



## Managing your kitchen staff: Staffing, professional development

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

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**Q** **Most 2021 CDI Week Industry Survey respondents (47%) said they entered CDI because they wanted to grow professionally, and CDI offered them a chance to do so. What was your initial reason for entering CDI? What career growth opportunities have you had or seen since being involved in CDI?**

**A** I honestly entered CDI unintentionally! I was recruited to manage the program based on my clinical and professional experiences—I knew little about CDI but was curious and excited about the opportunity. I accepted, as a professional step into a management role, and have had no regrets. My professional progression started from manager of one site to director of the central region, to senior director of the program systemwide. I left the department for about 10 years to expand my education and professional scope. Throughout that time, I maintained my CCDS as I knew the importance of CDI and there was untapped potential that would bring CDI to the forefront.

My first experience in CDI included internal onboarding in conjunction with formalized training and education through CDI and Coding Clinic webinars. I was strongly encouraged to obtain CCDS certification, which was funded by the organization. The facility covers ACDIS memberships and ad-hoc

specialty webinars in addition to the education and industry updates provided by our consulting group for the entire team. I attend yearly ACDIS and/or AHIMA conferences when possible and share the lessons learned and innovative potentials with the staff and organizational leaders to keep the program relevant and progressive.

The organization invested in a consulting company that offers CDI training, education for CDI specialists and providers, and analytical evaluation to assist in demonstrating the program benefit and targeted areas for program focus. Working in conjunction with this group, I have gained better insight into the impactful drivers for our facility in the areas of reimbursement, quality, and denials mitigation. I learn every day in this department, especially through the resources provided, networking opportunities, and connections made through *ACDIS Leadership Council* involvement.

I am fortunate to be in this position and have the organizational support from an executive team that values the importance and impact of CDI. As part of an academic organization, the value of growth is evident in the offerings and opportunities available to ensure my knowledge and capabilities are enhanced and driving the program to its optimal impact.

**Q According to the survey, 19% of respondents entered CDI because they were involved with a different department and were asked to fill a CDI role. Additionally, 36% of respondents said their CDI department includes members with an HIM/coding background. Do you feel it is important to have people involved in CDI with a nontraditional background, such as coding? What potential opportunities do you think might be missed if CDI programs staff the department with only one background type (i.e., physicians, floor nurses, or inpatient coders only)?**

**A** Diversity has played an important role in our department. The mix of backgrounds blends to provide different perspectives and helps to expand the knowledge and effectiveness of the staff and the program. Our current staff consists of LPNs, RNs, and foreign-trained MDs, with one of our LPNs also holding coding certification. We have nurses from critical care, medical-surgical, risk, utilization review, and case management. Each of our staff bring something important to the team as they all have an area of expertise or a perspective slightly different from others, even those with similar backgrounds. The important part is to recognize these differences and not let it be lost in the day-to-day focus of productivity. Showcase individuals for their strengths and promote them as a resource and reference for the rest of the team. As a team, we are better collectively and the broader our perspective, the broader our impact.

There are certain qualities and experiences that have demonstrated a faster onboarding or transition to the CDI perspective. Nurses with critical care experience require less focus on identification of clinical parameters and clues that may need further investigation but have a harder time shifting to the CDI perspective when reviewing the documentation. Nurses from the case management area or risk are better prepared to appreciate the CDI perspective and review focus but have required more education and time to pick up on clinical nuances. The foreign-trained physicians have an appreciation for the physician thought process that gives them a perspective that I have yet to be able to capture and share with the rest of the staff. That said, the process is to share the diverse perspectives

with the orientees once a foundational knowledge is established.

It is impossible for one person or professional entity to have the comprehensive perspective from all backgrounds. We need to share and support each other, know who our experts are, and utilize them when needed. This gives the program a multidimensional approach and enhances each team member. In the current environment, we need to be great at many things and in many areas. We risk limiting the perspective and impact if we only hire staff with a single background.

**Q According to the survey results, 79% of respondents noted their organization has a written policy requiring a clinical credential (i.e., RN, MD, etc.) for their CDI department. Does your organization have written policies about credential types required for a CDI specialist? How were these policies decided?**

**A** This is an interesting question, and I can argue support for either side. The organization developed a policy for clinical credentialing immediately prior to my return to the department. The requirement was established to hire only RNs with a BSN; an associate degree would be considered with adequate clinical experience. The LPNs in the department were “grandfathered in” but were then excluded for interdepartmental advancement to a senior or lead role based on the job descriptions. I do not have full appreciation for the driver in the development of this direction for the policy but believe it was intended to elevate and increase respect for the role as a specialty. It is hard to defend challenges to relevance and applicability if there are loose credentials and requirements for staff.

I have been a lifelong learner and therefore have a high appreciation for and value education and acquired knowledge. I support having established minimum standards for entry into CDI as it is not a role that can be done well without relevant experience or education. I also support having flexibility in the requirements, so we do not limit diversity and related program impact. I know highly educated individuals I would not consider for this position, with the converse also true. I believe consideration should also be given to the individual's personality and capabilities. There is more to a successful CDI specialist than credentials and education;

there is a perspective and drive that is hard to measure but is equally important. It is important to find the right balance in the candidates presented. I often interview people who do not appear strong on paper to determine if they may be an equal or better fit than someone with higher education and more clinical experience. The CDI role requires knowledge, experience, and passion. The hardest of those to teach is passion.

**Q Roughly 19% of respondents said they have foreign-trained medical graduates in their CDI department. Why do you think foreign-trained physicians might be drawn to the world of CDI? What unique knowledge or narrative do foreign-trained medical graduates bring to a CDI department?**

**A** We are fortunate to have two foreign-trained medical graduates on our team. From our conversations, they were not interested in the time and redundancy required to become credentialed to practice medicine in the United States. They were drawn to CDI as a good niche to keep them integrated in the comprehensive care of patients and loosely impact the care coordination through documentation clarity and specificity.

They collaborate with providers in a manner that is uniquely effective in getting responses. They have a sharper eye for subtle clues in the documentation that may be fostered for additional capture. On rounds, the conversation is enhanced by their firsthand knowledge and experience from treating patients in their native country. They pull information that may have been missed by someone not medically educated or trained. In reference to the credentialing question above, despite their advanced degree and clinical relevance, I struggled to hire them as they did not meet the RN, BSN requirements in the current job description!

**Q Most respondents (34%) said they have zero to five CDI specialists on staff at their organization. How many CDI professionals do you have on staff at your facility? How about systemwide? Does this feel like an appropriate number of staff for your organization's needs?**

**A** There are 18 staff dedicated to the facility with a total of 38 for the system. The question of appropriate staffing is an ongoing conversation and may vary over time as the scope and focus shifts for the

department. The scope when I returned to the role was primarily on revenue capture optimization, and staffing was adequate. Staff were able to cover all insurances and perform regular re-reviews. I had just transitioned from a role as the quality and safety director from another facility and knew the potential of leveraging CDI and the impact that could be made in areas such as quality, denials/appeals, and care management. I began reaching out to these areas to determine need and share potential of CDI involvement.

Once word was out about CDI, the demand started to grow faster than the capacity to support. It soon felt as though every department and service line had focused desires for the CDI and wanted a dedicated specialist. At points like this, discussion and evaluation of the desired focus and purpose for CDI need to occur. As our reporting structure to finance and the primary focus remained the same, we proceeded accordingly. I had many conversations with the department leaders for clarification related to CDI as a support for each department's efforts, and not the assumption of their work. In our current state, we are down staff related to retirement and resignations. Regardless of this gap, I believe we could benefit from an additional CDI specialist at each of the three primary facilities as the expansion of our scope has added more time to each review. The additional staff was confirmed by an updated staffing analysis I requested by the consulting firm.

The objective is to ensure support for relevant areas desirous of dedicated CDI. The message needs to be that CDI cannot chase metrics or diagnoses, clarifying that their specific goals will be supported if we maintain and allow CDI to stay focused on getting the record right. We can be more effective if we let the data do the work, showing the opportunities and then following up with appropriate education or mitigation strategies.

CDI is not the solution but a support to meet the objectives. It is not productive or beneficial for CDI to chase the various quality measures or the latest insurance criteria, as they are ever-changing and result in confusion and loss of purpose for CDI. It is important to educate CDI staff and provide them with awareness of these areas so they can use this information to enhance review capabilities, but the focus needs to remain on "getting the record right." If we accomplish this, all other things fall into place.

**Q** Just under 20% of survey respondents said their CDI program does not offer any professional development opportunities. Does your department offer professional development opportunities? If so, what are they? Which types of professional development opportunities have you found most beneficial personally?

**A** We offer some professional development opportunities for the staff through the department ladder structure that includes CDI specialist, senior CDI specialist, and lead CDI specialist positions. The progression is based on experience and acquisition of relevant credentials. There are associated salary increases with each level along with additional responsibility and accountability.

We have the benefit of focused training from the consultant group and access to their website that offers white papers, coding updates, industry research, and site-specific reports. Webinars are also provided.

Additionally, the facility pays for other ad-hoc webinar requests and staff memberships to ACDIS. The department will reimburse the cost for testing for relevant certifications or credentials and the recertification costs. The facility also offers staff a generous tuition reimbursement program for those who desire to pursue additional degrees.

The most beneficial for the department and growth as a CDI specialist in my opinion are the consultant education and feedback sessions based on chart reviews. They look comprehensively at selected cases for opportunities in coding capture, CDI review, query opportunity, most appropriate principal diagnosis assignment, and more. The education is based on themes that arise from the reviews and physician education is also provided so there is a consistent understanding between the necessary players—CDI, coding, and clinicians. This is in effort to move the CDI thinking and program impact to the next level.

For personal growth and development, I feel the tuition reimbursement is of great value. This allows individuals to pursue additional learning and a degree of their choice. The advanced learning and expanded perspective benefits not only the individual but the department and the facility. I am a big supporter of advancing knowledge and perspective.

**Q** In your opinion, what risks do CDI programs face in not offering staff development opportunities? What advice would you give to an organization with limited resources seeking to provide some type of professional advancement or development opportunity to its staff? What advice would you give to CDI specialists seeking professional development opportunities in an organization that does not offer them?

**A** I believe most people desire and appreciate an organization that invests in them. Not offering staff development is a risk to the organization as staff may leave due to feeling stagnant or not valued. The program suffers by reaching a plateau and may even decline as other facilities and programs continue to advance. Most staff want to be a part of a respected and highlighted program. Staff development is critical to a thriving program with dedicated staff who are flexible and dynamic in their approach.

Many organizations struggle with limited resources. To work around this, finding a champion in the department who can take the lead in educating and developing the staff is one approach. The organization invests directly in one individual, and that individual is then the source and reference for the staff. This “train the trainer” or “educate the educator” method is a proven model that can stretch limited resources.

Reaching out to nursing or other relevant departments to partner with their staff educational efforts to help grow CDI staff knowledge can be another means that utilizes existing resources. We utilize clinicians to present on conditions related to their area of practice such as stroke, trauma, palliative care, cancer, etc. This is a great resource for information and learning and a way to foster collaboration between CDI staff and providers. The nursing department has been a good source of education through the various on-going educational offerings for bed-side nurses as well as condition specific presentations from the nurse residency program graduates.

Another good technique I have used is to assign each CDI specialist a topic to research and present to the group. They advance their knowledge and become an expert for the team on the topic of focus. Creating a structure for advancement does not always need to have significant monetary increases. Find out what

other things are important to the staff. It may be a day of remote work or something else they find rewarding that will encourage them to seek further development and advancement.

If the organization does not provide opportunities for professional development, you must invest in yourself and seek them independently. Additionally, look for free webinars or scholarship opportunities from organizations such as ACDIS, which allows for development at little to no cost. Reach out to peers and discuss other options and network opportunities for potential development.

**Q The majority of respondents (60%) noted that their department hired new staff in the last 12 months. In your opinion, what might be contributing to this growth? Should CDI departments always be looking to increase their staff, or is there ever a point where staffing needs should be considered met? Did your organization hire new CDI staff in the last 12 months? How has that affected your department's focus, productivity, and program structure?**

**A** Significant factors contributing to growth in CDI may be financial drivers. Healthcare facilities experienced great insult to revenue due to decrease or cessation of elective procedures and outpatient encounters. In addition, coding and reimbursement changes related to care and treatment of COVID-19 patients required a close review of the documentation to verify capture of necessary components to qualify for enhanced payment rates. The CDI team was a beneficial element to accomplish this goal. Facilities are working to decrease the revenue loss and view CDI as a logical established resource to mitigate loss and capture appropriate revenue.

Increase in staff to provide more coverage is a small investment for the return they provide. Our facility has hired new staff recently, but it was related to staff attrition and not growth of the program. We suffered from a decrease in staff due to retirements and resignations attributed to COVID-19-related changes. Staff who retired determined the stress of the unknown and the increased pressure to close the revenue gap was not as desirable as making their own plans. Many of the staff who resigned did so after we were instructed to return on-site and re-implement rounding. They were

either fearful to return or preferred working from home and sought positions that accommodated their desire. We took a hit to coverage and productivity.

When there is such an insult to a program, you go into survival mode and focus on the basics. Start with the primary functions and expand as capacity allows. We narrowed the coverage focus to Medicare and Medicare Advantage plans as the priority, with review of other payers when able. Some staff decreased the amount of time on rounds by approaching their provider team with questions/queries first and returning to the department to allow time for more reviews. We were fortunate to be able to hire contract CDI staff to assist with coverage and allow me time to screen, hire, and onboard the right people instead of hiring just to have people.

Program growth was temporarily suspended, but the focus and plans remain a goal. As we recover, the objective will be to logically expand the program into other areas. We are looking to expand into the outpatient arena, where many other facilities are growing their programs. This will require additional and dedicated staff based on a comprehensive assessment completed identifying a suitable number. Staffing is always a topic of discussion and area of consideration. I believe there is an ideal number and the need for additional is only warranted if expansion is occurring or focus is shifting that necessitates more time per review. Continual analysis of the CDI scope of work, and evaluation of additional duties that creep in, is needed to ensure appropriate focus and staffing ratios.

**Q Is there a relationship between the rate of new hires and the "new normal" effects of the COVID-19 pandemic, in your opinion? Do you believe that the CDI industry fared better than some other healthcare-related fields in terms of maintaining program integrity? What are your own hopes related to CDI growth post-pandemic?**

**A** Our rate of new hires increased related to the pandemic due to resignations, not due to program expansion. I have heard of many CDI programs that are expanding at this time related to the enhanced awareness of the impact CDI can bring to a facility. The value has been made more evident, and organizations have a desire and need to optimize reimbursement to recover and survive after the great loss. CDI has a high

return on investment, and with expansion of an existing program structure, the result is very positive.

I feel the CDI industry fared well during the pandemic, comparatively. Our program was able to prove financial benefit throughout the pandemic. We broadened coverage to all payers and expanded reviews to areas not normally covered due to lower benefit, such as obstetrics. We did have two staff redeployed to bedside nursing, which seemed to increase the effort by the remaining staff, as many admitted being fearful of redeployment.

As of today, our program has returned to normal for the most part. We have returned on-site and re-implemented rounding on the units. We have maintained our purpose and focus, with adjustments made due to the temporary decrease in staff. I believe the experience

has increased respect and value seen by leadership toward the CDI team. Desire for support to grow the program will be readdressed in the future as staffing normalizes.

I have researched and proposed an outpatient program that was gaining traction prior to the pandemic. This step is the next logical area of expansion for the department. On the inpatient side, we can benefit from several new roles, including a manager to cover CDI onboarding and staff and provider education. I also desire a data analyst to assist with identification of staff and program areas of focus. A CDI quality reviewer and denials coordinator would also benefit the program and facility. Accurate quality metric capture and a dedicated resource for second-level quality and denial reviews would round out the ideal team.