Innovations in CDI education
FEATURES

7 Diverse backgrounds, diverse educational needs
ACDIS speaks with three CDI professionals from three different backgrounds and discusses what they needed for education when starting their new roles.

14 Continuing education for experienced staff
Training new CDI staff members is a big job that takes several months, but the end of orientation doesn’t mean the end of staff education.

26 So happy organizing meetngs together
The Chapter Advisory Board members share their expertise on hosting joint chapter meetings with groups inside and outside of ACDIS.

34 Building connections to make a difference
Follow the course of Christiana Care Health System in Newark, Delaware, as the CDI team pilots and implements an outpatient CDI program in the system’s medical practices.

DEPARTMENTS

3 Associate Director’s Note
Melissa Varnavas explains why CDI professionals need to continue their education well past the onboarding time frame.

5 Note from the ACDIS Advisory Board
Robin Jones shares her experiences collaborating with coding professionals and what she’s learned along the way.

12 Note from the Instructor
Allen Frady outlines the stages of CDI education and offers encouragement to new professionals.

17 Note from the CCDS Coordinator
Penny Richards walks CCDS holders through the recertification process.

24 Ask ACDIS
Sharme Brodie answers frequently asked questions about pressure ulcer documentation and queries.

41 Physician Advisor’s Corner
Erica Remer outlines three best-practice tips for educating physicians.

38 Coding Corner
Shannon McCall unpacks the recent changes to E/M reporting and what CDI specialists need to know.

43 Meet a Member
Susan Edamala is a clinical nurse consultant II and a CDI specialist at University of Illinois Hospital and Health Sciences System, and a member of the Illinois ACDIS local chapter.

OPINIONS & INSIGHTS

10 It’s hard to change hats
Angela Maxfield discusses the challenges for CDI specialists transferring from a different role and offers tips to ease the transition.

20 Why PSI 90 matters now
Cheryl Manchenton explains why, although public reporting of PSI 90 has halted, CDI specialists still need to pay attention to it.

29 Mood matters at work
Barbara Anderson unpacks the need for emotional intelligence in CDI and shares tactics for measuring it.

CONTINUING EDUCATION CREDITS

BONUS: Obtain one (1) CEU for reading this Journal
ACDIS members are entitled to one continuing education credit for reading the CDI Journal and taking the 20-question quiz. Visit the September/October Journal page on the ACDIS website to take the quiz.

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at www.copyright.com or 978-750-8400.

CDI Journal (ISSN: 1098-0571) is published bimonthly by HCPro, 35 Village Road, Suite 200, Middleton, MA 01949. Subscription rate: $165/year for membership to the Association of Clinical Documentation Improvement Specialists. • Copyright © 2018 HCPro, a SimplifyCompliance Healthcare brand. All rights reserved. Printed in the USA. Except where specifically encouraged, no part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro or the Copyright Clearance Center at 978-750-8400. Please notify us immediately if you have received an unauthorized copy. • For editorial comments or questions, call 781-639-1872 or fax 781-639-7857. For renewal or subscription information, call customer service at 800-650-6787, fax 800-639-8511, or email customerservice@hcpro.com. • Visit our website at www.acdis.org. • Occasionally, we make our subscriber list available to selected companies/vendors. If you do not wish to be included on this mailing list, please write to the marketing department at the address above. • Opinions expressed are not necessarily those of CDI Journal. Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions.
ASSOCIATE DIRECTOR’S NOTE

Back to the books? Ongoing education isn’t child’s play

by Melissa Varnavas

September comes bittersweetly for those unwilling to give up on idealized days spent lounging by the stream, ocean, or pool. Certainly, by mid-August, for kids cramming to finish their summer reading projects and begrudgingly relinquishing their super-soakers, September’s arrival no doubt falls more on the bitter than the sweet side. Yet, by summer’s end, most parents stand ready to return their offspring to the waiting arms of educators, open to the new lessons their children will soon learn inside those schoolroom walls.

While we send our kids off to grade school, high school, and even college, those working in the CDI field understand the truism that life requires an ongoing journey of learning. In fact, they embody it.

In many cases, you (dear ACDIS member) completed undergraduate studies to become a nurse or a coding professional. In some cases, you went on to get your master’s degree or became a physician. Others framed their degree, hung it on their wall, and went off to work caring for patients or crunching medical record information to snoop out the correct code assignment for each case. But no matter what role you assumed, all of you continued to wonder about the larger healthcare system. You picked up snippets of information that piqued your curiosity and sent you searching for more. You took on additional projects and began working with other professionals, picking their brains for experiences that might shed more light on how you could make a difference.

And when the position of CDI professional appeared, even though you may not have had any idea what this role entailed, you understood the enormous opportunity for learning and personal/professional growth it offered. That transition—from nursing or coding or primary...
patient care to CDI—is huge. It’s as wide as a canyon and high as a mountain, and for those of you who are just joining the CDI ranks today, let me warn you that it will at times seem too deep and too high for you to traverse.

Let me also reassure you, however, that you will prevail. (Read Allen Frady’s article on p. 11 to learn about the stages of CDI education or this article from the January/February edition of the Journal for tips on getting up to speed in your new role.) It takes time and patience, but you’ll soon come to understand what in the world an MS-DRG is and how to sequence a principal diagnosis; you’ll know how to ask a physician a question without giving him or her the answer to the question like a twisted Jeopardy match, and you’ll realize why proper query practice is so very important.

After those difficult first several months (and it does take several months), there’s still more to learn and more to be done. CDI specialists cannot even sit for the Certified Clinical Documentation Specialist (CCDS) credential until they have at least two years’ experience under their belts. By then (according to the CCDS candidates’ guide), staff should understand basic coding rules, pathophysiology, program structure and metrics, healthcare reimbursement principles, and government regulations, as well as be able to employ effective (and compliant) communication skills.

Many rejoice when they earn their CCDS credential and consider it the pinnacle of their career. While I don’t want to dissuade anyone from celebrating this important accomplishment, the truth is that there is just so much more to learn. Some CDI professionals may reach a level of competency within their daily record reviews and be content, but their journey doesn’t have to end there; they (and you) have numerous opportunities to continue down the path of lifelong learning within this profession.

Most advanced CDI programs now review all payers, or at least more than just Medicare patients’ records. They now review the record for more than just CC/MCC capture and MS-DRG optimization. Most have begun to look for ways to improve the patient’s apparent severity of illness and risk of mortality scores, reduce negative effects of Patient Safety Indicators on hospital reimbursement, and assist in reducing claims denials and defending against audits by ensuring complete and accurate documentation in real time, concurrently, while the patient is still in the hospital. And that’s just a small slice of the potential learning opportunities that exist on the inpatient side.

How can CDI teams promote and foster and energize colleagues in their journey of ongoing learning? The first step comes with self-education and self-awareness. Since you’re reading this, your feet are already on the road—you’re an ACDIS member and have the initiative to read and study the materials your association offers. Avail yourself of those materials—not only this Journal (although many members say it’s their most valued membership benefit) but the ACDIS Forum, the Resource Library, the white papers, position papers, Quarterly Conference Calls, and ACDIS Radio sessions. Each resource includes a wealth of information that may intrigue you and set you searching for more knowledge, introduce you to new peers to network and learn from, and offer you—and your program—new opportunities for growth.

There are dozens of other ways to continue learning and growing; some of these are explored further in the article “Continuing education for experienced staff” on p. 14, and in the column by Allen Frady, BSN-RN, CCDS, CCS CRC, on p. 12. One of the most fascinating things about
learning is that the more you learn, the more you'll want to accomplish. As you gain knowledge, you'll become more devoted to the success of your program and colleagues, and more invested in the program's processes and outcomes.

As Coral Fernandez, RN, CCDS, CCS, system CDI auditor/educator for Baptist Health System based in Lexington, Kentucky, aptly puts it: “If you continue to educate your employees, you impart a sense of investment in them and … that’s very important. … The more you know about what you’re doing, the better you feel about what you’re doing.” And, I might add, the better you’ll feel about why you’re doing it.

So, while we send our students back to the books, know too that your own education waits for you with open arms—there’s always something more to learn.

As Coral Fernandez, RN, CCDS, system CDI auditor/educator for Baptist Health System based in Lexington, Kentucky, aptly puts it: “If you continue to educate your employees, you impart a sense of investment in them and … that’s very important. … The more you know about what you’re doing, the better you feel about what you’re doing.” And, I might add, the better you’ll feel about why you’re doing it.

So, while we send our students back to the books, know too that your own education waits for you with open arms—there’s always something more to learn.

© 2018 HCPro, a SimplifyCompliance Healthcare brand

CDI Journal | SEPT/OCT 2018 5
These types of conversations became the catalyst for the communication pipeline built between the two teams. Communication is crucial in the concurrent environment to ensure productivity is not affected in the retrospective process.

Recently, I transitioned to a new organization in a new state as the CDI director of a division, and these same building-block principles are being used in the new structure being developed by myself and the coding director. When I came to the organization back in November 2017, communication had ceased between CDI and coding. Reopening the lines of communication was an essential first step, and now, monthly CDI/coding calls are picking up steam and enabling valuable education exchange between the clinical and coding teams. I am excited to witness and play a part in this fabulous, collaborative relationship.

At times, communication can lead to irritation or frustration. But communicating about documentation is part of caring for patients and doing the right thing for those we serve. As our CDI team and program grows, we will begin to incorporate information about risk adjustment, mortality, and value-based purchasing. Along with team development, the ability to change is imperative as well—as we all know, the payment structures are becoming more and more complex every year. I cannot imagine how our intercommunication will change over the next five or 10 years, but I’m confident that the collaboration between our teams will continue to result in accurate documentation.

As I have grown in CDI over the past 14 years, coding professionals remain some of my best teachers and biggest supporters in developing system-level CDI programs. One coding professional reminded me once to “step out of my black-and-white world and embrace the shades of gray.” As a nurse, every action has a reaction, so my pre-CDI world really was black and white. It was difficult to embrace the gray.

If the organization that you work for does not have a monthly call—whether it’s to discuss cases or provide education—I highly suggest implementing one. I have witnessed low-functioning programs become high-achievers solely by opening the communication between these two professions. Being successful in the CDI world requires teamwork, the ability to change, capturing the clinical picture, and ensuring that the patient encounter is complete, concise, and accurate.

Editor’s note: Jones is the west Florida division director of CDI for Florida Hospital West Florida Division, part of Adventist Health System, in Tampa and a current member of the ACDIS Advisory Board, serving through April 2019. The opinions expressed do not represent a consensus agreement of ACDIS or its Advisory Board. Contact Jones at robin.jones@ahss.org.
The CDI field is a heterogeneous one—filled with professionals from a wide range of healthcare backgrounds. According to the 2018 CDI Week Industry Survey, 93% of CDI programs employ nurses, 37% employ coding/HIM professionals, 35% employ physicians as advisors or champions, 15% employ foreign-trained medical graduates, and 8% employ other clinicians such as physician assistants and licensed practical nurses.

Though all these professionals fill essentially similar roles, their education on the road to becoming effective in the CDI field differs due to their unique perspectives and experiences. During this year’s CDI Week celebrations, ACDIS honors these differences, focusing on the larger picture, the beautiful mosaic that they create together. To accompany that theme, ACDIS caught up with a few of these individuals to discuss their unique preparations for the CDI role and what they had to learn due to their diverse backgrounds.

**Meet Adelaide Zimmerman**

According to the CDI Week Industry Survey results, the most common professional background represented in CDI is nursing, which is exactly where Adelaide Zimmerman, RN, CCDS, CDI specialist at Lehigh Valley Health Network in Allentown, Pennsylvania, started her CDI journey. “I’ve been with this health network for 31 years in September, so I came here as a fairly new nurse, and I was a staff nurse on a step-down telemetry unit,” she says. Her next step wasn’t into CDI, but to homecare and hospice, which she did for about a year before coming back to the hospital in a case management/utilization review role.

“I wasn’t in direct patient care, but I still got to interact with patients, families, and physicians,” she says. And that role prepared her to move into the denials and appeals department, which is really where her CDI education began, she says.

Working on appeals exposed Zimmerman to some of the documentation challenges and deficiencies often resulting in claim denials, but it also afforded her the opportunity to take an outpatient coding boot camp to strengthen
her appeals writing, which exposed her to another side of the healthcare system.

Finally, when she did step into a CDI role, Zimmerman was “able to draw on all that background,” she says.

Having more than 30 years’ experience within the same health system, Zimmerman built on her existing relationships with many of the physicians. “The relationships definitely become easier. I had known the physicians in my prior roles, but the hospitalists come and go,” she says. “There’s always new people to educate.”

While Zimmerman had had lots of clinical experience, existing relationships with the physician staff, and some exposure to coding through her outpatient coding class, the rest of the revenue cycle picture was entirely new.

“The case-mix index and how that affects our reimbursement, [understanding] how it all fits together was difficult,” she says.

Additionally, the coding side of things proved challenging as her boot camp training focused on outpatient rules, leaving Zimmerman with a lot to learn. “It’s learnable, though,” she says. “There are rules, and you have to follow them.”

Throughout her onboarding process, Zimmerman took every advantage of the resources available online, and she recommends the same for other new CDI professionals. “Someone recommended the ACDIS website [to me], and I just started reading and tried to learn as much as I could.”

Though the learning curve for getting into CDI may be steep, no matter your professional background, Zimmerman says that it’s well worth the trouble.

“Really, there’s not a lot of cons,” she says. “It’s a great job.”

Meet Irina Zusman

Irina Zusman, RHIA, CCS, CCDS, director of HIM coding and CDI initiatives at NYU Langone Health in New York City, immigrated to the U.S. and eventually found herself in the CDI field. However, her background was decidedly different from many in CDI.

Early in her career, coding actually involved a fair bit of what’s now considered CDI work. “For many years, it was the responsibility of the coder, while they were reviewing the record, to clarify anything that was unclear,” she says. “It was actually very difficult because coders are usually held to productivity standards.” This meant that any clarification time held up code assignment and had the potential to negatively affect a coder’s productivity levels.

When her original facility decided to start an official CDI program, Zusman volunteered to lead it, building it from the ground up. Eventually, the facility hired consultants who advocated for a CDI department solely populated by nurses. “I was welcome to stay, but I didn’t feel comfortable and left,” she says.

Many CDI professionals coming from the HIM/coding background share Zusman’s story, and many rail against it. According to the 2018 CDI Week Industry Survey, 15.99% of programs require their CDI professionals to hold a coding credential, while 77.55% require a clinical one and 17.35% require a CDI-specific credential. ACDIS’ official stance is that, although different backgrounds require different education focuses, all professional backgrounds bring something to CDI.

After a brief period of working as a coding professional again, Zusman had the opportunity to put the blended model into practice when the CDI and HIM/coding teams
came under her purview at her new facility.

“Our team remains blended, and we hope to keep it that way,” she says. “I strongly believe that in order for a CDI program to be successful, it has to be built on both coding and clinical foundations.”

While the clinical folks need more education on the coding side of things, and coding professionals have to acquire more clinical knowledge, Zusman believes that CDI success ultimately comes down to an individual’s experience and expertise and that everyone can bring something of worth—even her engineering degree has helped her as CDI becomes more focused on analytics.

“A lot of people think that coding professionals are not very educated, which isn’t true. Secondly, they think that coders are introverts and won’t be able to communicate with physicians—people are different, though,” she says. “You have to be able to think critically, have excellent communication skills, and be willing to learn. Everything else can be developed.”

Meet Faisal Hussain

“I’m a physician by background, by training. I completed my med school back in my native country,” says Faisal Hussain, MD, CCDS, CDIP, CCS, corporate CDI director in clinical services at a large multi-hospital system based in Tennessee, who immigrated to the United States from Pakistan.

Originally, Hussain’s plan wasn’t to give up practicing medicine, he says. Instead, after serving as a physician for some time in the U.S., he experienced what many physicians experience: burnout. “The 80-, 90-, 100-hour weeks were really taking a toll on me,” he says. “I wondered what I could do to still utilize all this education and training and put it to the best use for the healthcare system.”

Enter CDI.

“But, we have people from all backgrounds on our team now and I think that’s the best way to do this. It’s best to have different perspectives.”

Faisal Hussain, MD, CCDS, CDIP, CCS

A friend in the profession recommended Hussain give it a try. Once hired, however, he felt “thoroughly thrown off the cliff into the CDI job and left to fend on my own,” he says. “My first supervisor said that since I was a physician by training, I was more than qualified for this job.”

But, a CDI specialist’s job is much different than the role of a physician. One of his biggest learning curves, Hussain says, had to do with understanding rules and regulations governing the coding aspect of CDI.

At his first job, the CDI team wasn’t focusing on the coding at all, simply querying for anything and everything that was vague. “Because we weren’t doing any coding, we were blind,” he says. “We had a 50%–60% response rate.”

Because of this lack of clarity, when Hussain did transition to a different facility, the coding education there overwhelmed him. “The amount of learning I did in the first three or four months in that position was more than I’ve ever learned in any other program,” he says. “I had to learn a lot of coding. It was CDI education on steroids.”

Nevertheless, Hussain’s background as a physician did help in other areas of CDI, namely with physician engagement. “It’s relatively easier for me to approach physicians,” he says. “That’s not to say I don’t have my battle scars, but it’s all about how you approach them and connect with them.”

Because Hussain synthesized his clinical and coding knowledge (which, after all, is the main goal of all CDI professionals), he adequately prepared himself to be a CDI leader in his organization, which consists of more than 110 hospitals in 20 states. His story has prepared him to work with, and educate, people from a variety of backgrounds.

“But, we have people from all backgrounds on our team now, and I think that’s the best way to do this. It’s best to have different perspectives.”

Because I had the clinical background, I felt that my learning curve was very short. Because I had the clinical background, I felt that my learning curve was very short.
It’s hard to change hats: Orienting new CDI specialists

By Angela Maxfield, RN, CCDS

Steve Jobs once said that “the only way to do great work is to love what you do. If you haven’t found it yet, keep looking. Don’t settle.” How appropriate. But how often do we really think of how scary it is to change jobs? People change for different reasons—burnout, family obligations, or financial pressures—but no matter the reason, it’s still scary to “change hats,” especially for new CDI specialists.

Think about what it means to be “new” to CDI. New staffers probably left a job they were familiar with, even comfortable with, after being intrigued by the CDI job description. Maybe they don’t have any experience in the building blocks of CDI, yet they applied and were accepted. Now they’re confronting that very real fear of the unknown and asking themselves, “Now what?”

This fear should be considered when managers, mentors, preceptors, or educators orient new CDI specialists. If they’re coming from a nursing background, for example, bedside practice has become a part of their daily routine, as has discussing patients with providers. Now, in CDI, they are expected to discuss diagnoses with providers instead. Spending years thinking one way and then suddenly being asked to think differently can be a bit overwhelming.

Education for brand-new staff

In the orientation period, CDI educators (whether it’s their formal job title or not) should have an assessment tool that will allow them to evaluate the depth of new professionals’ clinical knowledge and areas of expertise. Doing so can serve two purposes: using new employees’ knowledge to advance the team, and encouraging growth in areas where they have less experience. This allows new CDI specialists to work within their wheelhouse and begin their transition from a comfortable place. It also allows them to immediately contribute to the team, providing them with a sense of inclusion and pride, especially if their talents fill a knowledge gap within the group.

Tailor expectations accordingly when orienting a brand-new CDI specialist versus someone who has CDI experience but is new to the facility or particular team. The time period for orientation and the educational resources used should both be different. Staff that are new to CDI will require longer to adjust to the CDI way of thinking. Brand-new CDI specialists will need extensive education in “the CDI way”—after all, they’re now wearing a totally different “hat” than the one they wore as clinical practitioners or coding professionals.

A brand new CDI specialist will need extensive education in “the CDI way,” realizing that this is a totally different “hat” than the one they wore as a clinical practitioners or coding professionals.

Start with the basics by giving an introduction of what CDI is. Explain how a CDI professional looks at a chart in comparison to how a nurse, coder, or physician might.

“And suddenly you know…it’s time to start something new and trust the magic of beginnings.”
Author unknown

Explore the CDI program’s compliance obligations and ethical constraints. Review the standards the team is expected to adhere to. All of this will give new CDI professionals a better base to build their practice on.

Next, the CDI educator will need to explain coding rules and guidelines as they pertain to CDI practices, including what should be documented to capture diagnoses in codes. Understanding how to use the Official Guidelines for Coding and Reporting will provide new CDI specialists with another resource to feel more confident in their unfamiliar world. Once they understand the basics of CDI, including coding rules, compliant query writing, and other guidelines, then you can help build on that knowledge.

Of course, all this takes time, and no brand-new CDI professional should be expected to jump into medical...
record reviews the first day on the job. Make sure you segment this training and augment it with on-the-job shadowing and record reviews to provide real-world examples of the lessons being taught.

**Education for experienced staff**

Let us not forget CDI specialists with only a year or less of experience. Are they considered “experienced,” or are they still considered new? Your program must decide and tailor its orientation and education accordingly. In doing so, answer these questions:

- What training did this CDI specialist get at previous programs?
- How does that training compare to your program’s expectations?

Some programs are financially based, with a focus on shifting the MS-DRG and capturing additional diagnoses that will change the reimbursement for a patient’s care. Other programs are more robust and innovative, focusing on quality reported data, mortality reporting, Hierarchical Condition Categories, Patient Safety Indicators, and overall chart completeness. A CDI specialist who is transitioning from the former environment to the latter may need additional education and mentoring.

Don’t assume that all CDI specialists come from the same type of program and have the same expectations. When onboarding staff, CDI educators should consider all CDI specialists as “new” in that they are new to the facility’s particular program. For the most success, orient new staff to your program’s way of doing CDI, as outlined in the mission and vision statements.

So, how do you approach training brand-new CDI specialists? First, recognize they are tasked with learning both a new approach to clinical thinking and a new way of communicating with physicians and providers. Help them to realize they still impact patient care, just in a different way. This will keep their clinical interest alive and maintain their passion for helping patients. It’s hard to change hats in the professional world, but recognizing each CDI specialist’s individual contribution to your program and helping the person develop to the next level will facilitate a successful transition.

The goal of orienting clinical professionals should be developing them into successful and passionate CDI professionals. 💯

**Editor’s note:** Maxfield is a CDI consultant with MAXIM HIM, based in Stanford, California. In her role, she is responsible for reestablishing programs, conducting provider education, and providing staff development. She has been in the medical field for more than 35 years, beginning her nursing career with an ED/trauma focus. Maxfield is on the leadership for the ACDIS CDI Educator Networking Group. Contact her at amaxfield@stanford-healthcare.org. Opinions expressed are that of the author and do not necessarily represent HCPro, ACDIS, or any of its subsidiaries.
NOTE FROM THE INSTRUCTOR

Struggling as a new CDI specialist? Don’t give up

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

CDI has a steep learning curve. Sometimes it can take several months, if not longer, to start seeing good documentation reviews from a new CDI specialist. The initial days of being a CDI specialist are almost exclusively task-focused. Before new CDI staff members can become pros, they must first figure out how to access the work queue, how to use an encoder and/or code book, and how to consult the DRG Expert. They have to be trained on what a query is and how to format one.

The early days working as a CDI specialist are all about procedural steps, so much so that it’s easy to lose sight of the work being done in favor of metrics and benchmarks. Without enough care, “CDI” will become more about doing things and less about accomplishing things. As the old saying goes, “don’t confuse effort for progress.”

After a few weeks, new CDI specialists can quickly discover that they’ve put in a huge amount of effort and accomplished almost no actual work. By that, I mean they can review a large number of records and place queries, but have little to no impact on the actual medical necessity, quality indicators, or assigned DRG.

Sound familiar? It should.

For those of you with a nursing background, this is not unlike new grads who have impeccable paperwork while all their patients seem to be in horrible shape, with lots of complaints, myriad medical fires having to be put out by fellow staff, and additional calls to those poor residents. It is noteworthy that this stage of a coder’s transition into doing CDI work is decidedly easier, as coding professionals come into the job already understanding most of the reporting rules and knowing what “buzzwords” will result in what changes.

When I trained staff in a facility (as opposed to the training I do now as a Boot Camp instructor), I used the four stages of onboarding to gauge where my trainees were:

■ A trainee starts as an enthusiastic beginner. This person has a very high level of commitment and a very low competence level.

■ Once that honeymoon period is over, the trainee becomes a disillusioned learner. A disillusioned learner has a limited competence and a low commitment to the task. This, of course, is the stage where you’re most likely to lose your trainee.

■ The next phase is the cautious contributor. This trainee is competent enough with his or her assigned tasks but has variable levels of understanding regarding the work, and variable levels of commitment.

■ Finally, the last stage is the self-reliant achiever, who exhibits both a high competence and a high commitment. People in this last group sometimes still contact me with questions, and I often reply, “This is not a student-teacher relationship anymore; we are equal colleagues. I am not even sure how to answer your question, but here are a couple common views.” When that happens, it always makes me (dare I say) proud.

I often see an accelerated transition from enthusiasm to disillusionment when RNs try to transition to a CDI specialist role (though, again, I don’t notice it as much in coding professionals making the jump). Where the honeymoon period in a typical job onboarding might last for months, I often witness these new staffers get disillusioned within the first week or two, complete with
all the trimmings: second-guessing, anger and frustration, and even emotional breakdown.

As the saying goes, “this too shall pass.” I do, however, see a few new CDI specialists get stuck at the disillusioned learner stage for weeks or months. The learning curve is steep, and not everyone progresses at the same level.

Once they break through, though, the block at the cautious contributor level can sometimes be even worse. Many CDI specialists get stuck here for months, years, or even permanently. These employees exhibit a fair amount of skill getting through the day and may consider themselves accomplished—yet when pressed, they can’t answer even some of the simpler DRG, coding, or advanced pathology tenets. These staff members can be particularly hard to deal with. You see, it’s not a talent block, but a mental one. They simply declared victory and closed their minds to further learning.

My advice to these staffers is: “Have faith in yourself. You can move to the next level. All it takes is a commitment to daily learning and an open mind.”

To conclude, I want to tell you about a recent encounter with a past student. When he first started, I did not think he had a chance to succeed. He was stuck at the enthusiastic beginner stage for a month and then bombed out, complete with tears and talking about quitting at the disillusioned phase. After eight weeks, he asked me, “What is CHF?” one day and wasn’t joking. I lost track of him for a few years, until I noticed he was speaking at this past year’s ACDIS Conference and working as a consultant. While you can’t see the smile on my face as I type this, let me assure you that it is genuine.

If you are considering giving up, don’t. At least, not yet. We need you, and you may be passing up on a distinguished career. 🌟

**Editor’s note:** Frady is a CDI education specialist for HCPro in Middleton, Massachusetts. Contact him at AFrady@hcpro.com. For information regarding CDI Boot Camps, visit [http://hcmarketplace.com/clinical-doc-improvement-boot-camp-1](http://hcmarketplace.com/clinical-doc-improvement-boot-camp-1).
Continuing education for experienced staff

Training new CDI staff members is a big job that often takes several months to conclude, but the end of orientation doesn’t mean that staff members never have to undergo education ever again. As most in CDI are keenly aware, the ground is always moving under our feet. From new regulations, to coding guideline changes, to new clinical definitions, the education for a CDI professional never truly ends.

“Originally, [leadership] expected our orientation and initial training to be it: ‘the end, go do it.’ That, of course, won’t work because things change at a minimum every quarter with new Coding Clinics,” says Coral Fernandez, RN, CCDS, CCS, system CDI auditor/educator for Baptist Health System based in Lexington, Kentucky.

However, it can be easy for CDI leaders to forget the needs of experienced staff members, who are working autonomously, in favor of providing education to the newbies—they need closer attention, after all. This could lead to staff members becoming stagnant, though. (For a discussion about the various stages of CDI staff education, read Allen Frady’s article on p. 11.)

“We have to promote continuous growth because CDI programs become stagnant when staff stop learning,” Autumn Reiter, BSN, RN, CCDS, CDIP, CCS, director of CDI services at TrustHCS, based in Springfield, Missouri.

While some organizations, like Baptist Health, employ dedicated CDI educators to handle both new and experienced staff education, there are several tactics any program can take to ensure their veteran staff members remain engaged and up to date on the latest changes and innovations.

Address program focus shifts

One of the most obvious times to provide ongoing education for CDI staff members is when a program as a whole matures and shifts focus. For example, many
CDI programs begin with a focus on financial reimbursement through CC/MCC capture and DRG optimization on Medicare charts. Over the years, however, programs tend to shift toward a more holistic approach and a further focus on quality.

“You never know what’s going to happen when the organization grows,” says Shari Nay, RN, CCDS, CDI specialist at West Virginia University Hospital in Morgantown.

“Everybody goes to the all-payer model [eventually] and the expectations [become] higher and higher on the CDI staff,” says Reiter.

Those expectations cannot be met, however, without providing a structure and educational framework on which to hang the new mission and goals of the program. Nay suggests that by inviting the CDI specialists themselves into the planning and research phases, program managers can build engagement and educate the staff on the new program direction.

“We had a supervisor who came to us and said we were going to do some team research projects and then we were going to come back and talk about what we could do to improve our program,” she says.

Not only did the staff members doing the research deepen their understanding of the topics, but because each group presented their findings, they were all exposed to more topics than they could have had time to research individually.

**Make education bite-sized and accessible**

One of the major issues with continued education for CDI staff is that it takes time out of their regular reviews and can be seen as hindering productivity. Because of this conundrum, educational materials should be presented in bite-sized chunks and made accessible for staff members as their schedules allow.

“I give them two five minute educational sessions each week—maybe it’s from ACDIS, the AHIMA Journal, or Coding Clinic. I try to attach it to our weekly CDI meeting minutes and I tell them it’s their bedtime reading,” says Reiter.

Materials Reiter provides to the staff don’t have to be read immediately or belabored in a meeting. Rather, they’re offered to her staff members as on-the-fly references, to be read whenever they have time during their busy work days.

Materials Reiter provides to the staff don’t have to be read immediately or belabored in a meeting. Rather, they’re offered to her staff members as on-the-fly references, to be read whenever they have time during their busy work days.

Materials can be pulled from many sources, Fernandez says, so CDI leaders needn’t rely solely on what they develop themselves. Rather, they should take advantage of the various professional associations and resources at their fingertips.

“We do ACDIS Radio, we do Talk10Tuesday, we share some scholarly articles on occasion,” she says. “We attend and bring back information from the local and regional ACDIS and AHIMA meetings.”

Nay also suggests creating an online database for staff members so they can access educational resources when they need them. “We have an online training manual. It has everything in it from policies, to workflows, to reference materials,” she says.

In addition to written educational materials, an online database can house recordings of the educational sessions offered to CDI staff, allowing them to relisten to particularly pertinent presentations and access any sessions missed due to time off or workloads.

Fernandez also suggests encouraging staff members to come to department managers rather than relying on managers and administrators to present education. Create an open-door policy, she suggests, which allows staff to identify an issue, research it, and bring forward their findings. “That’s the theme I try to hammer in when I’m training new employees,” she says. “When in doubt, ask or look it up.”

Additionally, Fernandez often approaches education from a positive rather than a corrective perspective, sending one-off emails to individual team members when
she notices a job well done. That way, when staff members do have questions, they’ll feel comfortable reaching out for help even if they’re past their initial onboarding period.

“I do a monthly audit of each of the CDI specialists in the system,” she says. “I try really hard to draw attention to a query that was exceptionally well-written. I’ll shoot some of our double-digit CDI specialists an email and say that they did a great job. I think that regular ‘attagirl,’ so to speak, is really important.”

Leadership also needs to make time for senior staff members to pursue more formal education, such as obtaining additional collegiate degrees, studying for certifications or credentials, or attending regional educational meetings as Fernandez recommends. If productivity standards are too high, staff members won’t have time to access those resources to begin with and will plateau in their positions.

Reiter suggests making it a part of their regular jobs. “We give everyone two hours per month paid for continuing education,” she says. That way, even if it’s not spent in formalized meetings, the staff has the latitude to access the resources available to them and further their knowledge base.

Meet regularly

Sometimes, more internal education is in order. These sessions can take any cadence that’s convenient for the team as a whole; some find that weekly, shorter meetings work best, while others favor longer meetings on a monthly or quarterly basis. Regardless, making that time shows the staff members that administrators value the team as a collective and are invested in each member’s professional growth and education.

One approach is to offer the education based on the timing of new regulations. For instance, Nay’s team follows the cadence for the Official Guidelines for Coding and Reporting for their larger group meetings. “When new coding guidelines come out, we take a whole day to go over this together,” Nay says.

Fernandez gets inspiration for her twice-monthly meetings from the findings of the consulting company Baptist employs. Recently, after attending a consultant-run webinar on cirrhosis and portal hypertension, she took the opportunity to turn it into a deep dive for staff education.

“It didn’t quite click for me, so I knew it wasn’t going to quite click with others,” she says. “When [the consultant] does educational offerings, they are almost exclusively text slides—and I’m a visual learner, and I’m sure we have some other visual learners out there too. So, I put together a PowerPoint on cirrhosis and portal hypertension and why and how those two are connected, etc.”

Regular continued staff education for CDI can also be linked to sessions offered to coders, Nay says. The two groups may have different focuses, but they have to work closely together to succeed. By holding joint educational sessions, staff from both teams stay up to date on the happenings of their peers and can grow in understanding each other’s needs and workflows.

“We attend the coder meetings so we know what they’re talking about, and they attend our meetings too,” she says. “The foundation of everything we do is education.”

Expand horizons

Without continued education, CDI staff may plateau, so leaders and educators should expand staff horizons and encourage curiosity.

“Education needs to be made a priority,” says Reiter. “Whether it is small pieces of activity or prompting staff to join ACDIS, be on the ACDIS Blog, or see what their peers are doing.”

CDI team leaders should encourage staff members to independently further their professional development by joining organizations such as ACDIS, reading relevant publications, and attending chapter meetings. “It’s important to maintain the intellectual stimulation however you can,” Fernandez says.

One way to accomplish this is by asking staff to research and present to the rest of the team (or to their regional chapter/networking group) on new and emerging topics.

“All our CDI specialists are nurses, and nurses have various
NOTE FROM THE CCDS COORDINATOR

Tips for keeping your CCDS up to date

By Penny Richards

Congratulations on earning your CCDS! Now that you have it, you need to develop a plan to keep it. That involves earning continuing education credits (CEU) and submitting proof of the required number every two years.

Here are a few of the most common questions I get about recertification.

When do I need to recertify?

Every two years on the anniversary of the day you passed the CCDS exam. If you passed on July 1, 2017, you will be due to recertify by July 1, 2019, and then again in 2021, 2023, and so on.

You may submit your application and proof of CEUs up to 60 days before your due date. If your due date is July 1, you can submit the paperwork on or after May 1.

When can I earn my CEUs?

Your CEUs must be earned within the two-year time period you hold the certification. If you pass the exam on July 1, 2017, your CEUs must be dated between July 1, 2017 and July 1, 2019. Your next certification period will be July 1, 2019 to July 1, 2021, and your next batch of CEUs must be earned in that time period.

knowledge bases. For example, not all our CDI staff systemwide have cardiac experience per se,” says Fernandez, who recently presented an in-depth presentation to her CDI specialists on congestive heart failure (CHF), complete with photographs of cross-sectioned hearts and scar tissue. Even though CHF is one of the most queried diagnoses around, those without a cardiac background may not have an in-depth understanding of the diagnosis beyond what’s needed to formulate a compliant query.

Nay, whose team sends all CDI nurses to a coding boot camp, suggests that providing coding education to CDI specialists with principally clinical backgrounds deepens their understanding of the process and enables them to query more effectively and collaborate more closely with their coding counterparts.

Denials can also serve as an entry point for providing a deeper level of education to mature staff. Whether it’s through involving them in the appeals-writing process or providing education on what the facility is seeing in its denials, it can be a real eye-opener and give seasoned staff a larger understanding of their work. “We talk about denials with the coding staff too, and we educate ourselves on what’s going on,” says Nay.

At the end of the day, whether the education comes through a shifting program focus, bite-sized education, or full-day educational events, investing in senior staff members will further the reach and effect of the entire CDI program and keep the staff engaged in their roles, Fernandez says.

“If you continue to educate your employees, you impart a sense of investment in them and I think that’s very important. The more you know about what you’re doing, the better you feel about what you’re doing.”

Coral Fernandez, RN, CCDS, CCS

“If you continue to educate your employees, you impart a sense of investment in them, and I think that’s very important,” she says. “The more you know about what you’re doing, the better you feel about what you’re doing.” 🌟
You may not submit CEUs you earned before you took the CCDS exam.

**How will I remember my due date?**

It is your responsibility to know your due date. I suggest putting a note in your calendar—maybe even set a reminder for 60 days before it’s due.

ACDIS will send you email reminders in the months approaching your due date. We send it to the email address on file in the CCDS database. You must notify the CCDS office (prichards@acdis.org) if your email contact changes. Notifying our customer service team about changes DOES NOT update the CCDS database.

ACDIS is not responsible for lapsed certification.

**What do I need to submit to recertify?**

You need to complete and submit the recertification application (available on the ACDIS website) and proof of your CEUs. You can fax it, scan/email it, or send it to us by U.S. Mail. These instructions are printed on the application.

**Do I have to send the actual CEU certificates with my recertification application?**

No, but you must keep all your certificates in a safe place in case your application is selected for an audit. If you are selected for an audit, you must follow the additional instructions and submit all your certificates to the CCDS office. If you are not selected for audit, you can recycle your paperwork once you receive your recertification confirmation letter.

**How do I pay the recertification fee?**

You can pay online, call us with your credit card number, or mail a check. If you choose to pay by check, mail it with your paperwork. Do not submit the paperwork by fax or scan if you plan to pay by check—this may lead to your paperwork being processed twice.

**What kind of CEUs can I submit?**

You may submit:

- All CEUs earned from all ACDIS and HCPro activities, including conferences, seminars, symposiums, webinars, eLearning, boot camps, ACDIS member quarterly conference calls, and *CDI Journal* quizzes.

- College coursework relevant to healthcare/healthcare management or CDI, or clinical coursework for credit or degrees (10 CEUs per credit).

- Speaking at local chapter–style events or other speaking engagements that are not part of work responsibilities (one CEU per hour of presentation).

- Speaking engagements at national seminars or conferences that are not part of regular work responsibilities (two CEUs per half-hour of presentation time). These engagements must be accredited through appropriate professional organizations such as ACDIS, AHIMA, or ANCC, and they must include a timed agenda and documentation of program objectives.

- Activities from other organizations (such as AHIMA or ANCC) that provide education or training in CDI, ICD-10, clinical (disease or diagnosis), coding, documentation improvement activities, or diagnosis/pathophysiology. You may submit a maximum of 10 CEUs for any single training event.

**How many CEUs do I need to submit?**

At this time, you must submit proof of 30 CEUs every two years. If you’re an ACDIS member, you can earn many of your CEUs through your membership by taking the Journal quizzes and by listening to the Quarterly Conference Calls and filling out the surveys. Just claiming these CEUs will award you 20 out of the 30 needed in a two-year period.

**Can I submit CEUs as I earn them?**

No. You must submit the completed application with proof of sufficient CEUs. We do not have a CEU tracker at this time.
My recertification is late. Can I still submit it?

There is a 45-day grace period from your due date to submit your CEUs without penalty. You do not have to submit a separate request to use the grace period.

If your recertification is six months late, your status is changed from active to suspended. If an employer or potential employer inquires about your status, they will be told your CCDS is suspended for failing to recertify. A $150 late fee in addition to the regular recertification fee is due with the application and copies of your CEU certificates to bring your status back to active.

If you have not recertified within a year, your CCDS will be revoked, and you will have to take and pass the exam again if you wish to hold the certification.

How will I know ACDIS received my recertification paperwork?

We will email a confirmation that we received your recertification paperwork.

Will I get a new CCDS certificate when I recertify?

We do not send a new certificate when you recertify, but we will send a letter with a wallet card.

My supervisor requires proof of my certification. What should they do?

Give your supervisor a copy of your CCDS certificate or a copy of your recertification confirmation letter. Your supervisor may email prichards@acdis.org and request verification of your certification. We do not verify CCDS status by phone.

Key takeaways:

When all else fails, here are a few tips to ensure you’re keeping your CCDS up to date:

- Know your CCDS recertification due date
- Keep a file of CEU certificates
- Submit paperwork and the fee up to 60 days before your due date
- Begin earning CEUs for the next recertification due date
- Notify ACDIS if your email address or contact information changes
- Remember that ACDIS is not responsible for lapsed certifications 🌷

Editor’s note: Richards is the CCDS coordinator at ACDIS. Contact her at prichards@acdis.org.
GUEST COLUMN
Understand why PSI 90 CDI reviews matters now

By Cheryl Manchenton, RN, BSN, CCDS

If you search for Patient Safety Indicator (PSI) 90 (Patient Safety and Adverse Events Composite) in the Agency for Healthcare Research and Quality’s (AHRQ) Version 7.0 software released in October 2017, you won’t find it.

PSI-90 is currently suspended.

That’s because the agency is in “data collection mode,” collecting and analyzing ICD-10 data so it can set expected rates for PSI 90, essentially creating an ICD-10 version.

PSIs are a set of measures that screen for complications or adverse events that patients experience as a result of exposure to the healthcare system. AHRQ’s methodology requires a five-year data set to create the modified PSI, and fiscal year (FY) 2018 is the third year of the five-year collection period that will ultimately influence expected rates.

Since AHRQ is busy creating an ICD-10 version of PSI 90, CMS decided to remove this quality measure from its Hospital Value-Based Purchasing (VBP) Program and Hospital-Acquired Condition (HAC) Reduction Program beginning in FY 2019. CMS doesn’t want to penalize hospitals for PSI 90 rates that are rooted in very old data (e.g., prior to September 1, 2015), especially because hospitals may have made significant strides in improving patient care since that data was reported.

Does this mean that CDI specialists can sit back and relax, knowing that PSI 90 is excluded from these two CMS programs?

Not exactly.

CMS’ removal of PSI 90 is temporary—not permanent. This means PSI 90 must remain on CDI specialists’ radar. In fact, now is the time to improve data quality and design quality-driven workflows as AHRQ will base expected rates and weights for PSI 90 on the data that organizations collect now.

Organizations can’t change data they have already reported, but they can start making improvements that will affect future payments. Remember, once expected rates are published, it’s too late to fix organizational performance.

That’s why it’s more important than ever to ensure that PSI metrics are complete and accurate.

PSI 90 changes on the horizon

AHRQ is expected to publish updated component weights for PSI 90 on its website sometime in FY 2019. According to the FY 2018 Inpatient Prospective Payment System (IPPS) final rule, CMS will adopt a modified version of the AHRQ PSI 90 measure for the Hospital VBP Program beginning with the FY 2023 program year.

More information on the timing may be forthcoming in the FY 2019 IPPS final rule that CMS will release later this summer.

In addition, PSI 90 continues to affect quality scores for HAC Reduction and VBP programs in FY 2018 and FY 2019, albeit with data from adjudicated claims submitted between July 2014 and September 2015.

PPrior to CMS’ temporary suspension of PSI 90, the agency included PSI 90 as part of both the Safety Domain for VBP and in Domain 2 of its HAC Reduction Program, where it represented 25% of the total score.

The agency continues to post PSI 90 data on its Hospital Compare website to help consumers make informed decisions and to promote safer, higher-quality, and more affordable healthcare.

Do note that in the proposed FY 2019 IPPS rule, the quality programs are being significantly modified so as not to duplicate metrics. We will await the final rule to determine under which program PSI 90 will be reported. But remember, it is also reported on the AHRQ website.
The following other organizations also continue to use PSI 90:

- Insurers and business groups to compare hospital performance rates and assess relative safety, quality, and affordability. Some commercial payers may incorporate PSI 90 benchmarks into the terms of their contracts.
- State agencies to publicly report on hospital quality, assess quality of care, and increase transparency regarding healthcare performance.
- State hospital associations, state data associations, and health systems to understand how hospitals compare on quality measures.

In addition, four of the PSI 90 elements continue to contribute to 5% of the Best Hospitals Patient Safety Score published in *U.S. News & World Report*. These elements include the following:

- PSI 04 (death among surgical inpatients with serious treatable complications)
- PSI 09 (perioperative hemorrhage and hematoma rate)
- PSI 11 (postoperative respiratory failure rate)
- PSI 15 (accidental puncture or laceration)

**CDI specialists’ effect on PSI 90**

Remember, everything CDI specialists do has a ripple effect. The data that organizations capture—or omit—affects quality profiles for both the hospital and physicians. This data also potentially supports or hinders opportunities for process improvement. This is one of many reasons why CDI specialists should continue to focus on PSI 90 even though it won’t directly affect CMS’ VBP and HAC Reduction programs just yet.

The AHRQ originally created PSIs to help hospitals—not the government or payers—evaluate their outcomes and ultimately improve patient care and safety. PSIs are a set of measures that screen for complications or adverse events that patients experience as a result of exposure to the healthcare system. Organizations can usually reduce these complications or events by making changes at the provider or system level. The idea is that organizations can use this data to gauge performance and identify ways in which they could take better care of patients.

Today’s organizations can use all PSIs, including PSI 90, to accomplish the following:

- Assist hospitals in assessing, monitoring, tracking, and improving the safety of inpatient care
- Compare public reporting and pay-for-performance initiatives
- Identify potentially avoidable complications
- Provide a perspective on potential complications and errors resulting from a hospital admission

**Staying focused on PSI 90: What CDI can do now**

There are several steps that CDI specialists can take now to ensure accurate capture of PSI 90. Consider the following:

1. **Create internal benchmarks.** Track current PSI 90 rates per 1,000 discharges and compare this data with that of previous years. Does the data trend downward, or have PSI 90 rates remained the same or even increased?

2. **Design quality–driven workflows.** Establish communication and remediation processes for CDI, quality, and coding, promoting collaboration to improve outcomes. Start with the most “pressing” PSIs, then expand after the process is refined. Use the time between now and when AHRQ publishes the ICD-10 version of PSI 90 to create workflows that support quality patient care.

3. **Educate staff.** Provide role-based education for health information management, quality teams, CDI specialists, coders, and physicians about the importance of PSI 90.

4. **Perform PSI 90 audits.** Consultants can perform retrospective audits that can help organizations identify documentation insufficiencies and potential coding errors.

5. **Prioritize CDI efforts.** Each of the PSIs included in PSI 90 are weighted differently, and the weights aren’t consistent from year to year. For example, the component weight for PSI 15 (unrecognized abdominopelvic accidental puncture/laceration rate) decreased by...
BEST PRACTICE FOR PSI 90 DOCUMENTATION AND DATA INTEGRITY

Consider the following documentation best practices to ensure accurate PSI 90 data:

1. Avoid documentation of “rule out” for deep vein thrombosis or pulmonary embolism without alternative diagnosis established after study. (PSI 12)

2. Distinguish between ecchymosis (flat bruising of the skin) and hematoma (bruising with mass). Also, distinguish between expected blood loss and hemorrhage. Document and code any existing coagulation disorders. (PSI 09)

3. Distinguish between lacerations or punctures that are incidental occurrences inherent to the procedure itself versus those that are a complication. If laceration of plaque is the reason for surgery, don’t code it as accidental. Query the physician if the postoperative/procedure note and operative/procedure note don’t clearly describe the circumstances of the puncture or laceration, or if the postoperative/procedure note documentation conflicts with the operative/procedure report. (PSI 15)

4. Distinguish between respiratory failure and respiratory insufficiency. Respiratory failure may be a normal part of the postoperative course. Document the reason for any longer than usual post-procedure ventilation. Also, document any neuromuscular or neurodegenerative disorders and craniofacial anomalies. (PSI 11)

5. Document the etiology of pneumothorax as well as whether it is spontaneous or congenital versus caused by medical intervention (iatrogenic). Pneumothoraces that occur during, or immediately after, a procedure are generally considered iatrogenic unless documented to be the result or component of an underlying clinical condition. Document and code any associated pleural effusion or chest trauma. Don’t code intentionally induced pneumothorax as a complication. (PSI 06)

6. Ensure accurate documentation of the present-on-admission indicator for pressure ulcers as well as documentation of the stage and location of the pressure ulcer. (PSI 03)

7. Ensure documentation of the depth of wound dehiscence as well as details such as external/superficial versus internal/deep. (PSI 14)

8. Identify the presence of clinical indications and treatment for postoperative sepsis. (PSI 13) Query the physician in the following circumstances:
   - There is no documentation anywhere in the record of sepsis other than the discharge summary.
   - Several progress notes state sepsis, but it’s not consistent in all of the progress notes and it is not documented at the time of discharge (i.e., discharge summary or final progress note).
   - Sepsis is documented early in the visit (i.e., the emergency department and first progress note) but is not listed as a diagnosis throughout the chart or in the discharge summary.
   - Both bacteremia and sepsis are documented. Seek clarification for conflicting documentation.
   - Sepsis is documented but not supported by the clinical evidence in the record.

9. Review ionic contrast documentation to assess whether the radiology contrast is the cause of any postoperative physiologic and metabolic derangement. (PSI 10)

Source: AHRQ Quality Indicators Toolkit, Table B.4, Documentation and Coding for AHRQ Quality Indicators, available by clicking here.
98.1% with the launch of AHRQ’s version 6.0 software. The component weight for PSI 14 (postoperative wound dehiscence rate) decreased by 51.1%, and the component weight for PSI 12 (perioperative pulmonary embolism deep vein thrombosis rate) decreased by 45.5%.

Likewise, the component weight for PSI 08 (in-hospital fall with hip fracture rate) increased by 389.4%, and the component weight for PSI 13 (postoperative sepsis rate) increased by 321.1%.

If your CDI specialists can’t perform concurrent reviews on all 11 PSIs included in PSI 90, focus on the PSIs with the highest component weights. These include the following:

- PSI 09 (component weight of 0.15026)
- PSI 11 (component weight of 0.21544)
- PSI 12 (component weight of 0.18429)
- PSI 13 with a component weight of 0.24132

6. Look beyond CDI. Reducing incidences of PSI 90 isn’t only about documentation improvement; organizations must also address deficiencies with quality of care. Improving the integrity of the documentation helps enhance data quality. When physicians trust the data, buy-in for clinical process improvement becomes much easier.

Editor’s note: Manchenton is the senior inpatient consultant, project manager and quality services lead at 3M Health Information Systems. She specializes in workflow design, program management, quality metrics, and performance. Contact her at cmanchenton@mmm.com. Manchenton’s comments and opinions do not necessarily reflect those of ACDIS, its Advisory Board, or 3M Health Information Systems.

### PSI 90 WEIGHTS: WHERE TO PRIORITIZE YOUR CDI EFFORTS

Summary of component weights in PSI 90, v5.0 and v6.0

Source: AHRQ PSI 90 Fact Sheet

<table>
<thead>
<tr>
<th>PSI</th>
<th>Indicator</th>
<th>Component Weight PSI 90 (v5.0)</th>
<th>Component Weight PSI 90 (v6.0)</th>
<th>Percentage Difference in Weights</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSI 03</td>
<td>Pressure Ulcer Rate</td>
<td>0.033006</td>
<td>0.059841</td>
<td>81.3%</td>
</tr>
<tr>
<td>PSI 06</td>
<td>Iatrogenic Pneumothorax Rate</td>
<td>0.075069</td>
<td>0.053497</td>
<td>-28.7%</td>
</tr>
<tr>
<td>PSI 07</td>
<td>Central Venous Catheter-Related Blood Stream Infection Rate</td>
<td>0.037684</td>
<td>—</td>
<td>N/A</td>
</tr>
<tr>
<td>PSI 08</td>
<td>In-Hospital Fall with Hip Fracture Rate</td>
<td>0.001796</td>
<td>0.010097</td>
<td>462.2%</td>
</tr>
<tr>
<td>PSI 09</td>
<td>Perioperative Hemorrhage and Hematoma Rate</td>
<td>—</td>
<td>0.085335</td>
<td>N/A</td>
</tr>
<tr>
<td>PSI 10</td>
<td>Postoperative Acute Kidney Injury Rate</td>
<td>—</td>
<td>0.041015</td>
<td>N/A</td>
</tr>
<tr>
<td>PSI 11</td>
<td>Postoperative Respiratory Failure Rate</td>
<td>—</td>
<td>0.304936</td>
<td>N/A</td>
</tr>
<tr>
<td>PSI 12</td>
<td>Perioperative Pulmonary Embolism and Deep Vein Thrombosis Rate</td>
<td>0.337900</td>
<td>0.208953</td>
<td>-38.2%</td>
</tr>
<tr>
<td>PSI 13</td>
<td>Postoperative Sepsis Rate</td>
<td>0.057308</td>
<td>0.216046</td>
<td>277.0%</td>
</tr>
<tr>
<td>PSI 14</td>
<td>Postoperative Wound Dehiscence Rate</td>
<td>0.018205</td>
<td>0.013269</td>
<td>-27.1%</td>
</tr>
<tr>
<td>PSI 15</td>
<td>Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate</td>
<td>0.439030</td>
<td>0.007011</td>
<td>-98.4%</td>
</tr>
</tbody>
</table>
Addressing common concerns about pressure ulcers

Q: Should we be advising our providers to start documenting pressure injury as opposed to pressure ulcer? Or, is it okay to document either term?

A: The coding of “pressure ulcer” has not changed. When you look up code category L89, Pressure ulcer, you will see the word “Includes” directly underneath the main bolded term in the Tabular List. This tells us the provider can use the terminology of “bed sore,” “decubitus ulcer,” “plaster ulcer,” “pressure area,” or “pressure sore” and it will code to pressure ulcer.

For physician education, make sure they know they need to document the diagnosis of pressure ulcer or injury or any of the other approved terminology listed as appropriate for code assignment. Also, emphasize that they need to include the site.

The stage of the ulcer can be determined and documented by another specialized trained individual, such as a wound care nurse.

In 2016, the National Pressure Ulcer Advisory Panel (NPUAP) announced a change in terminology from “pressure ulcer” to “pressure injury,” and they changed the stages of pressure injury. The change sought to more accurately describe pressure injuries to both intact and ulcerated skin. Under the old staging system, stage 1 and deep tissue injury both described intact injured skin, while the other stages referred to open ulcers, which led to confusion.

AHA Coding Clinic, Third Quarter 2016, p. 38, took on this change. The question asks whether coders can assume that documentation of “staged pressure injury” should be assigned to the corresponding decubitus/pressure ulcer codes. Additionally, the question asked whether new index entries would be added for documentation of “pressure injury” in the next code update.

Coding Clinic replied that, first of all, the change was to the terminology rather than to the definition. They went on to say:

“For the term, ‘pressure injury’ meaning pressure ulcer, code as a pressure ulcer by the site and stage or unstageable as appropriate. The stages of pressure injury used in the NPUAP’s updated terminology correspond to the pressure ulcer stages in ICD-10-CM.

Therefore, code a nontraumatic pressure injury the same as a pressure ulcer by site with stages one through four and unstageable. Pressure injury, stage 1-4 would be coded as pressure ulcer, stage 1-4. A deep tissue injury is coded as an unstageable pressure ulcer. In ICD-10-CM, there is an existing index entry under deep tissue injury:

- Injury
  - deep tissue
  - meaning pressure ulcer
  - see Ulcer pressure, unstageable, by site”

Back when NPUAP changed the terminology, I wrote an article for the ACDIS Blog that you may also find helpful.

PSI 03 exclusions

Q: If a patient has paraplegia and a stage 3 pressure ulcer that was not present on admission (POA), is the patient still excluded from reporting for Patient Safety Indicator (PSI) 03, Pressure Ulcer Rate?

A: Yes, the patient you described would be excluded from PSI 03.
There are actually a number of exclusions from this PSI:

- Stays less than three days
- Cases with a principal diagnosis of pressure ulcer
- Cases with a secondary diagnosis of Stage 3 or 4 pressure ulcer or unstageable pressure ulcer that is present on admission
- Cases with major skin disorders
- Obstetric cases
- Cases with hemiplegia, paraplegia, quadriplegia, spina bifida, or anoxic brain damage
- Cases in which debridement or pedicle graft is the only operating room procedure
- Discharges with debridement or pedicle graft before or on the same day as the major operating room procedure
- Transfers from another facility

I hope this is helpful. You can also visit www.cms.gov and www.ahrq.gov for more information on Patient Safety and Adverse Events Composite.

Editor’s Note: Sharme Brodie RN, CCDS, CDI education specialist and CDI Boot Camp instructor for HCPro in Middleton, Massachusetts, answered these questions. For information, contact her at sbrodie@hcpro.com. For information regarding CDI Boot Camps offered by HCPro, visit www.hcprobootcamps.com/courses/10040/overview.
LOCAL CHAPTERS

Joint events: So happy organizing meetings together

Over the years, more than a few local chapters have opted to hold a joint event with either a neighboring ACDIS chapter for a bi- or tri-state event or with a component organization from an affiliated association such as the American Health Information Management Association (AHIMA), American Academy of Professional Coders (AAPC), American Hospital Association (AHA), American Case Management Association (ACMA) or Case Management Society of America (CMSA).

The Maryland ACDIS chapter has an ongoing relationship with its AHA affiliate and has held its regular meetings at the AHA headquarters since the chapter’s inception.

For the past four years, the Massachusetts ACDIS chapter has coordinated with leaders from MaHIMA and NYHIMA for a full-day CDI/coding symposium in the summer that gathered roughly 200 participants this past August.

The Washington (Evergreen) and Oregon (Northeast) ACDIS chapters held their first joint meeting this past April, which gathered nearly 70 attendees.

In Missouri this coming October, the state’s three local chapters will come together for their third annual full-day event featuring an evening networking reception the night prior and a half-dozen educational seminars.

Collaborating with others represents a core tenet of CDI professionals’ day-to-day responsibilities, and it is a guiding principle of ACDIS’ mission in the field.

In that vein, ACDIS supports and encourages local chapter leaders to seek out opportunities to work with other groups for joint events. Potential benefits include:

- Introducing CDI to new markets/professional types
- Advancing CDI’s collaborative mission amongst various professional types (coders, case managers, hospital administrators)
- Growing local chapter membership
- Increasing the quality/quantity of educational offerings
- Sharing the responsibilities for meeting planning amongst varied team players
- Accessing potential vendor support

Timing the event

Local chapter leaders interested in joining with an affiliated association should look at their current calendar of events and determine the scope of potential involvement.

ACDIS recommends that chapters hold quarterly meetings for their
membership. These may be in-person events, teleconferences, or any combination thereof. If a chapter currently follows this cadence, its leadership team will need to determine which meeting a joint event will replace or whether a joint meeting will become an additional, fifth event for the chapter membership.

Determining the timing of the event will depend as much on the chapter’s own schedule as it will on its partners’. Leaders will also need to take seasonal obstacles into consideration, such as summer vacations, fall sporting events, winter travel difficulties, and the ACDIS national conference in the spring.

ACDIS recommends holding joint events either in late summer or late fall to avoid vacation rushes and travel difficulties. Ultimately, however, the timing of the event may depend on the availability of your chosen meeting space.

Fledgling chapters (those with less than two years in existence) may wish to wait until year three before embarking on joint efforts as specific policies related to vendor involvement, financial constraints, and leadership roles and responsibilities may come into play as planning progresses.

Reaching out, solidifying plans

Chapter leadership may be approached by a component organization, but if that hasn’t happened yet, feel free to do some research and make those connections.

The easiest way, and the most democratic, is to ask the membership what they think about holding a joint meeting with another association and asking anyone who has an affiliation with a component organization to contact that organization’s leadership team.

That individual may provide an introduction to leaders of the component organization and may choose to remain involved as both organizations begin planning.

“ACDIS recommends holding joint events either in late summer or late fall to avoid vacation rushes and travel difficulties. Ultimately, however, the timing of the event may depend on the availability of your chosen meeting space.”

Just like planning for any full-day event, leadership should start planning sessions roughly six months in advance. Make sure that all participating association leadership has equal representation on the planning committee.

Also, be sure to include ACDIS national administration on the invitations to these planning meetings. Planning sessions should take place monthly and may increase to weekly immediately ahead of the event to finalize plans and settle discrepancies.

Handling finances and logistics

ACDIS chapter leadership needs to clarify early in the process whether admission to the event will be free or if charges will be required. Many association chapters charge for their events and may wish to do so for a joint meeting as well.

Since there is no direct financial relationship between national ACDIS and the local chapters/networking groups, some chapters choose not to collect dues or charge for their events, while others have opted to create bylaws, establish themselves as nonprofits, and charge minimally for events and/or dues to offset the cost of educational activities.

If one party collects and the other does not, the leadership teams will need to determine how to best handle the scenario. Some establish two separate registration accounts and have two separate registration tables during the live event.

Others will collect funds centrally and split any remaining monies equally among the groups.

Still others will decide to forgo financial collections for this one event, with an eye toward expanding membership opportunities for all involved. Whatever the case, these details should be clear at the outset of the planning process.

Sponsors/vendors often express an interest in donating materials or providing lunch or other services during joint meetings.

During the early planning phases, be sure to discuss with the team any vendor policies or procedures currently in place and where ACDIS chapter policies either match or conflict with the component association’s processes.
At a minimum, ACDIS chapter leaders should be clear that vendor presentations should be educational in nature and not promote any product or services. They should also clearly define whether ACDIS chapter membership rosters will be shared with any vendor for the purposes of this event or whether that roster, or the specific registration list of the event, will be shared.

If the team believes sharing the attendee roster is in the best interest of the overall event, it should clearly inform the registrants and membership that it will be doing so.

On the educational side of things, if the event includes a non-CDI professional association, be sure that informational sessions include learning opportunities for everyone and that such learning is fairly evenly established. Try not to have five sessions focused on CDI metrics if the event is billed as a coding/CDI symposium.

Also, make sure that representatives from each leadership team have specific, visible roles and responsibilities to play on the day of the event.

For example, allow each member of each team to introduce a speaker, or pair up the presidents of both organizations to announce the raffle winners at the end.

**Other considerations**

Of course, there will always be additional concerns to address, but a few more questions for the leadership teams include:

- How big will the event be? (What is the size of the venue and how will the two groups market the program to increase involvement?)
- Who will handle continuing education credits? (Will the component organization obtain CEUs from its parent organization? Who will obtain CCDS CEUs from the ACDIS chapter?)
- How will you handle vendor involvement?
- Will you charge attendees for the event?

Make sure to have fun with the event. The day will come, and it will feel like leaders have poured their heart and soul into the gathering. Enjoy the opportunities.

Once the day concludes, be sure to send a thank-you note to all members of the planning team, a second note to the day’s speakers, and a third to the attendees.

Then, take a day off for yourself. You deserve it. 🌷
Mood matters at work: Translating emotional intelligence to CDI leadership and teams

By Barbara A. Anderson, RN, MSM, CCDS

Does your daily mood or attitude as a CDI leader or CDI specialist have any effect on the workplace and your organization’s bottom line? What about the mood or attitude of others on your team?

Most would say of course, especially those who have worked with a colleague or manager unaware of how their negative emotions affected the morale and productivity of the team. Mood and other emotional characteristics lie in the domain of emotional intelligence (EI). First widely publicized in 1995, EI has gained momentum as a leader/team assessment and training tool.

At its core, EI means the ability or tendency to perceive, understand, regulate, and harness emotions adaptively in oneself and in others, according to the article “Emotional intelligence and the construction and regulation of feelings,” published in Applied & Preventive Psychology, in 1995.

According to the 2012 book by Daniel Goldman, Emotional Intelligence: Why It Can Matter More Than IQ, EI competencies include:

- Personal (intrapersonal)
  - Self-awareness
  - Self-regulation
  - Self-motivation

- Social (interpersonal)
  - Social awareness (empathy)
  - Social skills

After years of research, Goldman concluded that effective leaders have a high degree of EI. Technical skills and IQ are important too, he says, but more as “threshold” requirements for leader roles, or the basics of management. The good news is that EI, unlike IQ, can be learned and improved, allowing one’s EI level to change with awareness, personal adjustments made in response to feedback, and practice.

This is even more of a good thing for leaders because effective teams also are successful relative to their level of team EI, according to the 1995 article.

Many individuals are drawn to healthcare due to their innately higher levels of EI. Over the course of a career, however, emotional burnout, methodological training, and corporate expectations can cause healthcare workers to check their emotions at the door.

EI research has brought emotions back, not only as a positive part of the human condition to honor and respect, but also as positive contributions to an organization’s effectiveness and financial bottom line.

In fact, many tech and design groups find that when EI is embraced at work, innovation, creativity, and employee retention are pushed to new heights, the 1995 article states. It has been shown to positively affect retention, prevent burnout, and improve both physical and emotional wellness.

All of these aspects are desired attributes in CDI, too, as we continuously adapt to change and become more value-focused and patient-centered.

Barbara Anderson, RN, MSM, CCDS

© 2018 HCPro, a SimplifyCompliance Healthcare brand

CDI Journal | SEPT/OCT 2018 29
There have been multiple research studies, some specific to nursing, supporting the fact that the highest performers in leadership and clinical practice roles measure high in EI.

How can EI be leveraged in CDI? The figure on p. 30 illustrates some common scenarios CDI professionals encounter and the corresponding EI category/opportunity.

What steps can CDI leaders take to create an environment that embraces EI and drives optimal communication and collaboration?

### Craft team expectations

Gather the CDI team together and explain basic EI elements. Perhaps assign some independent reading and research that each member can conduct, then have the team reconvene to discuss the highlights.

Pull out a whiteboard and ask the team to come up with ideas for behavioral norms that encourage the team to channel emotions in constructive ways to individual team members, to the larger team, and from the group to other departments or groups. Be aware

### COMMON WAYS TO LEVERAGE EI IN CDI

<table>
<thead>
<tr>
<th>Categories</th>
<th>Description</th>
<th>CDI Scenarios</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Self-awareness:** Deep knowledge of one’s own strengths, weaknesses, motivations, and emotional aspects | 1. Exhibits confident decision-making when told to cut departmental budget, bringing data and justifications to save it; seeks creative options when budget cuts are still needed  
2. Knows when personal time away is needed and plans in order to preserve uninterrupted family time |
| **Self-regulation:** Able to benefit from reflection, adapt to changes, control own impulsive behaviors | 1. Diffuses a highly charged CDI/coder staff situation with follow-up discussion after cool-down period  
2. Reflects on a high-value decision before finalizing |
| **Self-motivation:** High drive to achieve, passionate about the work, thrives when facing challenges | 1. Reads articles and takes courses to continue learning in CDI, coding, and leadership  
2. Takes on new initiatives to solve problems and foster department and interdepartmental relations |
| **Social**  |                                                                              |                                                                              |
| **Social awareness:** Consideration of how others are affected by (and feel) about actions taken | 1. Seeks input and takes time to actively listen to staff concerns prior to making decisions  
2. Holds discussions with physicians to understand the effect of CDI workflows on their work |
| **Social skills:** Building relationships with others to move them in desired directions | 1. Uses steering committee to garner understanding and support from other departments and obtains insight into their needs and overlap in department goals/abilities  
2. Works closely with physician advisor to develop tighter escalation process |
of those with varying EI levels and encourage quieter, more introverted team members to participate in the discussion.

This discussion may raise some previously unknown areas of concern or problems that other teams within the organization might face regarding CDI program activities, such as coder productivity related to CDI queries or delays in discharge-not-final-billed cases related to a low physician query response rate.

The team might discuss ways to allow individuals to constructively express frustrations as well as ideas for where and when such discussions might take place. Such ideas may include turning an office into a shared meeting room where individuals can go to review a difficult case together.

Other possibilities might be to create a meeting time where the entire team can review workload requirements and other CDI program metrics, or creating a collaborative lunch-and-learn monthly meeting with teams from other departments.

At a minimum, establish overall behavior norms for the group such that each CDI team member:

- Feels comfortable sharing thoughts and opinions in a constructive way
- Appreciates alternative viewpoints as opportunities to learn and collaborate
- Raises concerns regarding disruptive behaviors/emotions directly to the offending individual or, when appropriate, to the team lead or manager

Establish EI norms with other departments

While CDI department managers cannot dictate management styles to other departments or staff, they can set unambiguous expectations for how CDI staff interact with ancillary teams and clearly communicate EI initiatives.

When difficult relations with other departments affect work productivity and negatively affect staff morale, however, it might be appropriate to set mutual behavior norms with the manager, director, or chief of that other department.

For example, when the surgical group ignores queries and refuses to acknowledge the CDI staff civilly, and direct discussions with the individual surgeons have not been fruitful, a CDI manager meeting with the physician advisor and chief of surgery may be warranted to work through expected norms of behavior/interaction.

In addition, through the aforementioned steering committee meetings, CDI managers can explain EI concepts and what other departments can expect from CDI staff.

Evaluate progress on an ongoing basis. Such goals might include conducting at least one face-to-face physician query the first week and then progressing to two or three in subsequent weeks.”

Barbara Anderson, RN, MSM, CCDS

TEST YOUR TEAM’S EI

There are several free resources online, one by Psychology Today, and several formal testing options for gauging your team’s emotional intelligence. They include:

- Emotional and Social Competence Inventory: Evaluates several emotional competencies such as empathy, organizational awareness, inspirational leadership, conflict management, and teamwork. www.eiconsortium.org/measures/eci_360.html

- Bar-On’s Emotional Quotient Inventory: Measures competencies including self-perception, decision-making, stress management, self-expression, and interpersonal relationships. www.reuvenbaron.org/wp/

- Mayer-Salovey-Caruso Emotional Intelligence Test: Assesses an individual’s ability to perceive, identify, understand, and manage emotions. www.mhs.com/MHS-Talent?prodname=msceit
Setting clear definitions and communication pathways with members of the steering committee can help others participate in EI even if they only do so through interaction with the CDI team.

**Address low EI**

Some individuals will have higher EI than others—that's just nature. However, CDI program managers need to watch for staff who are frequently argumentative, disregard others' feelings or emotions, or respond to interactions in an overly emotional way.

Consider taking one of the EI assessments listed on p. 31 of this article, whether as an individual, as a manager, or as a team. Individual testing can increase self-awareness and set up a trajectory for improving EI. Sharing team assessment results can help guide interactions with team members.

EI might be taken on as a project, with staff volunteers responsible for conducting research and bringing information back to the group with suggestions on how the team could use EI skills for improvement in communication and collaboration. There might be formal EI training provided to the team either internally or externally, and the team would be encouraged to employ those skills in daily interactions.

As a manager, even without team testing, observed behaviors that work against positive interactions can be addressed using EI skills. For example, consider weekly or biweekly check-in meetings with a low-EI staff member, gaining a better understanding of the individual's drivers and motivators as well as pain points, and setting concrete situational goals.

Evaluate progress on an ongoing basis. Such goals might include conducting at least one face-to-face physician query the first week and then progressing to two or three in subsequent weeks. Alternatively, a goal might be to provide some CDI research and education to the team about a difficult query topic or situation, encouraging positive team interaction and sharing of knowledge.

Remember, not everyone will be able to progress to higher-level EIs. Don't throw out the baby with the bathwater—a lower-EI staff member may be perfectly content to review records and may exceed team productivity levels.

On the other hand, behaviors by an individual who continually drags down the mood of the team, blames others for mistakes, or acts indifferently or uncivilly toward other team members may need to be addressed through performance management. As part

<table>
<thead>
<tr>
<th>Signs of Needing EI Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently argumentative</td>
</tr>
<tr>
<td>Disregarding other's feelings because of a lack of understanding</td>
</tr>
<tr>
<td>Believing others are too sensitive</td>
</tr>
<tr>
<td>Not willing to listen to other points of view</td>
</tr>
<tr>
<td>Blaming others for their own mistakes</td>
</tr>
</tbody>
</table>

"Don't throw out the baby with the bathwater—a lower-EI staff member may be perfectly content to review records and may exceed team productivity levels."

*Barbara Anderson, RN, MSM, CCDS*
of a performance management plan for this individual, EI training—often provided by organizations, but also available from other sources or online—could be a requirement.

Managers with a working knowledge of EI can more wisely adjust team members’ roles and responsibilities, in addition to weighing their overall skills and career potentials. Watch for the signs illustrated in the chart below, which might indicate an opportunity for more formal behavioral norms or a need for EI training.

**Competition to collaboration through connection**

EI, as a component of empathy and highly developed social skills, reminds us to create environments where staff members feel safe and relatively stress-free, do not feel judged, and work as teams to accomplish group goals that tie into the organization’s goals.

This kind of environment fosters creativity, as mentioned earlier, and it is to be customized to the team and organization. The managerial tone is set in daily attitude and words, from the moment of hire and through all interactions with staff. It is also observed in the manager’s interactions outside of the department. 360-degree feedback from the team and from all levels of the organization provides a good gauge for the current level of EI.

Steps can be taken, as we have discussed, in response to those results to make improvements. Building relationships with all the stakeholders and collaborating on individual cases and committees with teamwork that values and respects everyone’s input goes a long way to ensure optimal outcomes. All of this helps move individuals toward a collaborative sense of accomplishment 🌟

**Editor’s note:** Anderson is an RN by background, having worked in various roles and settings. She has worked in performance improvement consulting for more than seven years, specializing in CDI, and currently is a Manager at Huron Consulting Group. Contact her at baanderson@huronconsultinggroup.com. Opinions expressed are that of the author and do not necessarily represent HCPro, ACDIS, or any of its subsidiaries.

---

**FURTHER READING**

This article references a number of excellent resources surrounding the topic of EI. To read more, here’s a list of those resources:


For those wishing to test their team’s EI, turn to p. 31 and visit the links provided there.
When Susan A. Carrier, RN, BSN, MBA, CCDS, CPC, went to school at Northeastern University in Massachusetts to become a nurse, the role of CDI specialist wasn’t even a far-off dream. She graduated, got a job working in pediatrics, and eventually moved into a sales position for a laboratory. Then she married, had children, and took time off to raise them. When it came time to return to the workforce, however, she decided that she wanted a position where she could use her “brain a little bit more.”

Then living in Maryland, Carrier took a job as a nurse coder for the University of Maryland before she heard about a position opening up at Christiana Care Health System in Newark, Delaware, and joined its six-person inpatient CDI team in 2011.

It wasn’t until 2016, however, that Carrier dove into outpatient waters. After Christiana administrators saw the system’s medical practices struggle with their Risk Adjustment Factor (RAF) and Hierarchical Condition Category (HCC) adjustments, CDI Project Manager Karen Frosch, CCS, CCDS, CRC, CPHQ, conducted an ambulatory CDI pilot program that was a success in less than three months, Frosch says. Carrier moved over and became the ambulatory CDI program manager by November that same year.

**Pilot efforts**

Once Christiana approached Frosch with its problem, she set to work researching and analyzing the system’s medical practice/outpatient workflow. She sat with the physicians, studied how they worked, examined how they processed patient documentation, and assigned codes for their patient encounters. She took courses on HCCs and outpatient coding.
“We needed to decide how we were going to do this,” says Frosch. “We needed to determine what metrics we were going to use to determine our success, how we were going to query physicians, what type of staff we needed to hire, and what our focus was going to be.”

While some programs consider a wide variety of initiatives as “ambulatory” or “outpatient” CDI—anything from CDI in the ED to assisting with medical necessity to working with physicians on their Evaluation and Management (E/M) coding—Frosch knew to focus on those physician practices.

During ICD-10-CM/PCS implementation and rollout, she says, the CDI team provided education on documentation specificity and told physicians not to worry about coding. Physician practices, however, have no coding support; they code and bill for their services on their own.

It’s not uncommon for physicians to assign their own patient care codes in the medical practice world, says Carrier. While many software vendors provide drop-down menus and other support mechanisms, these features fall short of providing big-picture instruction as to why coding rules exist and how they function, says Frosch, leading to inaccurate use of the system and ultimately inaccurate coding and billing.

“They have issues with their E/M codes. They check the first diagnosis they see in their problem list, they don’t understand coding guidelines or specificity requirements, and they select a code,” says Frosch.

Early planning discussions asked whether CDI staff would be able to assist physicians with their E/M code assignment as well as with RAF and HCC capture, Frosch says. “But in the beginning, you really need to focus. You have to start somewhere. You can’t do everything all at once, especially with limited staff.”

And staff time and effort is limited. Currently the team includes just two staff members—Carrier, and a CDI specialist—to cover more than 50 physician practice offices.

During ICD-10-CM/PCS implementation and rollout, she adds, the CDI team provided education on documentation specificity and told physicians not to worry about coding. Physician practices, however, have no coding support; they code and bill for their services on their own.

Physician engagement and leveraging metrics

Process improvement often seems like shampooing instructions—wash, rinse, repeat. Once Frosch and Carrier introduced the program, they began reviewing records.

Carrier conducts reviews both pre- and post-visit to identify opportunities, query the physician, and determine if the physician took any action (additional specificity or diagnosis changes were included in the medical record).

They conduct post-bill reviews for coding validation purposes and identify any additional education or documentation opportunities.

The ambulatory CDI team conducts education every six weeks and develops targeted information based on the data they collect.

Because outpatient CDI program software programs aren’t nearly as robust as on the inpatient side, Carrier does much of the analytics manually. She monitors:

- Number of charts reviewed
- Number of queries
- Top five queries by topic
- Physician response rate
- Projected risk capture
- RAF loss equivalent
- Coding validation

 Armed with that information, Carrier can then assess the information by physician practice and provide information about what each group may want to focus on or improve. She can even identify challenges physician face so they can amend their education accordingly.
The team does have a physician champion to provide peer-to-peer consultations if a particular situation needs to be escalated, but for the most part, Carrier says the physicians are excited about the program and happy to have the CDI team “in their corner.”

“You always have a handful of physicians that say ‘nope, nope, nope’ about CDI,” says Carrier, “but we’re sharing information with them about documentation and coding best practices that nobody ever told them before. No one gave them that information, ever, beyond their residency program.”

At roughly the same time their ambulatory efforts began, so too did the system’s transition to a new electronic health record.

Carrier became the face of the program, says Frosch.

“She loves to talk to physicians, so it worked out well,” she says. “And she was right there to help them. We told them we were going to help them with these transitions, that we were going to give them a tool. That tool was a person and our CDI program.”

That kind of support from physicians translates back into additional administrative support, as well, says Carrier.

Inpatient and outpatient CDI teams maintain different reporting structures. Carrier reports to the Medical Group of Christiana, led by faculty and a wholly separate administrative team with its own vice president of operations, to whom the ambulatory CDI program reports.

Since HCCs are assessed roughly every year, it takes 18 months of documentation improvement to see any financial returns, but now Christiana is beginning to reap those rewards.

“It’s like projecting sales for a company in some ways,” says Carrier, who explains that by assessing the documentation, she was able to accurately project the reimbursement calculations for one payer within a reasonable range.

“We were spot on in our calculation,” she says.

As the overarching CDI project manager for the system, Frosch remains involved in both inpatient and outpatient efforts, sharing important updates with both teams and maintaining regular contact with Carrier.

“We collaborate and make sure everyone is on the same page. We want to make sure that the message is consistent,” says Frosch.

That consistency also helps build physician support, says Carrier. “You have to be visible to the physicians, so they know who you are and that they can trust you and count on you. It’s really time and consistency. You blend in with the furniture. You show them over time, one documentation jewel at a time, and slowly they begin to understand, slowly they begin to see the bigger picture.”

**Symposium highlights**

Carrier and Frosch are currently putting the final touches on their November ACDIS Symposium: Outpatient CDI presentation and are looking forward to heading down to Orlando for the event.

“Really, I’m looking forward to getting the word out about our program and what we needed to do to get it off the ground,” Carrier says. “So many people don’t realize what it takes to develop an outpatient CDI program—they don’t realize how much work is involved and how many resources are needed to get the work done—so it will be good to share that and hopefully provide some programs with additional tools to help them get started.”

Carrier is also excited about learning from other programs’ successes and missteps.

“These events are always interesting,” says Frosch.

“These were uncharted waters two years ago: ‘Are we even doing it right? Let’s piggyback off of inpatient, but the workflow is different.’ When we started, compliance wasn’t comfortable with it. There are a host of lessons to be learned here from each other. It is challenging and exciting.”

Karen Frosch, CCS, CCDS, CRC, CPHQ

---

**Symposium highlights**

Carrier and Frosch are currently putting the final touches on their November ACDIS Symposium: Outpatient CDI presentation and are looking forward to heading down to Orlando for the event.

“Really, I’m looking forward to getting the word out about our program and what we needed to do to get it off the ground,” Carrier says. “So many people don’t realize what it takes to develop an outpatient CDI program—they don’t realize how much work is involved and how many resources are needed to get the work done—so it will be good to share that and hopefully provide some programs with additional tools to help them get started.”

Carrier is also excited about learning from other programs’ successes and missteps.

“These events are always interesting,” says Frosch.

“These were uncharted waters two years ago: ‘Are we even doing it right? Let’s piggyback off of inpatient, but the workflow is different.’ When we started, compliance wasn’t comfortable with it. There are a host of lessons to be learned here from each other. It is challenging and exciting.”

Karen Frosch, CCS, CCDS, CRC, CPHQ
REGISTER BEFORE SEPTEMBER 21, 2018 AND SAVE!

acdis symposium
OUTPATIENT CDI 2018

NOVEMBER 8–9, 2018
ORLANDO, FLORIDA

hcmarketplace.com/acdis-symposium-outpatient-cdi

Join us for the nation's only national conference dedicated entirely to the emerging field of outpatient CDI!
CMS tries to simplify E/M code subjectivity

By Shannon McCall, RHIA, CCS, CCS-P, CPC, CEMC, CRC, CCDS

It’s that time of year again: I am perusing proposed rules, which always hold a few interesting potential changes for the upcoming fiscal year. However, as I read the proposed rule for the 2019 Medicare Physician Fee Schedule (MPFS), which was released on July 12, 2018, I had to say, “Oh my!”

Back in January, I wrote an article regarding evaluation and management (E/M) codes and the need for changes to the documentation guidelines. In that article, I also suggested making E/M codes for office visits solely time-based to simplify the reporting of these very subjective codes. Little did I know that this was what CMS would propose months later.

CDI professionals typically focus on ICD-10-CM and sometimes ICD-10-PCS; E/M code assignment frequently falls outside their purview. Yet, E/M codes are principally associated with physicians’ own reimbursement. As such, basic understanding of the rules governing this system can help CDI professionals answer that timeless physician inquiry: “What’s in it for me?” It’s also vitally important for those working in the outpatient/physician practice setting.

E/M coding has always been subjective. As an educator, it is one of the harder topics to teach due to the varied ways to interpret E/M documentation, which impacts how providers address level selection. The Current Procedural Terminology (CPT) Manual, in which the E/M set can be found, has very generalized guidance on reporting E/M codes.

To accurately assign an E/M code, one must also be familiar with the CMS documentation guidelines (1995 and 1997 versions). However, neither of these guidelines are included within the CPT Manual, and both are outdated and do not coincide with current healthcare delivery systems; for example, they still include antiquated concepts such as legibility in documentation (hello, EHRs) and references to ICD-9-CM codes.

These days, most providers select E/M levels of service by relying on tools in the EHR that mostly involve checking a series of boxes to support the history obtained, examination performed, and medical decision-making (MDM) involved in the encounter. Providers at times are slaves to the number of boxes they check, which takes away from their ability to focus on providing quality care.

Three possible options

In the 2019 MPFS proposed rule, CMS suggests that providers may use one of three options as criteria for selecting a level of service for office and other outpatient service E/M codes (99201–99215):

1. MDM: Selecting a level of service based on the intensity of the mental work involved for a physician when evaluating and treating a medical condition
2. Time: Selecting a level of service based on the time spent interacting with the patient during a face-to-face visit.
3. Documentation guidelines: selecting a level of service using either CMS 1995 or 1997 Documentation guidelines

For the time-based option, CMS suggested three methods:

1. One typical time for all levels; 38 minutes (new patient) and 31 minutes (established patient).
2. Allow the reporting of the level of service if the midpoint is passed. For example, if the typical time for a level of service is 31 minutes, a provider can report that level once 16 minutes are spent face-to-face with the patient.
3. Continue to use the times already stated in the CPT Manual (e.g., the descriptor for E/M code 99214 already states that typically 25 minutes are spent with the patient).

The proposed changes do not eliminate the need for providers to continue to complete thorough
documentation of the visit for continuity of care purposes, but CMS is trying to ease the burden placed on providers by simplifying the most commonly reported CPT codes. CMS estimates that 40% of the allowed charges paid under the MPFS are E/M codes, and out of that vast amount, 20% are specifically E/M codes for office and other outpatient services (99201–99215). This proposal would only become effective for that series of E/M codes.

Now that we’ve discussed how CMS proposes to revise selection of a level of service, let’s move on to the anticipated effects on reimbursement. CMS proposes a single, base-payment amount for any level 2 through 5 E/M code (99202–99205 and 99212–99215).

CMS demonstrated the effect of the single, base-payment proposal (if implemented) on reimbursement by using CY 2018 data to estimate payment amounts for these codes (seen in Table 19 and Table 20 of the MPFS proposed rule). A single rate for level 2–5 codes in the 99202–99205 (new patient office visits) series would be reimbursed at $135, and the reimbursement rate for level 2–5 codes in the 99212–99215 (established patient office visits) series would be reimbursed at $93. The level 1 codes (99201 and 99211) would remain at the current rate ($44 for new patient office visits and $24 for established patient office visits).

The single base rate regardless of level of service reported would eliminate the need to audit for levels of service. Some auditors only dispute claims when the level of service differs by two levels or more from what the auditor believes should be reported. Others debate even a single-level differential. Many times, denials of a level of service are simply based on whatever the auditor considers appropriate.

### Payment rates for office visits for new patients would be:
- **HCPCS Code 99201**
  - 2018 non-facility payment rate: $45
  - CY 2018 non-facility payment rate under the proposed methodology: $44
- **HCPCS code 99202**
  - 2018 non-facility payment rate: $76
  - CY 2018 non-facility payment rate under the proposed methodology: $135
- **HCPCS Code 99203**
  - 2018 non-facility payment rate: $110
  - CY 2018 non-facility payment rate under the proposed methodology: $135
- **HCPCS Code 99204**
  - 2018 non-facility payment rate: $167
  - CY 2018 non-facility payment rate under the proposed methodology: $135
- **HCPCS Code 99205**
  - 2018 non-facility payment rate: $211
  - CY 2018 non-facility payment rate under the proposed methodology: $135

### Payment rates for office visits for established patients would be:
- **HCPCS Code 99211**
  - 2018 non-facility payment rate: $22
  - CY 2018 non-facility payment rate under the proposed methodology: $24
- **HCPCS code 99212**
  - 2018 non-facility payment rate: $45
  - CY 2018 non-facility payment rate under the proposed methodology: $93
- **HCPCS Code 99213**
  - 2018 non-facility payment rate: $74
  - CY 2018 non-facility payment rate under the proposed methodology: $93
- **HCPCS Code 99214**
  - 2018 non-facility payment rate: $109
  - CY 2018 non-facility payment rate under the proposed methodology: $93
- **HCPCS Code 99215**
  - 2018 non-facility payment rate: $148
  - CY 2018 non-facility payment rate under the proposed methodology: $93
Minimum documentation requirements

Since there would only be one payment rate, CMS has to establish some minimum documentation requirements to support medical necessity. CMS proposes that the required documentation will be equal to that of a level 2 visit by requiring at a bare minimum:

- An expanded problem-focused history and exam, straightforward MDM (new patient)
- A problem-focused history and exam, straightforward MDM (established patient)

There are some issues with having a single base payment rate for any level 2–5 visit. First, providers should not just opt to report the lowest level of service (99202 or 99212) for every visit with the mindset that the payment won’t differ for the higher levels anyway. Rather, providers should be documenting and reporting levels consistently based on the actual complexity. In addition, other governmental and commercial payers may not follow CMS’ lead (including Medicaid), and Medicare can sometimes be a secondary payer. Documentation and code reporting should always be standardized regardless of payer. This issue was seen in the recent past with Medicare’s decision to not recognize consultation services for payment, as the consultation E/M codes are still payable by most commercial payers as well as state Medicaid agencies.

Another recognized issue involves the fact that some providers evaluate and treat a broad spectrum of healthcare needs (e.g., primary care) and focus primarily on promoting ongoing relationships with their patients by routinely managing everything from very minor conditions up to the most complex conditions. Other providers, by the nature of their specialty, tend to see very complex patients (e.g., hematology/oncology) and rely mostly on E/M reporting.

It is important to have a way to compensate these providers for the higher-complexity visits. CMS therefore proposes to also add HCPCS II G codes for every E/M visit rendered by these providers to reimburse for the added complexity. The codes proposed include:

- HCPCS II code GPC1X (Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed healthcare services)
  - Reported in conjunction with the appropriate level of service (99212–99215) for every established patient visit
  - Can be reported by any provider acting as a primary care provider (e.g., OB/GYN), not just those designated as primary care (e.g., family practice, internal medicine, pediatrics)
  - HCPCS II code GCG0X (Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management–centered care)
  - Reported in conjunction with any level 2–5 E/M visit code (new or established)

Although the single base payment may seem unfair to some specialties, CMS is attempting to ensure reimbursement under this proposal would remain equitable with the current reimbursement system while removing some of the burden that comes with having to distinguish between levels of service.

Currently, the E/M chapter of the CPT Manual provides face-to-face prolonged service add-on codes (CPT codes 99354–99355). The prolonged add-on codes mention “first hour,” but the E/M subsection guidelines state the prolonged services add-on codes can be reported beginning at 30–74 minutes into the visit.

Another E/M concept that currently takes up a lot of auditor time and energy is reporting an E/M code on the same day as a minor procedure (zero-day global) with modifier -25, which is used to indicate a significant, separately identifiable E/M service by the same physician or other qualified healthcare professional on the same day of the procedure or other service. Providers have struggled with the documentation to support the modifier -25 standard of going “above and beyond” the usual pre- or postop care for a minor procedure. CMS proposes allowing providers to report both the E/M visit and the minor procedure on the same date of service when performed by the same provider and will allow
Of providers and CDI professionals.

Albert Einstein supposedly said, “The definition of insanity is doing the same thing over and over again and expecting a different result.” Does your CDI team have to query the same provider repeatedly? Does one of your physicians elicit numerous clinical validation denials because of diagnosing sepsis for every fever or acute hypoxic respiratory failure for every patient who is placed on two liters by nasal cannula? Is it driving you insane?

**Tip 1: Give feedback**

My first tip is to invest time into giving regular, directed feedback. It’s optimal to have queries give enough information, so the provider can make an informed decision and clarify the documentation. The next step is to close the loop. I often ask whether a CDI program gives providers feedback. The response is frequently, “We don’t have time to do that.” Yet they somehow have the time to generate the same query or fight the same denial battle over and over again. Strange!

I view queries and denials as teachable moments. CDI queries often frustrate clinicians because CDI specialists aren’t allowed to be leading—they can’t specifically ask (or tell) clinicians what needs to be written. Have you ever had providers implore you, “Just tell me what you want me to write!”? While that might be the question articulated, that isn’t what they’re really asking for. Instead, they really want to understand the underlying issue so they can document more wisely in the future to prevent another query or denial.

Whether it’s a result of mortality conference review, hospital-acquired condition/Patient Safety Indicator committee review, or a medical necessity or clinical validation denial, the physician advisor/educator should take the time to explain why the provider’s behavior elicited the concern and how the concern could be avoided in the future. Perhaps the provider wasn’t aware that his or her actions would result in a problem. While this explanation can be important, it should be done independently of the query, because it’s not compliant for a query to include quality or financial implications.

Like all good documentation, this education should take the time to tease out the most important points and compose the feedback so it can be taken in by the recipient. Imagine a physician documented acute kidney injury (AKI) that turned out to be chronic kidney disease (CKD). What does this physician need to know the most? In this case, the answer might be the criteria for AKI. Distill the education down to two or three takeaway points (e.g., AKI is denial-prone; if the
creatinine never normalizes or the baseline supports CKD, remove the diagnosis of AKI and instead diagnose CKD with stage). Give the physician references to use if he or she chooses to pursue the topic further, such as a link to the Kidney Disease: Improving Global Outcomes clinical practice guidelines for AKI. Create a condensed CDI tip sheet to attach to the email you send the physician.

**Tip 2: Educate**

My next tip is to educate providers where they are. Many organizations have CDI professionals participate in clinical rounding. When I round with the teams or do elbow rounds with a solo practitioner, I try to find a nugget for each patient.

Sometimes, the point is an acknowledgment of good behavior (e.g., “Excellent, you noted that this patient has severe protein-calorie malnutrition. You should be looking for that in patients with malignancy. Be sure to address it clinically—this is not just about documentation. It’s about taking excellent care of our patients.”). Sometimes it’s preemptive (e.g., “If this patient’s BMI had been over 40, you would want to be sure to pick up the diagnosis of morbid obesity.”). And sometimes it’s something that actually impacts that patient in the moment (e.g., “You said she was lethargic and very confused. Is there a diagnosis that goes with those symptoms?” This might lead to a couple of minutes of impromptu encephalopathy education and the capture of an MCC.).

Get yourself invited to morbidity and mortality rounds (M&M), morning report, or any other venue where the clinicians are discussing cases. I attended a surgery M&M where the surgeons presented a case of exsanguination by abdominal aortic aneurysm rupture. However, in a 10-day stay, not one provider had documented “shock,” and the principal diagnosis was not “with rupture”—this is one of those squirrely coding-clinical disconnects. I had the opportunity to educate the vascular surgeons that they need to explicitly document “with rupture” or “ruptured.” The terms “bleeding,” “hemorrhaging,” “torn,” or “leaking” go to “without rupture.” I even got to teach them to document, “contained rupture.”

It’s so much more powerful to provide this kind of education in real time, rather than sending an email memo three weeks later that might never be opened. It’s also optimal to teach multiple providers at once. In this instance, all the attendees heard the message; if they hadn’t, there could be 70 providers making the same mistake individually and needing the physician advisor’s attention one at a time. If you find patterns, redact the educational case and disseminate the information to the service, the division, or the department.

**Tip 3: Create teaching case files**

My final tip is to have the CDI team compile a collective teaching case file. On a moment’s notice, my radiologist husband can whip up 12 examples of a small-bowel obstruction to show his residents. We all see awesome cases of terrible documentation, of excellent documentation, of every specific CDI opportunity.

Not only can you use this case file to devise focused educational presentations for providers, but your CDI team can also use it to train new CDI specialists. You can’t do it retrospectively, because—hopefully, if you do your job—the final medical record won’t have the opportunity you originally found.

When you find a great case, download the original documentation pre-query. Make a file with this documentation, the query, the response, and the impact. You can then let your novice CDI specialist review the case and compose a practice query, which you can then provide feedback and suggestions on. You might even expand this concept to include DRG mismatch training. If you have a standardized set of training materials, you can judge a new CDI specialist’s progress.

No one wants to be wrong, but there is no improvement without practice, feedback, and education. Here’s hoping these tips will return a little sanity to your life.

**Editor’s note:** Remer is the founder and president of Erica Remer, MD, Inc., Consulting Services, and a member of the ACDIS Advisory Board. Contact her at icd10md@outlook.com. Opinions expressed are that of the author and do not necessarily represent those of HCPro, ACDIS, or any of its subsidiaries.
Meet a Member
Perseverance paid off for this CDI specialist

Susan Edamala, RN, MSN, CCDS, CCRN (Alum), is a clinical nurse consultant II and a CDI specialist at University of Illinois Hospital and Health Sciences System (UIHHSS). She is also a member of the Illinois ACDIS local chapter.

CDI Journal: How long have you been in the CDI field?
Edamala: I’ve been involved with CDI for five years now.

CDI Journal: What did you do before entering CDI?
Edamala: I was a critical care nurse and a nursing professor for 22 years. I was also an Advanced Cardiovascular Life Support (ACLS) instructor.

CDI Journal: Why did you get into this line of work?
Edamala: I used to work night shifts in the ICU and could not do it any more due to child care issues, so I was looking for a day position. A CDI job was posted at the time, so I talked to the supervisor to see if it was a good fit for me and applied for the position.

CDI Journal: What has been your biggest challenge?
Edamala: At the first place that I worked as a CDI specialist, I had a manager who did not have confidence in me. I didn’t have a good preceptor and was told this job was not a good fit for me. I was repeatedly told that this was not something I could do. Although it was very frustrating and disappointing at the time, I stuck with it and found a new position starting a CDI department of my own.

CDI Journal: What has been your biggest reward?
Edamala: Being able to start a CDI department at a university level with just nine months of job experience and share our success story at the 2016 ACDIS Conference as a podium presentation and at the 2018 ACDIS Conference as a poster presentation.

CDI Journal: How has the field changed since you began working in CDI?
Edamala: There have been a lot of changes since I began working in CDI in 2013. The implementation of ICD-10 and all the learning, training, and teaching that went with it was a huge change. Plus, we’ve had to learn to use different encoders, learn about the Medicare Access and CHIP Reauthorization Act (MACRA), Hierarchical Condition Categories (HCC), pediatric CDI and OB-GYN—it’s all new to me. The shift from MS-DRG based coding to APR-DRG based coding is also new. The industry is constantly changing. CDI is being given more and more importance and we’re...
learning how CDI work can affect Quality, Patient Safety Indicators (PSI), Risk adjustment, Mortality indexes, etc.

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

**Edamala:** ACDIS is a great learning platform. Having a membership with ACDIS has helped me get access to unlimited learning resources. I am able to keep abreast with the latest news on matters related to CDI, coding, and revenue cycle.

**CDI Journal:** How many ACDIS conferences have you been to? What are your favorite memories?

**Edamala:** My first ACDIS conference was in 2016 in Atlanta. I presented the topic “Kiss My Query” along with my boss, Dr. Karl Kochendorfer, Assistant Chief Medical Officer of UIHHSS.

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

**Edamala:** A CDI specialist is an important person who has the ability to make the organization look good to the public through quality scores. Don’t ever give up, especially when people try to put you down. Keep trying and keep learning.

A CDI specialist is also considered a clinical expert, so keep up with the latest industry trends and do the best for your hospital in terms of quality scores, reimbursement, and being the remote driver of excellent patient care.

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

**Edamala:** A professor in nursing, because I love teaching. I also have my own NCLEX training business.

**CDI Journal:** What was your first job?

**Edamala:** At the age of 17, I went into nursing, so I have not had any other career.

**CDI Journal:** Can you tell us a bit about your favorite things?

**Edamala:** I love being with friends, going on vacation with family, and doing adventure sports with my kids.

**Vacation spots:** Cancun; I’d also love to visit Europe (it’s on my to-do list).

**Hobbies:** Modelling, Singing, Photography, Bollywood dancing, Videography, Cooking, Directing and acting in plays, Script writing for plays, Choreography, Nail art.

**Non-alcoholic beverage:** Custard apple shake.

**Foods:** Mutton biryani, panipuri, cheesecake.

**Activities:** Being with friends and being goofy.

**CDI Journal:** Is there anything else you’d like to add?

**Edamala:** The CDI job is meant for those who love to investigate clinical scenes. I feel proud that CDI plays a key role in the financial sustenance of the organization.
ACDIS Webinars

- **JANUARY**
  - JAN. 25: CC/MCCs for CDI: Clinical Indicators and Query Opportunities

- **FEBRUARY**
  - FEB. 22: CDI Workshop: Unpack Clinical Validation Efforts and Query Practices

- **MARCH**
  - MAR. 22: CDI Conversations: Patient Safety Indicators and Effective Collaboration

- **APRIL**
  - APR. 10: Respiratory Failure: The Ins and Outs of Diagnosis Documentation, Coding, and Clinical Validation

- **JUNE**
  - JUNE 14: CDI Conversations: Simplifying Complex Trauma Reviews

- **JULY**
  - JULY 19: Sepsis: Resolving Documentation and Coding Conflicts Through CDI

- **AUGUST**

- **SEPTEMBER**
  - OCT. 11: Pediatric CDI in the NICU: Tiny Children, Big Documentation Requirements

Learn more at hcmarketplace.com