to the query, because they saw you before and are open to talk to you about clinical issues," Zusman says.

NYU recently joined forces with IT and clinicians to implement Epic flags—alerts when a patient's labs meet clinical criteria for certain conditions (e.g., CKD, acidosis, malnutrition) or when certain procedures are performed, such as blood transfusions or mechanical ventilation. Though this project has required significant time and effort, its goal is to streamline queries, increase productivity, and ensure that all diagnoses reflecting a case's medical complexity have been captured (see related story).

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Supplementing with educators, physician advisors

Both Orlando Health and NYU Langone enlist additional support for provider engagement initiatives. Orlando Health has a clinical documentation excellence educator who specializes in group and 1:1 physician education. She also drives the educational topics for CDI staff in the team's biweekly staff meeting.

Orlando Health also enjoys strong support from a physician advisor group. While most of the physician advisors are primarily aligned with care management and focus on inpatient/medical necessity denials, two designated physician advisors will supplement CDI education on complex disease processes like encephalopathy, with one taking the clinical piece and the other reviewing actual cases and engaging in physician-to-physician conversation. Both will also escalate unanswered queries.

"It's been such a win-win for us, we're going to use our dynamic duo and have them do the education for our hospitalists [later this year]," Blanchard says. "We have found value in that role, but we have also tasked each CDE team member as an educator as well, so if you're rounding, you're also in charge of that unit and that education. So it's not just one person doing all education."

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NYU Langone Health is in the process of designating a physician advisor to support its CDI staff. Zusman anticipates that difficult cases requiring peer-to-peer conversation will be elevated to this person.

Like Orlando Health, NYU Langone has the support of physician champions. The CDI leadership team met with every department chair to identify a contact for escalation, and worked with the chairs to identify and follow their preferences. The approach proved successful. "We have a contact for each service that we can go and ask for help. They don't work for CDI, but they lend their support when it is needed," notes Zusman.

NYU has developed its own internal CDI app that contains helpful documentation tips. "NYU physicians love using the internal CDI app," Zusman says. "Most doctors have the app downloaded to their phones and use it when responding to queries, as well as when writing their notes."

Impact on CDI productivity

To open up room for provider engagement while keeping chart review productivity high, Orlando Health removed all DRG reconciliation from its concurrent frontline CDI staff and reassigned that responsibility to dedicated reconciliation staff (it did not hire additional staff, but tasked CDI specialists with a CCS to perform reconciliation only). Blanchard also removed some concurrent coding responsibilities that were starting to scope-creep onto the CDI staff.

Blanchard made these decisions after taking over the CDI program and doing a thorough analysis of staff members' existing workloads, noting what tasks were taking the most time. She then put her proposed changes to a staff vote, and the majority of her team voted to remove and centralize reconciliation.

"I was a case manager at one point in time, and it always seemed like things were getting added to our plates all the time and nothing got removed," Blanchard says. "When you have an opportunity to see what someone does on a day-to-day basis, you can see pretty quickly that tasks get added on that don't need to be, or we can revise the way we do things to give time back and free up time for engagement."

The Orlando Health CDI concurrent team now focuses only on concurrent reviews, education, and rounding. Staff perform 20–25 reviews per day (8–10 are new reviews, while the rest are re-reviews).

"There are so many programs focused on this DRG reconciliation piece, which is in my mind absolutely unnecessary," Zusman concurs. "It is not CDI's job to code."

NYU Langone expects its staff to review 10 new cases a day, as well as cover its follow-up cases. It uses analytics to help determine which services have opportunity and should be reviewed. Coding and CDI staff work closely together, and coding staff are trained to identify opportunities. If a coder identifies a missed query opportunity, he or she will send the query to the CDI specialist who

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previously reviewed the record. If the case hasn't gone through a CDI specialist, the query goes to the CDI manager for assignment.

"I know that some CDI programs consider following on coding queries as a productivity loss. I, on the other hand, am responsible for both coding and CDI teams, so my goal is to assign the task to those who can perform it more efficiently," Zusman explains. "Members of the CDI team who already have the relationship with the physicians will present the case better and get an answer faster. This also helps with faster processing of cases and reducing the DNFB, so it's a gain from the organizational point of view."

The rewards of hybrid/remote and on-site staff

- **Greater job flexibility and staff retention.** Having some flexibility to work from home allows staff to avoid tough urban commutes into cities like Manhattan and retain staff in competitive hiring environments.

- **Learning from providers.** CDI specialists who maintain some level of dialogue and floor presence have the opportunity not only to educate providers, but also to get educated themselves on the latest treatments and terminology. "It gives us also as CDIs the opportunity to learn some of the new treatments, techniques, medications, evidence-based guidelines, so we're also learning as well," Blanchard says. "It's a win-win for both sides."

- **Seeing opportunities as they occur, in real time.** Blanchard says it's not uncommon for one of her CDI staff to see a physician performing a bedside surgical debridement and not document the procedure. Or a CDI staff member may look into a room and see that a patient has been placed on ventilation, dialysis, or an IV drip without a corresponding diagnosis. Those are the kinds of catches a purely remote CDI team wouldn't be able to make.

- **Keeping communication alive.** While the NYU CDI team enjoys its well-established relationship with the physicians, maintaining some on-site presence allows the team to ensure that connection stays strong. "I feel that keeping personal contact is invaluable," Zusman says.

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ENGAGING PROVIDERS IN EPIC FASHION AT NYU LANGONE

Christopher Petrilli, MD, SFHM, is the clinical lead of value-based management for NYU Langone Health in Manhattan. A former employee of the University of Michigan Health System, Petrilli was hired in July 2018 to help lower costs by improving the appropriateness of care. But his focus quickly shifted to CDI.

"You can reduce costs only to a certain point. The lowest-hanging fruit is probably improving provider documentation to allow for appropriate coding," says Petrilli, who spends half of his time as an internal medicine hospitalist and the other half in finance. "I always say, 'We're going to code for the care you're delivering. We're just going to enhance how you're documenting it.' "

Recently, Petrilli made significant inroads by creating a table in Epic that auto-populates applicable documentation into every history and physical (H&P). The left side of the table pulls in historical trends of lab values and vital signs already in Epic, such as creatinine and glomerular filtration rate (GFR), while the right side of the table lists potential applicable diagnoses, such as CKD. Typically the table will contain the last three to five values/vital signs, with dates of when they were performed/captured.

The default setting for these diagnoses is "not present," but the physician can scan the GFR ranges on the left side of the table for stages of CKD, for example, while deciding on an appropriate diagnostic choice. The table also provides a generic, modifiable plan of treatment that the physician can click and apply to the patient. In a CKD patient, it might say, "Avoid nephrotoxins. Give fluid as needed and renal diet. Continue to monitor creatinine while inpatient." This helps to ensure medical necessity.

The table helps capture NYU Langone's top 10 diagnoses with opportunity for improvement, as determined by comparisons against peer hospitals. This data comes from their proprietary database (Vizient). "We started it with the top 10 because we didn't want to make it overbearing for providers," Petrilli explains.

NYU Langone immediately saw the benefit of Petrilli's proposal and implemented it after CDI, coding, compliance, and legal reviewed the terminology for appropriateness and compliance. However, after completing the build, Petrilli still had to ensure that physicians would use the table, so he embarked on a roadshow where he met with physician groups to explain its value, including how it would impact quality and financial metrics. He also explained how to use it in their documentation workflow. When up and running, the table takes a provider about 60 seconds to complete.

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The table has been such a success that the organization is rolling out service-specific H&P tables to make sure that the work they're asking providers to do is applicable and helps them directly. At the time of this article, tables were up and running in seven service lines, with plans to develop tables for all services in the near future.

Petrilli describes the table build as a modified note template/dot phrase in Epic, as the functionality already exists within the EHR. He had worked on a similar build back in 2014 while serving as a CDI champion for the University of Michigan's hospitalist service alongside the CDI team and clinical leads.

At NYU Langone, Petrilli has also had the fortune of befriending Roland Casem, a coworker and Epic analyst who works in the IT department a couple blocks away. Casem takes Petrilli's ideas and rough templates and turns them into reality.

"I'll create something that doesn't work perfectly, and I'll say, 'This is what we're trying to build,' and he'll clean up [the template] and distribute it so that it automatically populates in the H&P," Petrilli says. "He and I make a great team. It's just been a fantastic relationship between CDI, the Epic team here, and myself. It's been a real pleasure to work with everyone."

Petrilli can monitor whether physicians are using the table, as well as the CC/MCC capture rate of providers who use it vs. those who do not. "We see pretty significant disparity there," he says. Petrilli also uses the data generated from the table to educate providers. For example, if a patient has a GFR of 12, and the provider indicates no CKD and no AKI, that presents an educational opportunity. "It's not punitive; we reinforce why it's important and where we need to go from there," he says.

About Orlando Health

Orlando Health consists of seven acute hospitals and one affiliated/joint venture hospital, totaling some 2,400 inpatient beds. Its CDI staff consists of approximately 60 team members, as well as physician advisors who provide support in daily clarification escalations and provider communication.

About NYU Langone Health

NYU Langone Health is a New York City academic medical center affiliated with New York University. The medical center comprises the NYU School of Medicine and several hospitals: Tisch Hospital, the Rusk Institute of Rehabilitation Medicine, the Hospital for Joint Diseases, NYU Langone Hospital Brooklyn, and most recently NYU Winthrop Hospital. NYU Langone also operates over 30 ambulatory facilities in Manhattan, Brooklyn, Queens, and Long Island. The addition of the Winthrop hospital brings the total bed count to 2,300.

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