A rising tide lifts all boats: CDI leadership and professional development
FEATURES

10 Welcome new Advisory Board members
Each April, four members step down from the ACDIS Advisory Board and four new faces, elected by the ACDIS membership, join. Get to know those new folks and join us in thanking those who are stepping down.

18 CDI leaders share their stories, tips
Whatever the path, leadership jobs will have their ups and downs. Luckily, many accomplished CDI leaders from all walks of life willingly extend a helping hand to share tips with those coming up.

22 12th ACDIS Conference: Simply magical
Melissa Varnavas recaps some of the highlights from this year’s ACDIS conference, including pictures from the event and attendee feedback.

29 Career ladders
Having a career ladder in place would improve employee satisfaction in most situations. Offering CDI professionals career advancement opportunities will hopefully ignite their passion for CDI and loyalty to their facility.

32 Original CCDS holders share stories, advice
This May, ACDIS celebrated the 10th anniversary of the CCDS credential. More than 100 hopeful CDI specialists assembled to take the first exam in 2009. Today, more than 4,500 CDI professionals hold the credential, with the number growing every day.

DEPARTMENTS

3 Associate Director’s Note
Melissa Varnavas shares tips from CDI leaders on how to be an effective manager and leader, whether or not your title matches.

6 Advisory Board Note
Tamara Hicks explains how her organization implemented a CDI career ladder and why it’s an important step for a mature program.

16 Ask ACDIS
Allen Frady unpacks some frequently asked sepsis Q&A and shares his advice for navigating this difficult diagnosis.

36 Physician Advisor’s Corner
Trey La Charité explains why physicians may feel that CDI professionals are asking too much and offers potential solutions to ease the tensions.

39 Meet a Member
Lawrence Berthold has worked for PENN Medicine his entire nursing career. Currently, he oversees the CDI teams across the PENN health system. He participates in both the South Jersey/Philadelphia/Delaware and the Central Pennsylvania ACDIS local chapters.

OPINIONS & INSIGHTS

27 Enjoy the twists and turns of your CDI journey
Sarah Matacale reflects on her professional journey to the CDI profession and encourages readers to enjoy every minute of their own.

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 this 20-question quiz.
Being an effective manager

By Melissa Varnavas

A CDI manager recently explained to me that while she and her team had a supportive administration for a number of years, mission creep eventually seemed to take hold, and those once-supportive leaders now seemed to ignore the team’s staffing needs.

“I suppose other initiatives took precedence,” she said, “but I needed leadership help within my department and could not get any. The staff was so stretched with our census growth, we did not feel we could pull anyone off reviews to help with leadership of the department. It was very, very frustrating.”

We’ve all had terrible bosses at some point. Who hasn’t? But what do CDI specialists want/need from their leadership teams? Most fundamentally, staff want a clearly communicated mission that matters for both patient and organizational health, along with true administrative support for their endeavors.

“Sometimes, to use an apt Pacific Northwest metaphor, we feel like salmon, fighting against the stream—begging for providers to understand why what we do is important, that we’re more than just ‘trying to make more money for the hospital,’” says ACDIS member Lillian M. Dickey, BSN, RN, BSBA-MIS, CCDS. “Ultimately, I would like my leaders (and their leaders) to dig in and see the bigger picture with us, so we can communicate that to providers.”

The problem is that CDI staff and management need to lead the leaders. CDI teams need to consistently reevaluate their efforts in order to address the facility’s most pressing needs without overtaxing the staff to the point where principal accomplishments flounder. As a team, the group needs to be able to make the value-proposition case for its staff and activities over and over again.

The ACDIS position paper “Developing Effective CDI Leadership: A matter of effort and attitude,” published in May 2017, addresses this. In it, the ACDIS Advisory Board quotes Woodrow Wilson as saying “You are not here merely to make a living. You are here to enable the world to live more amply, with greater vision, with a finer spirit of hope and achievement. You are here to enrich the world, and you impoverish yourself if you forget the errand.”
Wilson’s quote underscores the theme of the Advisory Board’s advice—you don’t need to be in a leadership position to be a leader. “Leadership has far less to do with authority and much more to do with setting a vision, mission, and strategy toward specific goals,” the paper says.

There’s plenty of advice out there on how to live a more productive and fulfilling life. It seems like every time I open my web browser, the home page recommends another piece on the topic. This morning it was “7 Skills That Will Help Reach Your Full Potential,” from Darius Foroux.

Title grammar error notwithstanding, the article included typical advice you’ve likely heard before: maintaining a healthy sense of self-awareness, obtaining leadership skills, developing clarity through writing regularly, practicing mindfulness, improving productivity, maintaining perseverance, and working toward excellence.

For its part, ACDIS’ position paper offers five tips:

- Establish your mission, values, and goals
- Establish your department’s mission, values, and goals
- Recognize your strengths and weaknesses
- Build a guiding coalition
- Monitor your progress and share your experiences

The ACDIS position paper further describes each tip, offering information about just how to take action. Under establishing your personal mission, it provides an example mission statement that I love:

*To make positive contributions to the greater good of my family, friends, employer, and society. To live each day with self-awareness and purposeful action. To improve each day and in so doing positively influence my peers and colleagues and provide a good role model for my family. To live life honestly, with good cheer, appreciation, and gratitude, and to operate with integrity.*

This sample personal mission statement reminds me of the ACDIS 2016 keynote address from Vicki Hess, RN, who told conference attendees all they needed to do to change their lives and revitalize their careers was to shift their perspective. While this advice may seem vague, Hess used a number of concrete examples to illustrate how something as simple as a smile can change your outlook and shift the attitudes of those around you. ([Click here to download Hess’ “Three Secrets to Engaging the Healthcare Team.”](#))

For my part, I love it when CDI professionals include a motivational quote in their email signature line, like the one ACDIS member Maryann Dinello, RN, CCDS, uses from 2018 ACDIS keynote presenter Allison Massari: “A key to happiness is deciding to be a source for it.” The quote embodies the concepts taught by Hess and Massari and provides a thought-provoking addendum to all of Dinello’s communications.

Choosing to embark down a leadership path means first taking stock of one’s life, as the position paper and most self-help gurus suggest. CDI professionals specifically need to know what their baseline expectations are and how to achieve them. If those expectations don’t exist or are murky, CDI professionals can create or clarify them by working with the team and requesting baseline data.

ACDIS has numerous articles, surveys, and papers on baseline productivity expectations. (A general search on the ACDIS website for “productivity” brings up [18 pages of results](#).) The adage “work smarter, not harder” holds sway in most organizations these days—we all have to do this, because the tasks keep coming. Nor can you stem the tide through efficiency because “work expands to fill the time available for its completion,” as the British historian C. Northcote Parkinson realized back in 1955 when he coined what would come to be known as Parkinson’s law. That’s mission creep, and CDI professionals know it well.

Yet, according to a tutorial from New York University (intended to assist students with their workloads), certain skills, such as the following, may be essential in managing daily tasks and balancing productivity with new initiatives:

- Planning
- Organizing
- Goal setting
Prioritization

Flexibility

Personal self-assessment (what time of the day are you most productive?)

You may already practice these, but it’s always worth taking a second look at how you schedule out your day and taking a step back to determine whether you could structure your activities more effectively. Something I’m trying these days is the Pomodoro technique.

It recommends setting a timer for 25 minutes, then forcing yourself to get up from your task when the buzzer rings and take a five-minute break—to walk around the building, get a cup of coffee, or whatever. The idea is that if you truly focus on that one task for 25 minutes, you’ll burn through the activity. Then, by giving your mind a five-minute rest, you’ll approach your next activity ready to give it your all. (Although, I admit that when I say I’m “trying” this technique, I actually mean I’ve spent the past two months thinking about trying it and haven’t set the timer yet.)

The 2017 ACDIS position paper on leadership suggests employing “Plan-Do-Study-Act” (PDSA) cycles, as recommended by the Institute for Healthcare Improvement. Essentially, a PDSA cycle includes identifying an opportunity, implementing a solution, examining whether the solution worked, and then acting to improve the process. Whether you’re a CDI manager or a staff member, you can stay attuned to opportunities by listening to those you interact with on a daily basis. A challenge for them may simply be an opportunity for you to change your process and become more effective.

“As a leader, try to view challenges as a chance to step up and prove yourself. This will require you to step outside your comfort zone—and likely outside your job description—but this is what good leaders do,” the position paper says. “Offer to help in areas where no one else has volunteered, and where the customer’s needs are not met. Then document your work, your approach, and the improvements. This output will be key in proving your value.”

So, what about that unicorn—the perfect boss, the perfect leader? Take a closer look at the position paper and you might just find some tips on how to become one yourself.

ACDIS member Molly Siebert, RHIA, CCDS (who in my opinion exemplifies excellent leadership herself), says she “happens to have the best CDI manager ever.”

The qualities Siebert lists below match what we’ve discussed and what the members at this article’s outset say they wish for:

- “She is a very effective communicator with physicians and works with them to make things more efficient (i.e. a better query template) that would make sense to the MDs.”
- “She is an excellent data analyst and is pulling data (financial and otherwise) that we either directly or indirectly effect (i.e. case mix index for each hospital) and effectively communicates that data to physicians, upper level management, and to us.”
- “She is effective staying current with CDI information and trends.”
- “She is persistent at solving issues while being flexible in process and outcomes without being pushy.”
- “Last but not the least quality, our manager listens to us.”

While these qualities may seem elusive, we hope that this edition of the Journal will help you hone a few of them, illuminating pathways down which you can venture to improve your leadership skills, whether or not you have a management title. We can’t wait to see where your CDI career leads you.
Implementing a career ladder in a multi-hospital health system

By Tamara A. Hicks, RN, BSN, MHA, CCS, CCDS, ACM-RN, CCDS-O

Wake Forest Baptist Medical Center (WFBMC), an internationally recognized academic medical center in northwest North Carolina, has more than 14,000 employees. It is the largest employer in Winston-Salem, Forsyth County, and one of the largest in the Piedmont Triad region.

WFBMC provides adult and pediatric healthcare services to the residents of 24 counties in central and northwest North Carolina and southwest Virginia. The medical center now has 170 buildings on 358 acres, including a 196-acre research farm and a downtown research center.

The CDI program, known at the time as the clinical documentation management program (CDMP), started in March of 1999 at WFBMC (formerly North Carolina Baptist Hospital). CDMP started as a traditional CDI program with a financial focus, covering only Medicare cases and reporting to case management, later known as care coordination. The original team had eight CDI specialists.

The CDMP program grew over the years, first adding Medicaid and review of pediatrics to the mix, and later adding all payers. The implementation of MS-DRGs brought a new focus on severity of illness and risk of mortality. In 2007, the team was already contributing to better expected patient mortality rates.

Acquisitions and advancement

In 2010, CDMP began working with a vendor to “refresh” the program, which led to additional staffing to allow for better coverage of all payers. In 2012, three staff joined the organization to conduct second-level reviews—these same staff now serve as team leaders.

Along the way, WFBMC encountered its share of mergers and hospital acquisitions, and as the organization grew, so too did the CDI department.

Of course, 2015 brought ICD-10. With that came the need to educate providers on the new concepts. The CDMP team helped with that training—in the inpatient and outpatient settings. At the same
time, leaders in the ambulatory space approached the team for help in capturing Hierarchical Condition Categories, so an outpatient CDI team was created to meet these needs. New staff were approved and funded by the ICD-10 steering committee.

The next year, the CDMP team was realigned into its own department, clinical documentation excellence (CDE), with two managers and a director.

The growth continued with the acquisition of Wilkes Regional Medical Center in 2016, which became WFBH Wilkes Medical Center. That brought two additional staff to the CDE team. And in 2018, High Point Regional Medical Center was integrated into WFBH, becoming WFBH High Point Medical Center.

WFBH now includes:

- Wake Forest Baptist Medical Center
- Wake Forest Baptist Health – Lexington Medical Center
- Wake Forest Baptist Health – Davie Medical Center
- Wake Forest Baptist Health – Wilkes Medical Center
- Wake Forest Baptist Health – Brenner Children’s Hospital
- Wake Forest Baptist Health – Comprehensive Cancer Center
- Wake Forest Baptist Health – High Point Medical Center

Today, the CDE department at WFBH includes 40 total staff members:

- One director
- One secretary
- One outpatient CDE analyst
- Two managers, one for inpatient and one for outpatient
- Three team leaders
- Seven outpatient CDE specialists
- 25 inpatient CDE specialists

The goal of the department is accurate, complete, and compliant documentation. Its approach is payer agnostic, and the department is moving toward better capture of risk adjustment.

**Growing pains**

Obviously, the WFBH CDE program has grown tremendously over the last 20 years. In the beginning, the growth was slow, at first expanding into pediatrics, the comprehensive cancer center, and smaller community hospitals. But in the last several years, the growth has picked up speed, adding three new hospitals in five years. These growing pains led the CDE leadership to step back and think about how to best integrate these new facilities into the “Baptist way” of performing CDI activities.

As part of the integration of High Point Medical Center, the team was able to conduct an assessment of the hospital and the CDI team there. Some of the things observed during that assessment affected how the new team would approach this integration, including facility size, patient acuity, average length of stay, payer mix, and varying expectations and cultures.

Evaluation of the existing CDI program showed that there were differences in priorities, baseline data, educational backgrounds, pay scales, systems used, and engagement with providers. The management team, together with its vendor, conducted a chart review using a representative sample of medical records to evaluate potential opportunities for CDI.

This assessment revealed a potential $1.5 million in revenue enhancement, a potential 5% increase in case-mix index, and an opportunity to improve expected length of stay. Additionally, the assessment showed education opportunities for the CDI specialists and coders. It also demonstrated that an additional four staff were needed to sufficiently cover all payers at this facility.

These findings allowed the leadership team to focus their initial efforts, identifying the areas of greatest need. It also pressed the management team to decide how best to integrate the CDI staff. Some of the elements that needed to be considered were advanced certifications, education, experience, and past performance.
The team also had to think about how to implement unified processes, which would require a transformation in behaviors, beliefs, and practices. The team knew it had to provide standardized communication and education, as well as standardized metrics.

Fortunately, the leadership team had already created a set of metrics; they would simply have to be rolled out to the team members at the new facility.

**Career ladder development**

CDE at WFBH is a corporate-level department, encompassing all facilities within the clinical enterprise. With the addition of new medical centers, the department gained existing employees with varying educational backgrounds, certifications, and experience levels. So, the leadership team at WFBH had a challenge in determining how to address these variables. After working closely with HR, they decided to take a tiered approach to staffing, which resulted in a career ladder for the CDE team.

The CDE career ladder consists of two levels for the CDI specialist. The CDI specialist I is a beginner or novice-level staffer who is expected to provide basic chart review, identifying opportunities for improvement. Historically, CDI specialists at WFBH have bachelor-level degrees in nursing plus at least five years of direct clinical experience. However, with the addition of existing employees from other medical centers, the staff had varying levels of education and certifications. It was determined that any added staff member who did not meet the historical minimum requirements would be placed as a CDI specialist I.

The CDI specialist II is an intermediate-level staff member who exhibits advanced expertise related to CDI. In addition to five years of direct clinical experience and bachelor-level degree preparation, specialists at this level must have at least two years of CDI experience and an advanced certification related to CDI (such as the CCDS or CDIP credential). Staff at this level are expected to coach and mentor the CDI specialist I staff. The CDI specialist II is placed at an advanced pay grade compared to the CDI specialist I.

The next level in the career ladder is the clinical documentation excellence team leader; this person must have, in addition to all other educational and certification requirements, five years of CDI experience. Previous leadership experience is also preferred. This is an advanced level for staff who are expected to provide a comprehensive second-level CDI chart review.

Team leaders are expected to provide daily staffing support and serve as subject matter experts. They are also expected to coordinate all activities related to compliance, quality assurance, and education with the CDE staff to improve overall quality and completeness of patient record documentation. The team leader is
placed at an advanced pay grade compared to the CDI specialist II.

The final two levels in the ladder include the manager and director levels. These positions require five years of clinical experience as well as seven to 10 years of CDI experience. They also require a graduate degree in healthcare as well as CDI and/or coding certifications.

These individuals must possess expert knowledge of CDI and provide leadership, coaching, and mentoring to their teams. The director must have demonstrated leadership/management experience, with three or more years of progressive experience in leadership positions.

WFBH’s CDE team adopted this career ladder in 2019. Since implementation, staff have been incentivized to seek advanced certification. The CDI specialist II staff function as team captains, mentoring and orienting new staff as well as assisting with routine questions and concerns. This has freed up team leaders to spend more time on physician education and quality metrics. In turn, the managers have more time to spend in day-to-day operations of the department.

I began my own CDI journey here at WFBMC back at the program’s start in 1999. Over the past 20 years, I’ve observed several truths. First, mergers and acquisitions can bring new opportunities for career growth. Next, the larger an organization becomes, the greater the need for a uniform structure and hierarchy of authority. Last, regardless of your healthcare system’s size or program staffing level, there are opportunities for structural changes to improve CDI career paths.

Examining the various record review opportunities now open to CDI, and conducting internal and external research on how these reviews can affect your organization, could provide the leverage you need to gain additional staff and implement a career ladder at your facility. 🌱

Editor’s note: Hicks is the director of CDE at Wake Forest Baptist Health in Winston-Salem, North Carolina. She’s served two terms on the Board, most recently ending in April 2019. She was awarded the 2019 CDI Professional of the Year Award from ACDIS. Opinions expressed do not necessarily represent those of HCPro, ACDIS, or any of its subsidiaries. Contact her at thicks@wakehealth.edu.
Serving on the ACDIS Advisory Board requires dedication, patience, and expertise. Members guide the association and the profession over their three-year terms. During that time, the board volunteers participate in ACDIS’ quarterly membership conference calls, hold meetings, write ACDIS position and white papers, respond to questions from members, and much more.

Each April, four members step down from the board and are replaced by four new faces from a pool of candidates chosen by the Advisory Board election committee and voted on by the ACDIS membership. The ACDIS team wanted to spend a little time thanking the folks who recently rotated off and getting to know the new members. (To see a full list of the Advisory Board members, see p. 6.)

**Leaving members**

Sam Antonios, MD, FACP, FHIMSS, CPE, CCDS  
Chief Medical Officer, Medical Director Information Systems  
Via Christi Health  
San Antonio, Texas  
Samer.antonios@via-christi.org

ACDIS: How long have you been in the CDI field, and how did you get started in the field?

Antonios: I have been working in hospital operations including documentation integrity for the last 12 years. This has included many projects, including medical necessity and ICD-10 conversion along with electronic health record implementation with standard templates.

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

Antonios: Keep track of the evolution of healthcare. Learn its history to be better prepared for the future. Develop as many mental models as possible.

ACDIS: What’s been your biggest reward/favorite memory in serving on the board?

Antonios: Interacting with other board members and receiving questions from fellow CDI professionals.

ACDIS: What made you decide to apply for the ACDIS Advisory Board?

Antonios: Given my experience and my love for CDI professionals, I wanted to give back to the community by serving on the board and providing input where it might be helpful.
ACDIS: Now that you’ve rotated off the board, what do you have planned for your new-found time?

Antonios: Focus on understanding how clinical documentation affects quality measures more, and the outcomes of data on quality.

Paul Evans, RHIA, CCDS, CCS, CCS-P
Clinical Documentation Integrity Specialist
Sutter West Bay Area
San Francisco, California
evanspx@sutterhealth.org

ACDIS: How long have you been in the CDI field, and how did you get started in the field?

Evans: I sent my first “query” in 1989, and have been issuing them ever since. At that time, issuance of a query was simply a routine part of my duties as an RHIA supervising advanced coders. Then, working as a coding educator, I noted a need to query staff for specificity affecting various quality indicators. I discussed the needs and benefits of a CDI program with our medical director, and he came to agree that our facility would benefit from a CDI program. So I left the world of coding about a decade ago and began to work solely as a CDI specialist.

Obviously, the query process has evolved tremendously over the years.

ACDIS: What made you decide to apply for the ACDIS Advisory Board?

Evans: I applied for the board because I absolutely knew it would provide me with the opportunity to work with, and learn from, some of the most informed and advanced CDI professionals in the industry. I also wanted to help to advance the concept that a compliant CDI process can help ensure that the clinical truth is charted and reported.

I wanted more facilities to understand the importance of the CDI mission. I also wanted to help small, newly formed CDI teams that perhaps lacked the resources to attend seminars and conventions. I understand the learning curve inherent to the CDI process, and I wanted to offer practical tips, workflows, and hints to CDI teams that work in the “real world.”

ACDIS: What’s been your biggest reward/favorite memory in serving on the board?

Evans: Simply coming to know the many wonderful people that I served with on the board. Each of them has a great deal to offer the profession, and I feel I have learned something from each and every one of them.

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

Evans: Don’t be too hard on yourself! This is a complicated field of work, and no one masters all the intricacies. If you ever meet a person that tells you they “know everything about CDI,” I suggest you run away from them as fast as possible. Take advantage of any and all opportunities to learn—on a practical note, there are many excellent references to be found in the ACDIS Resource Library, and I suggest our members avail themselves of these resources.

ACDIS: How long have you been in the CDI field and how did you get started in this industry?

Hicks: I’ve been in CDI for more than 20 years. After 15 years as a staff nurse in a critical care setting, I was looking for something different to do. So, in March of 1999, I became one of a team of eight clinical documentation consultants at Wake Forest Baptist. Not long after taking the job, it became apparent that our team needed a leader, and I stepped forward. From that point on, I really immersed myself in all things CDI. Back then there was no ACDIS and very few CDI programs in the country, so it often felt like we worked in a very lonely silo.

ACDIS: What made you decide to apply for the ACDIS Advisory Board?

Hicks: This was my second term on the Advisory Board. I was on the very first Advisory Board, serving alongside luminaries in the industry such as William Haik, MD, and
Robert Gold, MD, and Gloryanne Bryant, RHIA, CDIP, CCS, CCDS, among others. I still remember the first few calls we had; we were a very diverse group of individuals from all over the country who had been working in CDI, and all of us had been trying to find others doing what we did. It was so refreshing. That was 2007, so I’d already been in the business for eight years.

That was also the year I changed roles and became the manager of care coordination. I still had responsibility for CDI, but I took on additional responsibility for utilization management and case management. I held that position for nine years, and I truly didn’t have time to be involved in ACDIS, and I really missed it. I remained on the Certified Clinical Documentation Specialist (CCDS) credential exam committee, but I couldn’t do more than that. I tell people that my life was pretty schizophrenic in those days.

In 2016, we were finally able to create our own department of clinical documentation excellence, and I was named director of the department. I was finally getting back to what I really loved—CDI. That is when I decided that I could once again afford the time to get more involved in ACDIS, so I applied to be on the Advisory Board again.

**ACDIS:** What’s been your biggest reward/favorite memory in serving on the board?  

**Hicks:** The accomplishment I’m most proud of is the revision of the ACDIS/AHIMA Guidelines for Achieving a Compliant Query Practice—2019 Update. That was a huge undertaking, but it turned out to be a great piece of work that involved so many people. It’s been extremely rewarding to work on the CCDS-Outpatient committee developing that credential as well. When I applied for the board, we had just started our outpatient CDI team, and one of my goals was to work with others in establishing guidance for those expanding into that space. Being able to help write the CCDS-O exam was just icing on the cake.

I don’t have one specific memory from serving on the board; I have several of them. I have made so many friends within the ACDIS community, but some of my closest friends are the ones I’ve served on the Advisory Board with. And I will take those friendships with me as I move on.

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

**Hicks:** We have all nurses on our team, and usually they are coming to us from the bedside, so this is very new to them. Just like when I started, most of them don’t know what a DRG or ICD-10 code is. So, it takes a while for the connections to occur. The advice I always give new CDI specialists is—be patient. The light bulb will come on.

**ACDIS:** How long have you been in the CDI field, and how did you get started in the field?  

**Jones:** I began my CDI career on June 28, 2004. Prior to CDI, I was a neonatal intensive care unit nurse at Children’s Hospital in Cincinnati, Ohio. I stepped away from the bedside to take an “emotional break.” I knew nothing about a principal diagnosis, CC/MCC, DRG, etc., but I fell in love with CDI and have never looked back.

**ACDIS:** What made you decide to apply for the ACDIS Advisory Board?  

**Jones:** I still remember the day clearly. One of my CDI managers came in my office and strongly suggested that I apply as she felt I had a great deal of experience that could help propel CDI forward. I must admit I was very hesitant and was shocked when I was elected. Since then, I’ve never regretted my time on the board. I have been so blessed to give input about CDI, write Journal articles, speak on ACDIS committee, and I hope to continue to be able to speak at the annual conference. Beyond that, anyone who knows me knows that I love my dogs. My husband and I have five of our own, and we often have a foster hanging out at our house. So, I will be spending as much time as I can with my furry babies!
Radio, meet CDI colleagues throughout the country, and write white papers. I will always cherish my time on the board.

ACDIS: What's been your biggest reward/favorite memory in serving on the board?

Jones: I enjoyed presenting as part of the panel presentation at the ACDIS Conference in 2018, which was about work processes that we had implemented at our organization. It was humbling to be among such innovative stakeholders in CDI. In addition, I enjoyed the ACDIS Radio live session at the beginning of the ACDIS Conference in 2018 in which ACDIS Director Brian Murphy asked me questions about my CDI journey. It is something I would not have been comfortable doing a few years ago, but I found it rewarding on both a personal and professional level.

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

Jones: Be persistent. As you begin to review charts and learn the foundation of CDI, own the patient charts and keep the integrity and compliance of that chart at the forefront of your review. Remember that your role is to ensure the patient’s record is accurate. Be patient. You are learning something unique; give yourself the time and space to learn this new practice. Have fun. Learn your new role and be able to laugh at yourself.

ACDIS: Now that you’ve rotated off the board, what do you have planned for your new-found time?

Jones: My son just got engaged, so I am helping to plan a wedding, and after that I am going back to school to get my doctorate in nursing practice. In addition, I moved to Florida in November 2017, so weekend beach time is important. I hope to serve on a board or committee with ACDIS again, in some capacity, in the future. I love CDI and want to stay involved at any level.

New members

Sheri Blanchard, RN, MSN, FNP-BC, CCDS, CCS
Corporate director of CDI
Orlando Health
Orlando, Florida
Sheri.1986blanchard@gmail.com

ACDIS: How long have you been in the CDI field, and how did you get started in the field?

Blanchard: I have been in the CDI field for more than 11 years. It has been the best decision and one I do not take lightly. There are so many moving parts to this role—that’s what keeps things exciting! Over the years, I was given opportunities to work in some of the best hospitals from the East Coast to the West Coast and places in between. I have worked side-by-side with some of the most amazing team members and continue to do so to this day. CDI is truly a family.

CDI crossed my path at a perfect time. I was working as a case manager, covering a medical-surgical unit of 28 patients, solo, job sharing with one other care manager, splitting 12-hour shifts where we only worked together for four hours one day a week; doing the admission to discharge process, utilization review, medical necessity reviews, setting up home care, hospice, skilled nursing facilities (SNF), and a host of other activities. We documented all of the care provided, assessments of each patient, and interviewed the patient and family for needs once discharged. We rounded with providers to let them know it was time for the patient to discharge and all the coordination that goes with it.

I had a wonderful coworker and friend who had trained me in this role who had taken a job in CDI a year later. After several conversations, this CDI role sounded perfect for me. It brought my experiences across the healthcare spectrum together, aligned my desire for teaching and marketing, alongside compliance. After an interview, I was selected and have never looked back. The role has changed for the good, but I will never forget my first day as a CDI specialist. I had no idea what I was doing at first.

ACDIS: What made you decide to apply for the ACDIS Advisory Board?

Blanchard: I wanted to be able to support our membership. ACDIS has been a part of my CDI career for more than 11 years. It is my way of giving back to our mission and vision for CDI both locally and nationally. I view my role as a conduit for all of the CDI team members across the nation.

One of my goals is to help break down the silos we all see in our hospitals and link departments together. CDI programs are no longer in the office in the basement with a small
group of members, unknown by hospital leaders; CDI departments have matured into strong departments that use their knowledge—whether it is clinical or coding—to showcase our hospitals for the care they provide.

I think my experiences will help me provide the ACDIS community insight into areas we can collaborate on, improve outcomes, and unite to make a difference.

ACDIS: What are you looking forward to the most about serving on the Board?

Blanchard: I am so excited to work alongside the board members and mold the future of CDI programs across the nation. The growth, changes, and focus of both ACDIS and the CDI profession from when I first started to where it is now are amazing. There are so many areas that CDI can touch.

Being a part of the board will afford me the opportunity to provide insight into what the CDI profession should be involved in, what is out of our scope, what true CDI is, and how to show the benefits of a strong CDI team. Financial outcomes and improving the case-mix index are no longer the principal reason to have a CDI program. Now, the main reason is to ensure the charts are complete, that they can withstand an audit, and tell the story of our patients’ care while within our four walls.

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

Blanchard: It will take close to six months to a year to feel comfortable in your new role. When I transitioned from case management, I really felt like a new employee with zero experience though I had been a nurse for years.

Each new CDI specialist will bring their knowledge from previous experiences, but this is a very unique role. The language spoken, the diagnoses, and what you need to have for accurate coding is all new. It’s like starting a brand-new job and feeling lost at first. Keep working hard, learning every day regardless of the years of experience, and you will continue to grow and excel as a CDI specialist.

Always remember, you are the expert in the room when it comes to CDI work no matter how long you have been doing the role. Never give up and always be open to learning. This role is really a marketing job. We sell the concepts of accurate documentation and how this is vital in telling the stories of our patients.

Tracy Boldt, RN, BSN, CCDS, CDIP
Manager, Clinical documentation integrity
Essentia Health
Duluth, Minnesota
Tracy.boldt@essentiahealth.org

ACDIS: How long have you been in the CDI field, and how did you get started in the field?

Boldt: I worked as charge nurse and decided I wanted to do more for patients to ensure they received the resources needed to heal and eventually be successfully discharged. I left the bedside in 2008 to start a new program at Centegra Health System in the Northwest suburbs of Chicago, and I never looked back.

ACDIS: What made you decide to apply for the ACDIS Advisory Board?

Boldt: I have experienced so much opportunity in the CDI industry, from speaking at several ACDIS conferences, volunteering with the conference committee, co-authoring The Outpatient CDI Specialist’s Complete Training Guide, educating practitioners through the transition from ICD-9 to ICD-10, and volunteering with the CCDS-O certification development.

I wanted to learn more about what the ACDIS members’ needs are and help identify a better way to bring the needs of the membership to the board for further discussion and potential change.

ACDIS: What are you looking forward to the most about serving on the Board?

Boldt: I am looking forward to working with a knowledgeable group of individuals on behalf of the ACDIS membership.

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

Boldt: Take your time to learn the process and the reason why you are in the role of clinical documentation specialist. Remember, quantity of work is not nearly as important as the quality of work.
ACDIS: How long have you been in the CDI field, and how did you get started in the field?

Matacale: I began my career as a hospitalist in 2003 and quickly developed an interest in documentation and billing as well as denials. I learned a great deal through collaboration with our HIM department. In 2007, I underwent formal training in DRG management and began working in the field. In 2013, I took a full-time position as a physician advisor and now have a team of five physician advisors providing documentation support to our entire health system.

ACDIS: What made you decide to apply for the ACDIS Advisory Board?

Matacale: After attending the ACDIS Conference for years and making so many friends in the field, I felt that it was time to volunteer to support ACDIS. I see the role of CDI quickly expanding and evolving and wanted to lend my knowledge, experience, and time to helping us stay ahead of the rapidly changing environment. There are many problems with the reimbursement and risk adjustment systems in which we operate, and if you bring a problem to the table, you’re obliged to be part of the solution.

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

Matacale: I’d advise a new specialist to take every opportunity to learn and never say no when someone asks for documentation help. Even when the question seems unrelated to CDI’s role, you never know what you might find and what effect you can have.

I’d also caution a new specialist not to get discouraged in the face of constructive criticism and feedback; while difficult to accept sometimes, it’s how we learn to be better. The more facets of documentation you understand, the more effective and valuable you’ll be.

Chinedum Mogbo, MBBS, MsHIM, RHIA, CDIP, CCDS, CCS
Manager, CDI
Tenet Healthcare
Dallas, Texas
mogboc@gmail.com

ACDIS: How long have you been in the CDI field, and how did you get started in the field?

Mogbo: I trained and worked as a physician before changing career paths about seven years ago to HIM with a focus in CDI. Being a physician, it was an easy transition, and I started off with coding and CDI at the same time. My passion for the CDI field got me into leadership roles that saw me training and managing fellow physicians and HIM professionals in CDI. The rest, as they say, is history. I got my master’s degree in HIM and many other certifications that have allowed me to thrive in the field, and I have been involved with a good number of industry-shaping processes, and I am very involved with AHIMA as well.

ACDIS: What made you decide to apply for the ACDIS Advisory Board?

Mogbo: My decision to apply for the Advisory Board stems from my passion for doing what is right for the patient and working with like minds in the industry in providing guidance and formulating policies on documentation integrity and its unparalleled role in ensuring better patient care and outcomes. I would like to see ACDIS be more involved in policymaking in healthcare and driving positive changes in the CDI profession and changing the traditional mindset of CDI.

ACDIS: What are you looking forward to the most about serving on the Board?

Mogbo: Working with a diverse group of individuals with various levels of experiences.

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

Mogbo: Be open-minded and willing to learn. The CDI field is evolving, especially in the age of modern technologies, and you have to be willing to be innovative and flexible at the same time.
Sepsis FAQs

Q: I’ve heard that, due to the inflammatory response related to septic tissue, perfusion will decrease, and hyperlactatemia and mottling are likely if left untreated. Decreased perfusion means that organs/tissues would get less blood. Is that how mottling (discoloration in irregular areas) happens?

A: Mottling is the observable manifestation of decreased tissue health in the visible skin. This is also considered a possible indicator of shock. The decrease in oxygen utilization is not limited to the organs; the skin will be affected as well.

Q: I know that hyperlactatemia means increased levels of lactic acid in the blood, but how is it related to the decreased perfusion?

A: As the tissues become hypoxic, there is a switch to anaerobic cycle and function without oxygen in order to burn glucose and stay alive. This process is nearly identical to what happens with strenuous physical activity in skeletal muscle.

The process is much worse in septic patients, as it is not limited to overworked muscles but happens in the vital organs as well. If you remember the Krebs cycle in school, this process is referred to as anaerobic glycolysis. Well, that’s the HISTORICAL viewpoint.

Increased lactate accumulation can happen even with adequate oxygen to the tissue. For this reason, the concept of “blood flow to the tissues” is incorrect. It isn’t about blood perfusion; it’s about oxygen utilization and cellular functioning. To demonstrate the point, even the lungs are producing lactate during sepsis, and they have full access to oxygen.

So, what’s happening then? Essentially, the inflammatory response produces endogenous epinephrine and stimulates the beta-2 adrenergic receptors. This, in turn, increases glycolysis and generates a byproduct known as pyruvate used by the mitochondria in excess. The excess pyruvate is then converted directly into lactate, and voilà—excess lactate production. The entire process occurs in an entirely aerobic state.

Increased lactate may even be a positive compensatory mechanism that helps fuel cardiac and neurological processes, but the presence of significant elevations in some cases is a sign that the patient is severely ill. Remember, however, that lactate is not a waste product at normal levels; it is an important metabolic cofactor necessary for cellular function.

This is why occult shock is absolutely a thing and can occur in the presence of both adequate oxygenation and adequate perfusion—as opposed to the Sepsis-3 definition, which only defines shock as hemodynamic instability. These patients are having a catecholamine-dependent shock state, not dissimilar to a shock state supported with norepinephrine or vasopressors.

Patients with sepsis-induced hypotension actually have a better prognosis in many cases than patients in septic shock with lactic acidosis; therefore, the elevated lactate levels signal the increased catecholamine release and serve as a useful marker of both sepsis and septic shock.

There is even some criticism that the Sepsis-3 cutoff for a lactate level of 4 being an indicator of shock is somewhat arbitrary, considering that elevations of lactate have continuous curvilinear association with mortality.

Keep in mind that there are many other known physiological mechanisms that will artificially elevate lactate but have nothing to do with sepsis or shock (normal production but poor lactate clearance, organ failure preexisting or unrelated to any shock state, for example, abnormal metabolic process from neoplastic tissue, sampling and collection...
errors, ARDS, ischemic or infarcted tissue, bowel compromise, muscle fatigue from increased work of breathing, etc.)

The concept of “elevated lactate = give more volume and oxygen” may at best not be very helpful and at worst actually cause harm, assuming a reasonable amount of fluid is already on board. The elevated lactate may instead be signaling that we do not have adequately functioning liver and kidneys, or that there is tissue damage occurring due to concomitant processes that are not necessarily related to volume and perfusion.

If you’d like to take a deeper dive into lactate in sepsis, I’d recommend this article from PulmCrit.

Q: How should I present this type of information to providers? I get intimidated by providers very easily (because there is so much clinical stuff that I do not know). What would be the best way to present this type of information?

A: There is no need to be intimidated. Providers are already very well aware of the standard deviations for procalcitonin, the significance and values of elevated lactate levels, etc.

All you need to do is present the clinically indicated and relevant abnormal values in a coherent way with a cogent and compliant query. The physician, upon seeing that you chose relevant data points and asked a reasonable question, should (usually) respond in kind with an appropriate clinical judgment.

Editor’s note: Allen Frady, RN, BSN, CCDS, CCS, CRC, CDI education specialist for HCPro in Middleton, Massachusetts, answered these questions. Contact him at AFrady@hcpro.com. For information regarding CDI Boot Camps, click here.
Stepping into any new leadership position, even one you’ve been properly prepared for, can be a challenge. Many CDI leaders find themselves in roles they never imagined they would inhabit and have to learn on the fly. Some started as frontline CDI specialists, reviewing records, and advanced up the career ladder rung by rung to their current job; others were put in management over CDI because they had leadership experience, not because they had CDI experience.

Whatever the path, leadership jobs will have their ups and downs—just like any other role. Luckily, many accomplished CDI leaders from all walks of life willingly extend a helping hand to share tips with those coming up. Here is some of their best advice.

**On leadership support**

Just like a CDI team needs C-suite support, so do CDI leaders, whether they’re newly minted or seasoned.

“My organization was willing to take a risk on me because I’m not a CDI by background and I’m not a nurse by background,” says Rachelle Buol, RHIT, director of coding and CDI at UW Health in Madison, Wisconsin. “I don’t know if I’ll ever feel comfortable completely. CDI is a very intense profession.”

That administrative support provides new leaders a sense of confidence, says Buol. It may also help instill staff with a sense of confidence in their new leader, too. After all, the organization hired you, so they believe in your abilities and trust your capability to learn and lead.

That administrative support can also be employed when dealing with difficult physicians, Buol says. “You’re going to get pushback from some providers, so having the backup from senior leadership is key,” she says.

Those additional leadership voices also let you play to your strengths and abilities, letting other leaders play to their own, says Alison Bowlick, BSN, RN, CCDS, CRCR, associate vice president of CDI, revenue cycle, at Ensemble Health Partners in Ohio.

“I have a great leadership team that assists me. We all bring certain strengths and perspectives to our jobs, Bowlick says. “I can’t do all of this by myself. I’ve learned from leaders that have done this before. I’ve learned that you have to lean...
On knowing your staff

While building trusting relationships with organizational leadership will help in many ways, CDI leaders won’t be successful if they don’t know their staff members, both on a personal and a professional level.

“You have to know your staff. Do they have pets? Do they have a work-life balance with their family?” says Franchesca DeLisser, MSHI, BSN, RN, CDI director at Bon Secours Mercy Health Richmond (Virginia). “You don’t have to be their best friend, but you have to show that you care about them.” Knowing your staff on a more personal level will help you motivate them more effectively and show them that you care about their personal and professional development, she says.

DeLisser also recommends building staff appreciation activities into your regular schedule. For example, leaders could give staff members a remote day per month, or the option to work remotely on their birthdays. Leaders could also offer to pay for staff members’ educational activities and CDI-specific certifications.

At her facility, staff get reimbursed for the CCDS exam if they pass, and the organization pays for staff members’ first year of ACDIS membership. “The team goes out to lunch together or brings potluck to work,” says DeLisser. “We also have a summer meeting for employee engagement—we’ll do an escape room next—and we’ll go out for the Christmas holiday.”

While leaders should do everything within their power to understand, know, and listen to their staff members, managers won’t be able to make everyone happy all the time. Sometimes, CDI leaders have to do things for the benefit of the organization and the team as a whole that individual staff members may not love, Bowlick says. And that’s okay.

On transparency

Transparency goes along perfectly with knowing and listening to your staff. If you’re stepping into a leadership role for a department you’ve never been a direct part of, take time to let your new team get to know you as a person. This will foster long-term trust, DeLisser says.

“People did not know me because I didn’t come from within the team,” she says. “I had to share my background and let them know that I’m here to help grow them professionally.”

While there are many important qualities that leaders should foster in themselves, DeLisser says that transparency should underpin them all. Transparency isn’t just about sharing your own personal strengths and weaknesses with the team. It’s also about sharing program goals, setting a vision and mission for the department, helping the team understand how their daily tasks are important to the larger organization, and creating achievable goals for their own professional development.

“CDI leaders need to have patience, flexibility, and understanding. You have to know that everyone is different. Your have to be a visionary—see the writing on the wall that nothing is going to be the same. The only given is that change is constant. And be transparent with your team. That might be the most important part.”

Franchesca DeLisser, MSHI, BSN, RN

“The biggest challenge I’ve seen in myself and in others is the sense of wanting to make your team and everyone else happy,” she says. “You can’t make everyone happy at the same time—everyone has different needs and goals.”

For example, Buol oversees both the CDI and coding teams at her facility and says those in leadership positions need to understand the differences between the two groups for engagement and educational purposes.

“CDI and coding in a lot of ways can be polar opposites, especially when you’re talking about personalities,” she says. “You have to understand the background of the team. Understand what makes a person become a nurse, what makes a person become a coder. Each member brings a different viewpoint to the table, and you have to be aware that not everything that works for one will work for the other.”
that everyone is different. You have to be a visionary—see the writing on the wall that nothing is going to be the same. The only given is that change is constant. And be transparent with your team. That might be the most important part.”

Remember as well, Buol says, that transparency should go both ways. By being open with your staff about new goals, review focuses, etc., you’re creating an environment where staff members are willing to share their thoughts, concerns, and questions about the department and their roles freely with you.

“I study a lot of reality-based leadership and believe in leadership transparency,” she says. “The one-size-fits-all approach has never worked, and it won’t work here either. […] Be mindful of how staff need to learn and bring them to the table in a comfort zone way.”

On continued education

CDI directors and managers need to put in the time to continue their own personal and professional education, too.

“The best advice I can give [to those new to CDI management] is to continue your own professional and personal development,” Bowlick says. “The most detrimental thing to organizational success is to get stuck in the status quo.”

This education can happen both within and outside the organization’s walls. Taking an external leadership course will be helpful, but it won’t speak to the direct situation at your organization. According to Buol, one of the best things new leaders, or those about to step into a leadership role, can do to prepare is to study the organizational structure of the departments associated with the job’s core responsibilities. “Go and observe different leadership meetings,” she says. “Meet one-on-one with someone when they’re dealing with an employee issue. It’ll help you understand if you’re actually cut out for that.”

I would say the most important quality for a CDI leader is being able to love what you do. If you’re passionate and have confidence in what you do, people will naturally follow you. […] If you don’t believe what you’re preaching, people will know.

Julian Everett, RN, BSN, CDIP

Leaders can also look outside their organization and educate themselves on trends in the larger CDI industry. This can come through listening to staff, networking with other CDI professionals during an ACDIS local chapter meeting, or staying up-to-date on industry surveys and publications.

For example, Bowlick knew that increasing technological capabilities could make hybrid remote work possible and learned from industry surveys, such as those published by ACDIS, that remote opportunities might even increase staff productivity. She then reached out and talked to other organizations about their processes. Bowlick realized that in order to keep her staff engaged and attract new CDI professionals to the department, her organization needed to further investigate hybrid remote options.

“Becoming a leader isn’t just maintaining the status quo; you always have to be innovative and look for opportunities for improvement,” she says.

On passion

No one wants to follow a glum pessimist. Leaders, regardless of their field, need to be passionate about what they do in order to inspire staff and move the team forward.

“I would say the most important quality for a CDI leader is being able to love what you do,” says Julian Everett, RN, BSN, CDIP, CDI educator at Orlando (Florida) Health. “If you’re passionate and have confidence in what you do, people will naturally follow you. […] If you don’t believe what you’re preaching, people will know.”

For those coming to their CDI leadership role from a field outside of CDI, that passion will come through continued education and learning more about CDI’s mission. Even on stressful or discouraging days, Everett says, try and focus on that mission and stay positive.

“If you’re not mindful of the type of energy you’re projecting, then your team won’t be enthusiastic either,” she says. “I’ve seen how rewarding educating and engaging physicians is, and I want my team to be enthusiastic too.”

Julian Everett, RN, BSN, CDIP
DeLisser says that professional passion may be the key to landing a leadership role in the first place. And stepping forward for leadership responsibilities takes courage. Don’t be afraid, she says, of showing your passion and asking to take on those responsibilities when they arise.

“If you want a leadership role, you can’t have fear and faith in the same place. You have to go for it,” she says.

If you want to move into leadership, “just be yourself. Be positive,” Everett adds. “Let your work speak for itself. There are people watching you and you don’t even know it. I was doing things because I wanted to do them, not because I wanted to be in leadership.”

**On boundaries**

When you’re passionate about a role, it can be easy to let it infiltrate your home life, warns Everett, who only recently stepped into her leadership position.

“In a new role, you want to do everything. There are so many fires you want to put out, and I was finding myself bringing things home. It started to really roll over into my personal life, and eventually my supervisor told me that we’re not going to finish everything every day,” she says. That came as a great relief and allowed her to say that “once I’m done, I’m done. Home is home and work is work.”

It’s not just the actual work that can follow you home, adds Buol; it’s the emotional strain too. If you’ve had a particularly difficult day—maybe the staff was unhappy with one of your decisions or a physician pushed back harder than usual—it’s easy to let that color your whole evening, even after you’ve left the office. Repeating that kind of pattern, she says, is unsustainable.

“I recommend [that those entering leadership roles] do some reading on emotional leadership,” Buol says. “You have to learn how to put your emotions aside. This job can eat you up. If you let it, you will burn out.”

Some days will require more than others, however. “Some days, you may have to work longer hours in order to get your work done, and that’s okay occasionally,” Bowlick says. “But don’t make a habit of it. It’s all about prioritizing your day.”

Directors and managers may feel not only the pressure of an administration that depends on them, but also the weight of a team that needs them. Knowing when to quit for the day is really an art form, she adds. In the moment, managers can feel like they are drowning and have to just keep going, but sometimes the best thing is to leave the problem alone, work on something else, or just call it a day.

“You always question whether you’re doing enough,” Bowlick says. “When you’re in the midst of things and it’s really stressful, just stop, walk away, and come back later. You might see something you totally missed before just because you’re stressed.”

**On the next generation**

One of the most important things leaders do is build up the next generation of leaders behind them.

“The biggest thing I’ve learned about leadership is that it’s not just about leading,” says Bowlick. “It’s about growing people and helping them become leaders.”

This process starts on day one, if not sooner, Bowlick says. In accepting a new position, be mindful of the responsibilities left behind. Ask whether the staff has been groomed to be effective when opportunities arise.

Ensure that transparency extends to managerial-level tasks and responsibilities. Assigning competent individuals to the open positions ensures the department continues to run smoothly, allowing each individual to focus on new tasks, she says.

“As I’ve advanced, I needed to bring people up to fill the roles behind me as I left them,” she says. “I didn’t have to worry that tasks were falling through the cracks.”

Once you’re in the new role, be mindful of how you’re training staff members to be leaders in their own right, DeLisser adds. Presumably, in the past, someone took an interest in your own professional development and prepared you for your leadership role, so try to do the same for others.

And remember, DeLisser says, just because someone doesn’t have a leadership title doesn’t mean that person isn’t a developing leader.

“I enjoy growing new leaders,” she says. “You don’t have to have a title, but you do have to enjoy what you do.”
12th ACDIS Conference in Orlando: Simply Magical

By Melissa Varnavas

There was that castle in the distance, of course. You know the one. It’s started so many animated feature films over the years, and purportedly housed sweet Cinderella once the glass slipper finally slid into its proper place on her tiny foot. And while many of the more than 1,700 attendees of the 2019 ACDIS Conference did waltz past her dream-like abode and meander through the parks at Walt Disney World, there were more than enough magical moments to be had right on the conference campus of the Gaylord Palms hotel and resort in Kissimmee.

The Gaylord Palms is a unique resort in its own right. It features a biosphere of botanical gardens and luxurious appointments, a steakhouse in a tree house, and a seafood restaurant on a “ship” that juts out into a bay filled with stingrays and other fish. You can even feed baby alligators. Turn another corner, though, and you’d find yourself amidst a sea of a different sort—Charting the Course (which was this year’s conference theme) through a seeming ocean of purple and orange-clad attendees navigating the waters of a host of networking and educational opportunities.

Puppies, pancakes, possibilities

Even before guests arrived at the event, the networking had begun on the conference app and social media. These platforms allow folks to ask questions of fellow attendees, get a feel for what others are looking forward to, and have a little fun while packing their suitcases. In years past, attendees have posted pictures of their mani-pedis (some even with the ACDIS logo), their hairdresser appointments, and even their pre-conference shopping sprees. This year the app was filled with pictures of people’s pets, many of whom were sadly trying to cram themselves into their owners’ suitcases, not wanting to miss an opportunity to attend ACDIS.

The conference app also offers a set of discussion groups focused on the 2020 IPPS proposed rule, first-time attendees, managers/directors, local chapters, and other areas. The app serves as a great tool to craft a schedule of sessions to attend, get instant reminders on upcoming events, and take notes on conference presentations. This year, new app features included an opportunity to share virtual business cards—making it easy to remember the name of the individual you spoke to with the amazing outpatient ideas—and a scavenger hunt through the ACDIS conference space.

The conference opens every year with a welcome reception in the exhibit hall. This gives early arrivals an opportunity to register for the main event, grab a drink with colleagues, and get a sneak peek at various vendors’ offerings. Although no pooches smuggled their way into the conference educational sessions, the exhibit hall did have a visit from a few Nuance-employed
therapy dogs so ACDIS attendees could spend some quality time petting the dogs and not missing their own pets back home.

And therapy dogs notwithstanding, there were plenty of amazing activities throughout the exhibit hall. Iodine had a planetarium where attendees could relax and charge their cell phones, and they gave away CDI-inspired t-shirts, screen printed and made to order. 3M brought several artists to create caricature luggage tags and also sponsored the closing night reception. Title sponsor TrustHCS invited Dan-cakes back for a second year and sponsored one of the lunches. Dan-cakes has been featured on several television news and entertainment programs for their unique ability to turn any photo into a pancake.

Despite all the wonderful gifts exhibitors provided ACDIS attendees, perhaps the most meaningful were the insights they offered. These experts came to the national conference armed with a global perspective on CDI expansion across the country and the tools to help with those expansion efforts. Time and time again, conference goers would come back to the exhibit hall space to share a snack and pearls of wisdom gleaned from the session they’d just attended, and exhibitors were all excited to share what they’d learned as well.

**Ideas, inspiration, innovation**

While Disney may be known worldwide for its Imagineering, the 12th ACDIS Conference was memorable for its plethora of ideas, inspiration, and innovation. With more than 60 sessions and 120 speakers across six educational tracks for a variety of experience levels, there was something for everyone in each time slot of the day.

This year’s conference included a new track called “Idea Laboratory,” which brought speakers from different perspectives together to share the stage for 30 minutes each. Some of these sessions covered CDI and population health, CDI and its role in the healthcare revenue cycle, and CDI efforts and outcomes related to healthcare research. There was also a track called “Innovation & Expansion” in which CDI experts explored cutting-edge advancements such as concurrent coding, second-level chart reviews, data analytics, remote CDI, and more. This year, too, ACDIS expanded its traditional management track to include sessions that offered tools for personal and professional advancement.

And while repeat attendees may have initially felt comfortable with their general knowledge of common concerns included in the “Clinical & Coding” track, session speakers managed to offer new insight into ongoing trouble spots.

For example, the session “GLIM: The New Malnutrition Clinical Criteria and Implications for the CDI Profession” included one of the co-authors of the new global malnutrition criteria, Charlene Compher, PhD, RD, LDN, FASPEN. Compher spoke with noted CDI expert Richard D. Pinson, MD, FACP, CCS, author of the CDI Pocket Guide, about the impetus behind the most recent consensus statement. One session attendee wrote, “I emailed a dietician friend of mine about how great this [session] was, and before the conference was finished, she said she wanted to connect with me to help educate the providers she works with. Wow!”

Also in this track, Rhoda Chism, BSN, RN, CCDS, and Laura White, MHA, presented “Untangling the Sepsis Web: Surviving Sepsis in 2019.” During their presentation, the speakers explored how interconnected the clinical, documentation, and coding worlds need to be in order to not only abide by changing clinical practices, but also effectively align the goals of CDI, coding, and quality outcomes. Chism and White also explored payer and regulatory governance related to sepsis clinical definitions and code assignment, and they gave attendees a blueprint to take home to build or enhance their own hospital’s sepsis processes. This was “hands down the best explanation of the whole

---

**ACDIS CONFERENCE BY THE NUMBERS**

- 2.5 days
- 1,700 attendees
- 6 educational tracks
- 60 educational sessions
- Roughly 120 speakers/presenters
- 6 professional awards
- 40 exhibitors/vendors
- 25 core ACDIS staff
confusing thing we call sepsis. I plan on sharing this information with my staff,” wrote an attendee in her evaluation notes.

Take-home inspiration was a frequently mentioned topic among attendees who took the ACDIS post-conference survey. One attendee called the conference “very pertinent to our next steps,” and another said, “Excellent, [this conference] had a lot of doable steps to revitalize/grow a CDI program.”

The keynote speakers on Day 1 and Day 3 of the conference brought inspiration to the annual event. Natalie Stavas, MD, took the stage on Day 1 to kick things off. On April 15, 2013, Stavas was running the Boston Marathon when two bombs detonated at the finish line. With only a moment’s pause, she ran into the fray and began to treat those who were wounded in the attack. Her experiences that day led her to consider how humans deal with chaos, stress, and challenges. Building on the research of Nobel Prize winner Elizabeth Blackburn, AC, FRS, FAA, FRSN—who discovered that people who view a challenging situation as an opportunity, rather than a stress, can actually prolong their lives—Stavas encouraged attendees to embrace challenges and run into the chaos.

“When we’re faced with adversity,” she said, “we only really have two options: We can run toward it, or away from it. People who choose to take actions have strong synapses [in] the brain. If you seek out these opportunities [to run toward challenges], you’ll be the kind of person who takes action when called upon, or better yet, when you’re not called upon.”

While something may seem impossible, Stavas told attendees that changing your perspective shrinks seemingly insurmountable challenges to scalable ones. You may not see the immediate effect of your actions—much like the many first responders at the marathon bombing, who were devoted to individual victims and unaware of the many lives saved in their midst—but your actions will make a difference, both in your own life and the lives of others around you.

“Never underestimate how important you are,” Stavas told the crowd. “Never underestimate how important your actions are.”

On the final day of the conference, speaker Joe Tye took the stage to share advice and challenges for seeing a lion in your mirror, overcoming negative self-talk, becoming a better human, and positively changing the culture around you.

“Cultures don’t change until people change,” he said. “And people will not change unless you provide them with the tools to do so.”

Tye then walked attendees through seven promises—one for each day of the week—and encouraged them to say those promises four times per day, taking up roughly one minute of their time per day. Each promise encourages individuals to improve their outlooks, ask for help, and ultimately become better people. After a certain period of time, he said, those promises will take hold and become reality.

“We will definitely be initiating this in our leadership team,” wrote one ACDIS attendee. “I have already sent the info to my team!”

**Teamwork, time, tales to tell**

Speakers, vendors, staff, and attendees all left ACDIS with tales to tell and experiences to share with their colleagues back home. At the center of every conference, however, lives ACDIS’ core mission to “serve as the premier healthcare community for clinical documentation specialists, providing a medium for education, professional growth, program recognition, and networking.”

Doing so takes teamwork. From those who put forth their thoughtful proposals to the conference committee who evaluates and chooses the presenters; from the core ACDIS team to the supportive events, marketing, sales, and production teams; without all of these collaborators, the conference wouldn’t be possible. Even the attendees who come with open hearts and minds to absorb as much learning as possible bring forward their experiences and love of the profession to make this event one of the best in the healthcare industry—over and over again.

Believe it or not, the ACDIS 2020 Conference Committee has been selected, and the call for presentation proposals is open. We hope you’ll consider offering your insight. See you next year in Vegas!
Enjoy the twists and turns of your CDI journey

By Sarah Matacale, RN, BSN, CCS

It is slightly ironic that I’m writing this during this year’s national ACDIS Conference. You see, most people I speak with in the CDI or HIM field get here by choice. They either transitioned through their own efforts or were sought after for their skills and experience by management or colleagues.

I am not exactly one of these people. I feel like I was dragged along kicking and screaming. And some days, when I feel deflated by mismatched DRGs or “helpful suggestions,” I feel like I’ve been plopped onto my own deserted island in the world of CDI, equipped with the latest Coding Clinic, some less-than-stellar charting, and a cup of coffee.

I am a nurse first and foremost—and a good one at that, if I say so myself. I have always worked in critical care and hospice, feeling like those areas allowed me to use my people skills, critical thinking, and compassion to the fullest. After the birth of our third child, however, my husband began to complain about my hearing. At the same time, I started to notice the deafeningly loud ringing in my ears that seemed to never end. I agreed to a hearing exam, and to my surprise, I failed miserably. I was nearly deaf in both ears out of nowhere. I was told then and there that I would need hearing aids for the rest of my life.

Eight years later, what caused the loss is still a mystery, but I did not return to bedside care. Accommodations and technologies are available to bridge my handicap; however, I don’t feel safe as a bedside nurse anymore. I know what I am supposed to be able to hear—the subtle sounds that signal my patients’ declining status—but these sounds are now lost to me. I can’t trust ears that are not my own. At the end of the day, I feel like I cannot be the nurse that I would want my family to have at their bedside. This was a very difficult and personal choice.

So, after the pity party was winding down, I decided it was time to put on my big girl breeches and find a new way to use my skill set. At this point, my husband was working as a physician advisor role with a CDI program. He felt that CDI might be a good fit for me.

I applied and completed an 18-month intensive medical coding, billing, and auditing program offered through a medical college. I thought that I would smoothly transition into a job. My education plus my many years of nursing experience would mean I’d be turning jobs down, right?

Wrong. I could not get my foot in the door. Everyone wanted two years of CDI or coding experience. So, once again, I regrouped and thought through how to prove myself competent and stand out from everyone else. I was eligible as a nurse to take the Certified Coding Specialist (CCS) exam, so I did, and passed. That turned out to be the ticket to getting a job in CDI, and I began my new role as a remote CDI specialist with a great deal of excitement.

That was more than two years ago. Since then, there have been daily ups and downs. I love concurrently reviewing charts. I love using my critical thinking skills to problem-solve within the hospital records. [...] What I wasn’t prepared for, though, was the loneliness of working from home. Not being face-to-face with questions and communication regarding the hospital record, clinical care, and coding questions is difficult for me at times.

Sarah Matacale, RN, BSN, CCS
What I wasn’t prepared for, though, was the loneliness of working from home. Not being face-to-face with questions and communication regarding the hospital record, clinical care, and coding questions is difficult for me at times. I am a verbal learner, so I’ve had to shift my learning style. I’ve also found it difficult to build relationships with fellow CDI specialists and coders as well as the physicians whom I query.

The biggest and most difficult pill for me to swallow surrounds the question I hear regularly: Am I still a nurse? Each time I’m asked, I feel a pit form in my stomach. Each time I hear someone tell me to let go of the bedside nursing care role, that I’m not writing nursing notes anymore, a piece of my heart hurts a little. I am and always will be a nurse. I struggle with no longer caring for patients, to be honest. I also struggle with struggling. Every day is a “learning opportunity”—in other words, every day is a reminder that I don’t know everything. In order to learn in this role, you have to get things wrong. You must be open to criticism and education. That part is hard. It’s not personal, but it sure feels that way sometimes.

Another difficult part of this job is that those on the receiving end of a query don’t always like answering them, no matter how sweetly, politely, and directly I address them. At times, the responses are not nice. They can come across curt, direct, sarcastic, and just plain flippant.

So, after two years in CDI, I am preparing for further certification. I am reaching the point where I can be face-to-face with our providers as I am competent in my working knowledge. I know that I will really enjoy being in the hospital again. I have learned to work with my strengths and weaknesses. I still struggle and am humbled daily, but that’s okay. I am learning a new way to use my nursing brain. I’ve volunteered within my organization on new projects and with professional committees and find that I love that part of my new role. I can interact with others, be smart, think critically, problem solve, and be part of something bigger.

As for career goals, well, I was very happy to be at the ACDIS Conference to learn and network with others in our field. I am not sure where I will find my niche just yet, but I will keep learning and volunteering so that I can grow into whatever roles come my way. If you had asked me 10 years ago where I would be professionally in 2019, it would not have been here.

From that, I’ve learned to always be open to opportunities, experiences, and people. You never know what doors may open. CDI has proven to be a perfect fit for this crazy mom of three busy kids, two big dogs, and a physician husband who is very professionally active. As the song says, “God bless the broken road.” Oh, and God bless coffee!

Editor’s note: Matacale is a CDI specialist at Vidant Health in Greenville, North Carolina. She was a member of the 2019 ACDIS Conference Committee and is a frequent author on CDI topics for nursing publications. Her husband Vaughn Matacale was recently elected to serve on the ACDIS Advisory Board. Contact her at sarah.matacale@gmail.com. The opinions expressed do not necessarily reflect those of HCPro, ACDIS, or any of its subsidiaries.
According to the latest ACDIS poll on the topic, only 15% of respondents currently have a career ladder in place for their CDI department. Though it seems many programs have moved away from formal career ladders, having one would improve employee satisfaction in most (if not all) situations. By offering CDI staff members career advancement opportunities and compensation to match, it will hopefully ignite their passion for CDI and loyalty to their facility and department.

“[A career ladder] gives a great motivation to the staff that they can grow within CDI. They don’t have to leave CDI to grow professionally,” says Guzel Wardell, RN, BSN, MBA-HCM, CCDS, CDI director, HIM, at Methodist Health System in Northern Texas. “So far, it seems like everyone’s really excited about the growth potential and promotions and the different skillsets they can learn within CDI.”
Where to start

If your program doesn’t have a ladder in place, it can be mystifying as to how to start the process of implementing one. The first step, according to Wardell, is to get approval from facility or system administrators and begin discussions with the HR team.

While many CDI leaders may have struggled with administrative support regarding career ladder implementation, Wardell says the real struggle may come with HR, as you’ll need to explain the differences in skill level and knowledge for each step on the career ladder.

From the HR team’s perspective, each rung needs to be a distinct position. The CDI manager/director needs to explain what those levels represent and outline the different skills individuals at each of those levels need to have, she says.

In her experience, the best approach is to put various concepts in writing. Managers may want to work with the facility administration to brainstorm benefits and collaborate with other ancillary department heads to troubleshoot problem areas such as overlapping responsibilities. Working with ancillary department heads can also help managers learn from those who’ve implemented career ladders of their own.

Nevertheless, the CDI manager/director will ultimately need to be the expert on the purpose of the new career ladder, the tasks each new position entails, and the knowledge base each new role requires. And this person will need to be able to effectively communicate the importance of these changes to the organization’s leadership and HR.

As we evolve, and as CDI responsibilities grow, we tend to do a little more. But if the pay remains the same and the title stays the same, [CDI specialists] think they have to leave to advance. [Career ladders] give them hope that they can grow and expand as CDI specialists and as people.

Guzel Wardell, RN, BSN, MBA-HCM, CCDS

Dividing responsibilities

At Wardell’s organization, they divided the various ladder rungs by job duties rather than by length of experience (though time in service and experience levels do come into play).

Under the newly instituted career ladder structure, Wardell’s CDI team is expanding to 18 members, broken into three levels:

- **CDI I**: Duties include basic chart reviews with some quality reviews. These nine individuals are allowed to work 100% remotely due to their limited function, Wardell says.
- **CDI II**: Duties include some of the CDI I and II responsibilities, plus working with the denials management department and writing appeal letters. Like the CDI IIs, these two individuals are allowed to work remotely a set number of days per week.
- **CDI III**: Duties include some of the CDI I and II responsibilities, plus working with the denials management department and writing appeal letters. Like the CDI IIs, these two individuals are allowed to work remotely a set number of days per week.

Though the CDI level I staff are the only ones that work 100% remotely, Wardell says that each level is compensated accordingly for its ascending responsibilities. “It makes them feel like they’re getting reimbursed for their extra work,” she says, “rather than taking on more and more responsibilities with no new title or raise.”

This model also plays to the strengths of each individual CDI professional in the department, rather than shoehorning staff members into roles they are ill suited for. “Just because someone can review a chart and send a query doesn’t necessarily mean that they can write an appeal letter, or present to the physicians, or analyze the data,” Wardell says.

The risk of not having a career ladder

Those debating about instituting a formal CDI career ladder also need to consider the risks associated with a lack of staff mobility within the organization. CDI professionals...
frequently come into the field enamored of their new responsibilities, excited about the prospects of ongoing challenges, and ready to learn what lies before them.

As experience levels grow, most professionals will want to keep up that level of engagement and excitement, but they may feel thwarted by stagnant programs, lack of educational support, and absence of professional growth options.

Crafting a career ladder will not only enable staff to stay engaged in the CDI field generally, as Wardell says, but will help them be more engaged within their organization as well. Organizations that invest in their staff will have staff who, in turn, invest in their organization.

Furthermore, while the margin of programs with ladders may seem slim according to the poll results, there are organizations offering generous compensation and benefit packages with future career pathways outlined in their contracts. Those unhappy with their current situation may feel trapped in their current salary bracket or title and decide to move on to greener pastures.

Without career pathways, “there’s a risk of losing talent. As we evolve, and as CDI responsibilities grow, we tend to do a little more. But if the pay remains the same and the title stays the same, [CDI specialists] think they have to leave to advance,” Wardell says. “[Career ladders] give them hope that they can grow and expand as CDI specialists and as people.”

WHEN A LADDER MAY NOT BE NECESSARY

While a career ladder is overall a valuable boon to the health of a CDI team, there are some instances in which the addition of a ladder may not be warranted—like when the CDI team or the organization is so small that there’s no way of differentiating between rungs.

“Before I became a CDI specialist, I had a clinical ladder program as a critical care RN in the ICU and I worked my way up the ladder” says Rosemary Mallik, RN, BSN, CCDS, CCS, CDI specialist at Indiana Regional Medical Center. “But there were more staff involved, and it was a larger hospital system.”

When Mallik stepped into her CDI role, she was one of three people on the team, so there wasn’t much need for a ladder. However, that didn’t mean management at the organization neglected incentivizing the CDI staff, according to Mallik.

According to Mallik, the key to keeping staff motivated without employing a ladder is offering continuing education opportunities. While an individual staff member’s title may remain the same, fostering education enables the employee to grow and mature professionally and personally.

“I have to give a shout out to my boss, Susan Pierce. She’s very education oriented. We may not have a ladder, but she gave us the opportunity to get our certifications; they paid for our ACDIS membership, our recertifications. She encouraged us to get our coding certification. They pay for our recertifications through AHIMA, too. And last year, she even sent all three of us to the ACDIS Conference in Texas,” Mallik says. “At my last job, even though we had a ladder, I had to pay for all my education myself.”

Leaders can also incentivize staff members by offering non-monetary and non-title opportunities, says Mallik.

Ultimately, if a program is too small for a formal career ladder, leaders need to be inventive and offer other professional development opportunities instead. With those opportunities in place, staff members will in theory stay motivated, remaining loyal to the profession and to the organization.

“I’m very happy with my job, and I love the fact that my boss supports us education-wise,” Mallik says. “I don’t feel like I’m at a loss without a ladder because of how they support us.”
This May, ACDIS celebrated the 10th anniversary of the Certified Clinical Documentation Specialist (CCDS) credential. At the 2009 ACDIS conference in Las Vegas, more than 100 hopeful CDI specialists assembled in a room at the close of sessions on the last day and took the very first CDI credentialing exam with paper and Scantron sheets. Today, more than 4,500 CDI professionals hold the CCDS credential, with the number growing every day.

“I was so nervous,” says Sharon Cole, MSN, RN, CCDS, manager of CDI and utilization review services at UASI, remembering that day 10 years ago. “The room was freezing, or at least it felt like that to me. I was having hot flashes because I was nervous, so I kept taking my jacket off and then getting cold and putting it back on again. I think I must have done that 30 times. I was so worried that the proctors would assume that I was cheating because I was squirming around so much.”

“There was a level of stress in the room,” agrees Robin Jones, RN, BSN, MHA/Ed, CCDS, division director of CDI, west Florida division, at AdventHealth. “Afterwards, though, there was such a feeling of community. We were all in the hallway, talking about the questions we could remember and whether we got them right or wrong. I remember coming together and realizing that we were all trying to do something that had never been done before.”

“It was really like a community,” says Sheila Graham, LPN, CCDS, CCS, CRC, an associate director of CDI consultant in clinical economics for Berkeley Research Group, LLC, based out of Maryland. “I remember talking to people after the test and being curious about what I had gotten wrong and interested in learning things from the other people who’d taken the test too.”
Though much has changed—the number of credential holders, the medium of the test (now entirely electronic), and the content, which changes with regulatory and clinical updates—those individuals who took that first exam still have valuable advice to share with those who plan to sit for the certification in the future.

Plus, their status as the very first to have taken the exam a decade ago gives them a broad view of the CDI industry as a whole and the importance of certification as the industry progresses.

**Why sit for the exam**

According to the 2018 CDI Week Industry Survey, 17.35% of respondents’ programs require that their CDI staff hold a CDI-specific credential, such as the CCDS or the Certified Documentation Improvement Practitioner (CDIP) credential from AHIMA. In light of this, many CDI professionals now pursue certification because their job requires them to do so.

Back in 2009, however, that was not the case. Instead, CDI professionals sitting for that very first exam did so out of a personal desire.

“I’m a naturally competitive person and I was always passionate about CDI, so when there was an opportunity to be competitive about something I was passionate about, I wanted to jump right in,” says Dee Banet, RN, MSN, CCDS, CDIP, system director of care management, care continuum, at Norton Healthcare in Louisville, Kentucky.

Those first CCDS holders also pursued the mark of distinction for the sake of future generations of CDI professionals, says Stacey Lynne Martin, BS, RN, CCDS, CDI specialist at Houston (Texas) Methodist Hospital. Setting a positive example would encourage other CDI staffers to better themselves professionally.

“As soon as I came back and got the results of the exam, I really felt like I was recognized within my organization. I was so proud to put that credential behind my name.”

Donna Fisher, CCS, CCDS, CHC

always want to be the best I can be and to learn something new every day. I also thought it would encourage other people to also want to be certified and make our profession acknowledged more,” Martin says.

“I think certification speaks volumes,” agrees Jones. “Back then, CDI wasn’t taken very seriously, and it wasn’t seen as an important program. Of course, that’s changed, but I believed that having the certification would help to get us more visibility in the healthcare setting. So for me, it was a professional accomplishment and folded out from there.”

For others, the drive to earn the first-ever CDI-specific certification came from a deeply ingrained pattern of seeking certification in their individual specialization areas. Any subject-specific certification provides a mark of distinction, both among a professional’s peers and to potential employers.

Cole, for example, points to certifications in nursing specialties and credentials held by coding professionals. “Coming from that nursing background, everyone always gets certified in their specialty, so that was something that I wanted to do. I think it validates what we do when we have that certification behind our names,” she says. “I know the coding world has lots of credentials as well, so I think it helped us be more credible with them too.”

Obtaining certification benefits career development, says Cara Belnap-Moss, MSN, CCDS, CDI analyst for Nuance/J.A. Thomas based in Pocatello, Idaho.

“When I took the exam, I worked for a hospital where we reported up through case management and we had a clinical ladder, so it was offered as an option to us that if we wanted to take the exam and get certified, it would apply to our clinical ladder,” says Belnap-Moss. “It also just showed a level of confidence, the level of knowledge that we had in our profession.”

**The effect of certification**

While like Belnap-Moss, some saw a job title change or salary raise with their certification, the effects of certification can be much more intangible, but nonetheless important. Many who passed that first exam found that, upon returning to their facility, they were treated
as experts in the department and gained standing among their peers.

“As soon as I came back and got the results of the exam, I really felt like I was recognized within my organization,” says Donna Fisher, CCS, CCDS, CHC, CDI/coding denials manager at UF Health Shands Hospital in Gainesville, Florida. “I was so proud to put that credential behind my name.”

The news of new credentials gave CDI administrators the chance to introduce staff as documentation experts, says Belnap-Moss.

“When we came back, our manager used it as a marketing tool. She put it in emails, included it in the hospital newsletter, telling people that we had gotten our certifications,” she says. “We were a brand-new program, and I think it really helped the physicians to feel more confident in us. It helped the coders, and the rest of our coworkers, to have confidence that we knew what we were talking about.”

Though it may take some time, credentialed CDI professionals who hold an industry-specific credential may be singled out for future leadership roles based on their demonstrated expertise.

“I think it was a catalyst for me getting into the management role that I’m in now,” says Shawn (Trish) Endress, RN, BSN, CCDS, documentation specialist manager at Memorial Hermann Health System in Austin, Texas. “Of course, it took several years because we were a small department at the time and still had to grow, but it prepared me.”

**How to prepare for the exam**

Coding rules, regulations, and even the scope of CDI programs have all changed over the years, and the CCDS exam has changed with them. In fact, the CCDS Certification Committee reviews the exam on a regular basis to ensure it’s up to date with the CDI industry. Those preparing for the exam, however, can follow the path set out by those who took it in the past, leaning on their study tips and advice for guidance.

One of the best ways to get ready for the exam, according to Banet, is to become an expert in your CDI role. That’s exactly what those first test-takers had to do since there weren’t study guides or courses available yet. Even if there are areas on the exam you’re less comfortable with, studying the exam content outline and leveraging your existing CDI knowledge to inform those areas can be extremely lucrative.

“The part that I was the most surprised about was truly the program oversight—the metrics that were associated with how your program is doing. But at the same time, I think doing the work of a CDI, you could probably make educated guesses on those things,” she says. “Now, I do feel that the study guides adequately address all those areas, so it wouldn’t be as much of a surprise for those taking the exam.”

“I really felt confident going into the exam because I had run the program for four years. I felt like I was really well prepared for it,” agrees Fisher.

If you’re a new CDI professional, setting your sights on the CCDS once you meet the prerequisites, there are things you can do to prepare even before you gain the required level of experience, says Jones. While using the study guide can be extremely helpful as Banet says, hopeful candidates shouldn’t neglect the resources at their disposal within their organization’s walls.

“Build a collaborative relationship with other disciplines in the hospital. For example, I think coders are incredibly gifted at what they can do and what they can teach you,” Jones suggests. “Get a good friend who can teach you the coding side, collaborate with quality, and learn about their rules and regulations.”

Be open to, and seek out, all forms of education, adds Banet. As you prepare, take advantage of the many free resources available through your professional association memberships (such as ACDIS or AHIMA).

“The more education you can get, the better,” she says. “Read;
stay on top of the ACDIS Blog and what’s new on the ACDIS website.”

Studying for the exam may even make you a more well-rounded CDI professional, says Margi Brown, RHIA, CCS, CCS-P, CPC, CCDS, a national provider services professional at Anthem/WellPoint in Orlando, Florida, so the benefits reach beyond adding a credential to your name. Studying previously unfamiliar areas will give you a broader view of your role as a CDI professional.

“The exam marries the two fields—clinical and coding. You have to look at CDI from both angles to be successful,” says Brown. “I recommend that everyone sits for the exam as soon as they are eligible.”

**Why recertify**

While the hardest part may be over when you pass the CCDS exam, certification holders have to recertify every two years from the date they passed the exam in order to keep their certifications current. This means that those first test-takers have chosen to recertify five times now. Why? Well, first, according to Banet, choosing to recertify allows you to continue being recognized as a CDI expert.

“It may not have been mandatory or required when we took the exam, but it is now mandatory in most organizations, and it’s definitely more recognized” as a mark of experience, expertise, and excellence, she says.

More often, too, the CCDS credential can set you apart from other job candidates, adds Graham. Though it’s not a requirement everywhere, having that added proof of expertise can give you the edge you need to land a job when there’s a pool of otherwise equally qualified candidates.

“The CCDS is one of those credentials we look for when hiring new CDI staff,” says Graham. “I really think [the CCDS] shows a knowledge base.”

“It’s part of our hiring process here, so if I had two applicants and one had it and the other didn’t, I’d choose the one who had it,” adds Jones.

Even with the best of intentions, it can be difficult to keep up with your recertification, and many feel lost when encountering the process for the first time. Since CCDS holder are responsible to remember their due date (though ACDIS does send reminder emails to the address on file with the CCDS office), they should build reminders into their personal schedules, says Cole.

“I was so terrified that I would miss my first recertification that I put it in my Outlook calendar at work,” she says. “A month or two before, there was a reminder to fill out the application and renew.”

Over the course of those two years, CCDS holders need to earn 30 continuing education units (CEU) to submit for their recertification. Building checkpoints for yourself over the two-year period can be helpful, Belnap-Moss says. For example, try setting a calendar reminder for the one-year mark to earn 15 of the 30 CEUs.

“Keep track [of your CEUs] all along rather than trying to cram all the education in the last month before you have to recertify,” she says. That way, all you’ll have to do before the recertification date is fill out the paperwork and submit it.

Ultimately, CCDS holders should continue to recertify because they’ve worked hard to earn the distinction through months of study and extensive testing. Keeping current displays your dedication to the CDI profession and to your own professional standing.

“My CCDS is just as important as my RN license,” says Martin. “Currently, the certification isn’t required at my company, but I will continue to recertify this year and every two years.” 🌟
When you work in the CDI program of a medical facility, you are continually thinking of ways to elicit improved documentation from the medical staff. You also spend a fair amount of time lamenting why some physicians or service lines seem to ignore all educational efforts regarding the importance of explicit and accurate documentation. “If it is important to us,” you might say, “why is it not to them?”

Ideally, your providers will recognize and appreciate what CDI is trying to accomplish for them, their hospitals, and their patients. However, after a recent—and somewhat shocking—encounter with a provider, I have to pose the following two questions:

- Do we in CDI have unreasonable expectations of our healthcare providers?
- Are we asking the correct personnel to improve the caliber and volume of the medical record?

Spoiler alert: Yes, and yes!

Recently, I met with a group of physicians to summarize documentation improvement opportunities discovered from a chart review. This was the first CDI intervention with this group as they had previously resisted all prior CDI efforts. Almost all members of the group attended this early morning session, and all were professional and respectful.

When I was finished, however, the most senior-appearing doctor in the group looked at me and very politely said, “I am 60 years old and will be retiring in a few years. I am unwilling to change what I am doing at this point in my career. I don’t mean to be rude. I am just telling you that I won’t be doing what you ask.” Shocked and taken aback, all I could think to say was, “I am sorry to hear that. Don’t you want to leave a thriving practice to your partners when you retire?” He quickly responded with, “All of my partners have full practices. They and this practice will be fine.”

Immediately, I wondered why he didn’t get it, if I said something wrong, what I was going to do with this guy, if I was wasting my time, and just how this could have happened. While his response was not what I wanted or expected, it certainly gave me pause and made me reevaluate some prior convictions. The conclusion I reached is that, yes, we in CDI may be expecting too much from some doctors.

**Physicians’ perspective**

On average, physicians are 31 to 33 years old when they start practicing. After 15 to 20 years of practice, they may be reaping some very pretty fruits of their labor—fine houses, fancy cars, lavish vacations, and summer homes. They have a thriving practice as well as a satisfying and successful career.

Suddenly, in the midst of this utopia, they are introduced to the concept of CDI for the very first time. Regardless of the number of valid reasons we give them to adopt CDI goals and best practices, from their perspective, what they have been doing thus far has obviously been working pretty darn well.

Their point is this: Why should they fix what is clearly not broken?

Additionally, we in CDI cannot forget that time is the most valuable commodity to any practicing clinician. Asking busy doctors to do something that increases their work hours is immediately perceived as a reduction in time spent with family or leisurely pursuits. That is the busy physician’s mindset. I, as a physician, can personally attest to this (albeit without the fancy cars, homes, and vacations).

Each case brings increased pressure and an associated mental calculation regarding how much later I am going to get home that night. We must remember that CDI is asking busy doctors to increase the amount of time they spend documenting in the medical record.

CDI needs more diagnoses than currently exist. Those diagnoses need more specificity and detail than
is currently provided. The CDI program is not going
to get these things without more time being spent by
doctors working as doctors. We in CDI may need to reevaluate whether all of our valid reasons for adopting CDI goals really and truly outweigh these perceived negatives for the busy, successful, and happy doctor.

If we do have unrealistic expectations of these doctors, what are the ramifications for our CDI programs? Our hospitals and patients need better documentation. Poor documentation dramatically impedes our ability to pro-
vide the care our patient populations desperately need. Do we just forget about these doctors and hope for the best? What if an entire essential service line at a smaller hospital takes the “no participation” approach to CDI?

My current suggestion for increasing the involvement of NPs and PAs in CDI [...] goes beyond merely increasing your program’s educational efforts with them. I believe the next evolutionary step is to hire an NP or PA strictly to do all of the in-hospital documentation for an attending or service line.

Trey La Charite, MD, FACP, SFHM, CCS, CCDS

While I have always believed that CDI will not be able to reach every doctor regardless of what carrots or sticks are employed, the truly recalcitrant are usually a very small percentage of any given medical staff. We still need better documentation. However, if the doctors are not the best vehicles to achieve our goals, how do we obtain the improvements we need?

If your CDI program lives in a busy, academic medi-
cal center with lots of residents, your task is much easier. Resident physicians are traditionally compliant and willing to help with requests for better documentation. They have not yet been jaded by the evil specters of success and time. Additionally, it is much easier to con-
vince their attendings to hold the residents accountable for the documentation, as the attendings would have to provide it themselves if the residents do not.

In my hospital, residents do the vast majority of the documentation. Since my CDI program focuses heavily on them, we get most of what we need from their ranks. However, my institution also has an increasing num-
ber of nurse practitioners (NP) and physician assistants (PA) who are frequently the best documenters in the house. These clinicians, hired ostensibly as “physician extenders” to increase the patient care capacity of their attendings and service lines, are an excellent way to further your CDI efforts.

NPs and PAs

My current suggestion for increasing the involvement of NPs and PAs in CDI, however, goes beyond merely increasing your program’s educational efforts for them. I believe the next evolutionary step is to hire an NP or PA strictly to do all of the in-hospital documentation for an attending or service line. In other words, this person would not participate in procedures or help in the operating room. Nor would he or she participate in the discharge process of writing scripts, interacting with case management, or providing patient instructions. Docu-
mentation would be this professional’s only responsibil-
ity and function.

With documentation as the NP/PA’s only job—writing notes that capture every diagnosis, problem, and solution affecting a patient’s care—imagine the level of completeness and specificity that could be obtained. To clarify, this role is much more than an hourly scribe who cannot diagnose conditions or institute treatments. Scribes can only document what they are told and can-
not function independently from the busy doctor.

Could this work in your hospital? A success story from my hospital might provide the necessary incentive for your administration to give this a try. Several years ago, I worked with a surgical practice that was not accurately capturing every disease process affecting their patients. Their case-mix index (CMI) at the time was 2.35. I participated in morning rounds with one member of the group on one day for four consecutive weeks.

During those four morning rounds sessions, I found 34 additional diagnoses that were clinically present but not documented. Fourteen were CCs, and seven were MCCs. The resulting MS-DRG changes from those findings increased the CMI of those cases by about
0.74, added an extra 19.7 days to the overall geometric length of stay, and produced approximately $45,000 in reimbursement. At this rate, the yearly cost (salary and benefits) of a PA or NP would be completely recouped in only three months of work, leaving nine months per year as your return on investment.

With these results, it was easy to make the case for hiring an NP or PA to take over the inpatient documentation responsibilities. Since that service line hired a PA strictly for documentation, it has consistently maintained a CMI of 2.65 and has just added a second full-time PA at the hospital’s expense—once again solely for documentation needs. Additionally, my hospital is probably going to do this for two other surgical service lines by the end of this year.

If you have an attending or service line that could easily generate improved reimbursement and performance metrics with improved documentation, this is a viable strategy to achieve your CDI program’s objectives.

As indicated by my spoiler alert, yes, I am throwing in the towel with some doctors. I am not giving up on obtaining better documentation for their patients, though. My determination to have every patient’s complete clinical situation accurately portrayed in the medical record is unswayed.

However, I am no longer convinced that specialized and very busy doctors should be the focus of our educational efforts. By presenting CDI to those doctors as a time reducer through the efforts of a dedicated documentation NP or PA, physician buy-in should skyrocket. Those doctors will certainly be more enthusiastic about CDI, and your program should see immediate and sustainable results.

Editor’s note: La Charité is a hospitalist with the University of Tennessee Hospitalists at the University of Tennessee Medical Center at Knoxville, a clinical assistant professor, and the medical director for UTMC’s CDI program. La Charité’s comments and opinions do not reflect necessarily those of UTMC, HCPro, ACDIS, or any of its subsidiaries. Contact him at Clachari@UTMCK.EDU.
MEET A MEMBER

When you get stuck, phone a friend

Lawrence J. Berthold, RN, BSN, who goes by Larry to most, Larry Joe to some, and Lawrence to few, has worked for PENN Medicine his entire nursing career, even going back to his first clinical rotation. Currently, he oversees the CDI teams across the PENN health system. He participates in both the South Jersey/Philadelphia/Delaware and the Central Pennsylvania ACDIS local chapters.

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

Berthold: This year marks my 11th year as a CDI specialist. I’ve worked as a chart-side CDI specialist/entity-based team lead, then the manager of two CDI teams across entities, and now am the corporate director of CDI across PENN.

ACDIS: What did you do before entering CDI?

Berthold: In my nursing career prior to CDI, I worked as a case manager on a geriatric-acute care for elders (ACE) unit, and as a bedside and charge nurse on a medical-surgical unit with an oncology and human immunodeficiency virus specialty, all at PENN.

Prior to PENN, I worked as a shift supervisor and computer operator in a data center and have been paid as a poet, writer, tutor, singer-musician, dog walker, burger flipper, etc.

ACDIS: Why did you get into this line of work?

Berthold: In terms of nursing, it was more in response to life changes. My previous employer was closing local offices, and I had to decide whether to keep my job and relocate (away from family) and/or take the opportunity to reeducate and redirect my career. Nursing seemed to offer a myriad of opportunities in all kinds of directions.

As far as my CDI career, it was introduced as a new discipline/department coming to PENN. As a case manager/utilization review nurse and as a bedside nurse, I often saw the effects of documentation on outcomes and successful care and tried to fix it in various ways when it was broken—as a peer instructor/mentor, via our documentation committee, and in various discussions with clinical colleagues.

Also, a friend, who was a new internist when I was a unit nurse, took on the role of our chief of quality and safety when CDI hit PENN in 2007. At the time, I worked as a case manager. No one knew what to make of CDI, just that documentation was something that had to be fixed. My friend came to me and said, “I want to take this on and figure it out. You complain and teach all the time about documentation. Come along and help me do this.”

That friend is now one of our chief medical officers (Dr. Kevin Fosnocht), and I am the corporate director of CDI. We’re still figuring it out every day. It’s that curiosity and optimism for the best case that drives us. Basically, we were brave enough to jump in when others weren’t and weren’t afraid to ask for help, respect those that offered, and remain open and curious.
ACDIS: What has been your biggest challenge?
Berthold: Taking the “ask” of CDI from the stage of “can you do us this favor” to “can I help you with that so we get it right,” changing the providers’ concept of what codes (and the related documentation) represent from something that’s needed for billing to the building blocks of the clinical portrait that represents each individual patient across the continuum — in quality and care protocols, research, public health initiatives, marketing, etc.

ACDIS: What has been your biggest reward?
Berthold: The positive effects of CDI on patient care, hearing one physician teach another physician about why documentation matters and how easy it is, and being able to offer another level of opportunity to nurses that are already experts at what they do, just like the opportunity I found in CDI.

I love to help fellow RNs take their clinical knowledge and experience, introduce the coding discipline and literally expand their understanding and horizons beyond the bedside capacity, and help them become experts in how health systems work and how care is best represented and delivered.

ACDIS: How has the field changed since you began working in CDI?
Berthold: What often started as a matter of financial survival (MS-DRGs!) has become a unique and well-respected discipline that is driven by quality. CDI shines a light across the continuum of care and works to benefit patients. This comes from the availability of better references, better-pointed care via provisions of a knowledgeable baseline, better communication of such, and better protocols and safety understanding related to care via detailed and true clinical portraits.

ACDIS: Can you mention a few of the “gold nuggets” of information you’ve received from colleagues on The Forum or through ACDIS?
Berthold: Mostly, the camaraderie has been the epiphany repeatedly for me. I started as the sole CDI specialist at one of our entities (technically, I was the “team lead,” which isn’t as easy as it sounds — I can be a handful to manage), but had a second colleague (hello, Florenda!) added in a few months later.

For a few years, it was just the two of us (it would be six years or so until we went corporate), and the few gatherings we could get to quench our collegial thirst (symposiums, web and telephone discussions, and the initial visits within ACDIS) were our biggest bright spots.

To realize there were others with similar challenges and navigating similar pitfalls, and to hear how innovative they were and to find them as open to share what they learned, tied us back to the teamwork we always knew as nurses and kept us challenged and repeatedly renewed.

ACDIS: If you have attended, how many ACDIS conferences have you been to? What are your favorite memories?
Berthold: I have been lucky enough to attend seven ACDIS conferences. PENN is very supportive of education, and I/we have always made sure it’s an important part of progression for myself and our team, but also across our system. CDI specialists are, in essence, teachers of documentation. The individual chart might be the task, but the larger-focus culture shift takes time and lots and lots of patience and teaching.

My favorite memories are related mostly to being able to put faces to names—saying thank you to all the people that have mostly anonymously helped me, taught me, and laughed and cried with me over the years and getting to know them as people. These are people like Robert Gold, MD, James Kennedy, MD, Erica Remer, MD, Richard Pinson, MD, Chuck Buck, Brian Murphy, Melissa Varnavas, Cheryl Erickson, Suzanne Rogers, etc.

I love being able to hear all of the stories and experiences each year and to occasionally be able to provide some experiences myself. It’s a warm, tactile, friendly, progressive group of which I am privileged to be a part.

ACDIS: What pieces of advice would you offer to a new CDI specialist?

Berthold: Patience is a huge benefit, both to provide for yourself in terms of giving yourself time to arc and flower, but also in your teaching and attempts at culture shift.

Pay attention to compliance. It can feel frustrating at first, but it’s really the thing that keeps us honest and respectful in our roles as CDI specialists. Learn its hows and whys. It’s an underrated but very important aspect in every conversation we have.

Let the chart give you what it gives you. Don’t take an agenda in with you.

Remember to phone a friend if you get stuck, if you get beat up and need a laugh, if you’re feeling unsure, or if you just need a sounding board. For many people, this discipline can feel oddly autonomous. Just remember you are never alone.
Be creatively assertive, not ruthlessly aggressive.
Be kind. Always.

ACDIS: If you could have any other job, what would it be?
Berthold: As a young lad, I wanted to be a baseball player. In my teens, a rock star/musician. Always, a writer.

ACDIS: What was your first job?
Berthold: I walked neighborhood dogs and delivered newspapers.

I also worked as a burger flipper and fry guy. Financially, it was the pits, but in terms of friendships and fun, it was the best. It taught me teamwork, and that hard work and a light heart can be its own reward. I still have friendships to this day from those two years.

ACDIS: Can you tell us about a few of your favorite things?

- **Vacation spots**: Ireland, camping almost anywhere, treehouses.
- **Hobbies**: Laughing and listening, reading and writing, music, collecting signed first edition books, enlarging my circle of family and friends.
- **Non-alcoholic beverage**: Coffee jolts. Tea heals. Water is life.
- **Foods**: I love to cook. Mostly, I enjoy recreating and adding my touches to our old family recipes and recently I have been exploring pan-Asian cooking, root vegetables from all over the world, and varieties of mushrooms.
- **Activities**: My favorite days are communal gatherings that take their own path (private selves made slightly public). I love Ireland for the family pub sessions of both stories and song, cooking that expands on traditions but remains respectful of source, and cosmically dancing around the fire and a bit of howling at the moon. Any day that ends in a “kitchen party” is a good day. Also, there is NEVER ENOUGH time to catch up on reading…

ACDIS: Tell us about your family and how you like to spend your time away from CDI.

Berthold: I’m the middle child of three, and three years separate us all; I have an older sister, Maryann, and a younger brother, Michael.

From my mom, I got her love of reading and music. From my father, who was my coach in reference to baseball and in being a man, I got my ridiculous sense of humor, my love of people and music, and a crazy head of hair.

I come from a tiny family. German and Irish by culture. I married into a very large Irish family. It took me a few years to learn all their names, and every time you turn around there’s another to learn. We never go hungry nor lonely.

I’ve been married to my wife, Bridgid, for 26 years. She does her best to keep me alive and has, over the years, perfected the art of laughing out loud while also shaking her head from side to side. My son, Chris, is married to a lovely woman, Amanda, and lives in Florida (somehow, he survived me and turned out to be a pretty spectacular human whom I love to spend time alongside).

We’ve had as many as three dogs (I would be unable to keep from adopting untold numbers if left to my own devices), although we currently only have one (shout out to Riley Roo!) and I am always openly recruiting.
REGISTER BEFORE SEPTEMBER 21, 2019 AND SAVE!

hcmarketplace.com/acdis-outpatient

NOVEMBER 14–15, 2019

AUSTIN, TX

Join us for the nation’s only national conference dedicated entirely to the emerging field of outpatient CDI!
WANT TO STAY UP-TO-DATE ON ALL THINGS ACDIS?
SUBSCRIBE TO CDI STRATEGIES!
Visit the ACDIS blog weekly to find out what events are coming up in your area!