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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.
Those on the ACDIS team know that I am a huge data nerd. Each month, part of my job is to analyze ACDIS’ website data to identify our membership’s needs and interests, helping us shape our offerings and better serve members’ needs. While talking to members one-on-one or through our boards and committees on a regular basis provides us with the individual stories and experiences to help shape our educational efforts, data provides an invaluable backing to those stories and a benchmark against which to measure future interests, needs, and success.

While it may be surprising given my love of data, I have never been a numbers person. Math was my worst subject all through school (a real embarrassment since my dad is a software engineer and my brother has a master’s degree in nanotechnology, but I digress). I have always been someone who cares more about words and personal interactions than numbers. And to be completely transparent, I’m still like that.

Over the years, however, I’ve come to understand that you can’t provide meaningful offerings and serve your community well without knowing where they concretely stand right now. And without monitoring data and trends over time, you won’t know how things have changed, where they need improvement, and where you’ve succeeded. Monitoring and benchmarking your data over time shines a light on what you’ve accomplished and helps illuminate your next right step along the road.

Data analytics and benchmarking may not be a glamorous topic, but it’s essential for all CDI professionals. CDI leaders can leverage return on investment (ROI) data to secure more staff and resources and protect existing staff members from furloughs and layoffs; they can use CDI metrics to understand where their team members or physician staff may need additional education. Frontline CDI specialists can use their individual data to benchmark their progress when learning a new review area; they can use physician data to shape their conversations with the medical staff and secure that all-important physician engagement.

Given its centrality to the CDI process, we’ve devoted this entire edition to benchmarking and data analysis.
easy metric to provide, there are numerous nuances to these calculations that CDI professionals need to take into account. Turn to p. 6 to read about these conversations and metrics from Editor Carolyn Riel.

As the CDI industry has expanded and matured, other nonfinancial metrics have become more and more important in monitoring departmental success, which is why we’ve included articles focused on quality and physician education ROI on pp. 10 and 39. On the topic of quality, this edition also includes a guest column all about using the five traits of high reliability organizations to shape quality review efforts (see p. 13).

Of course, the type of organization also affects all aspects of a CDI department’s work. This edition features articles focused on monitoring outpatient CDI success and on the components that make CDI in a Veterans Administration organization unique (pp. 18 and 21).

No matter the type of CDI program or its age, the mountain of data produced can be overwhelming. To help you begin to dig out and set a course for metric success, this edition includes articles focused on real CDI professionals’ experiences with data analytics. Turn to p. 9 for insight on leveraging data to prove ROI, illuminate opportunities, and increase physician engagement from Albany (New York) Medical Center. Flip to p. 41 to read about the key performance indicators monitored and challenges faced at University of Tennessee Medical Center. On p. 23, you’ll find a deep dive into the roles of CDI analysts, system specialists, and informaticists, plus advice on how these roles can help with data management and analysis.

In addition to outward-facing metrics to prove programmatic success, we know that staff productivity remains a focus for many CDI leaders. On p. 30, you’ll find an article written by yours truly offering advice from ACDIS CDI Leadership Council members on the considerations and practices leaders can leverage to set realistic goals for their team.

Of course, the past year has not been a normal one by any stretch of the imagination, and discussions about metrics and benchmarking cannot happen without acknowledging that fact. While the long-term effects of the pandemic on CDI departments remain to be seen, ACDIS has gathered some data to shine a light on where CDI programs stand right now and where we might be headed. Turn to p. 34 to read all about these findings from Associate Editorial Director Melissa Varnavas.

This edition also includes a summary of CDI research focused on utilization management/CDI collaboration and the importance of self-care on p. 36, and advice from one of our ACDIS members on p.44.

Even if you’re not as much of a data nerd as me, I hope you’ll enjoy this edition and find something of value within its pages. Happy reading!

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CDI Journal | MARCH/APRIL 2021
While the CDI industry has evolved slowly away from strictly financial focuses to a more holistic record integrity approach that encompasses all aspects of the healthcare story, nearly 31% of CDI professionals still say that financial metrics take precedence over other measures of success, according to ACDIS survey data.

CDI’s role in an organization is of course larger than reimbursement accuracy, but financial return on investment (ROI) is still part of the picture. Communicating that ROI remains important in ensuring continued support for the department and securing valuable organizational resources.

Tracking difficulties

At first blush, tracking financial ROI for CDI efforts may seem straightforward, but that’s not always the case, says Tamara Hicks, BSN, MHA, RN, CCS, CCDS, ACM-RN, CCDS-O, director of clinical documentation excellence at Wake Forest Baptist Health in Winston-Salem, North Carolina. In order to prove a positive ROI, you must first extrapolate what the reimbursement would have been without CDI intervention.

“We calculate the financial ROI based on queries and responses to queries,” she says. “We also look at the change in DRG that a diagnosis would have gone to and the DRG that it ended up going to after any query or intervention by CDI.”

To calculate this financial impact, Hicks looks at how much revenue the department brings in each month and subtracts the cost to run the CDI department, which gives her the net ROI amount each month. This information is presented in a monthly dashboard and goes out to the organizational leadership team. Before being imported into the dashboard, the financial ROI information is pulled into a spreadsheet workbook with combined information for the overall health system, as well as broken out into separate spreadsheets for each of Wake Forest’s five facilities.

“When we first started tracking this financial ROI information, we...
had a consulting group come in that helped us decide what to track and what not to and were advised on some tools that would help us with this,” Hicks says. “CDI staff manually put in the information, so still to this day we go back and spot check from time to time to make sure everything was entered correctly.”

**Educating, identifying trends**

While calculating the financial ROI may take time, the truly challenging part is training staff to see the financial improvement opportunities within a chart, beyond simply CC/MCC capture, Hicks says. One such opportunity is when the CDI specialist queries for a diagnosis that changes the DRG, but then the patient has a procedure that changes the DRG again. The challenge is helping the CDI specialist understand that with the procedure, the starting point for the DRG has to change to calculate the impact of the query.

“Some staff have a hard time wrapping their brains around that concept, so anytime I see an impact going from medical to surgical DRG, I spot check those,” she says.

A big part of hitting ROI goals, Hicks says, is reviewing all the cases that need reviewing, so she has traditionally monitored review rates over time to ensure her staff see the cases they need to see. That process, however, will soon change with the help of technology, hopefully enabling staff to see the right cases—those with the most opportunity for improvement—and make bigger impacts.

“We’re going to be implementing a prioritization tool. Up to now, I would be more concerned with if we are getting as many cases as we can,” she says. “Now we will be getting to the cases that we need to.”

Hicks also suggests, regardless of prioritization software use, aligning your review focus to the areas with the most opportunity. For example, at Wake Forest, the sickest patients with the most opportunity for documentation improvement are generally admitted in the general medicine or ICU service lines. Rather than focusing her limited staffing resources on elective surgeries or joint replacements—cases that typically have fewer opportunities—Hicks focuses her team’s primary efforts on general medicine and the ICU. This approach will get you the most bang for your buck.

“Make sure to take a step back from time to time and see the whole picture to make sure you’re reviewing the right cases and getting at the right opportunities,” she says.

When dips in financial ROI metrics occur, Hicks suggests taking a step back and first looking to see if there is a logical reason behind the declines.

“During the summer and Christmas, we tend to have dips because people are taking time off and out of the facility,” she says. “You can always expect to see dips when there are people taking vacations or there are furloughs.”

One of the major contributing factors impacting CDI programs’ ROI in 2020 was, of course, the COVID-19 pandemic. **ACDIS survey data** and **industry news** show that healthcare organizations suffered massive financial hits over the course of the ongoing pandemic. Much of the impact came from cancelled elective procedures and drops in non-COVID-related admissions.

While Wake Forest’s census did drop at the beginning of the pandemic—they anticipated a larger influx of COVID-19 patients than they experienced—Hicks says that the CDI team viewed the drop in census and work queue numbers as an opportunity. By treating it as such, the team was able to continue making positive financial impacts, which in turn helped the organization stay in the black.

“Honestly, COVID-19 really has not impacted our ROI. At the beginning we expected a huge surge that we did not get,” Hicks says. “The census went way down, so we were able to get our coverage rate up, so we were able to get to more [patient charts].”

While that coverage rate is now starting to drop again as the census recovers, Hicks remains positive about the fact that Wake Forest’s financial ROI will not dip. “In terms of financial ROI, it has stayed the same for us throughout all of this,” she says. “Patients are just as sick or even sicker, so the opportunities for CDI to make those financial impacts are still there.” 🌿
“We found this gold mine, and it was data analytics,” said Ashley Telisky, DO, MBA, CDI physician advisor at Albany (New York) Medical Center, during ACDIS’ fall 2020 online event Curtain Call: Behind the Scenes of Star-Studded CDI Programs, where she presented “Data Dives for Physician Education, Engagement, and Enlightenment.”

Telisky’s organization covers more than 20 counties in the region with a mission that focuses on patient care, education, and research. In joining the CDI effort, she and the team identified two important elements they wanted to focus on to bring the CDI program to the next level—data analytics and physician engagement.

They knew they needed to create score cards or benchmarking reports that would illustrate the status of program efforts and the strength of physicians’ response. To do that, however, they needed effective data mining and data reporting. So Telisky and her colleagues pulled internal data on query, financial, quality, and CMS-related outcomes.

“Physicians, particularly from an academic setting, love data, love research,” she told attendees. “So, if you have the data, share it with them. If you don’t have the data, dig into it and figure out ways to gather it and share it. Just remember that it’s got to be relatable. So while yes, it’s true that physicians love data, the CDI program needs to bring it home in a way that shows physicians that it’s their data—our data. It’s data about our patients, about our facility. That matters.”

In rolling out physician education, Telisky brings providers back to basics, letting them know how their
documentation translates to coded data and how that data, in turn, gets translated into a host of metrics including:

- Reimbursement
- Facility quality metrics
- Public health data
- Medical research
- Claims denials
- Population health statistics

“If you don’t take it back to basics, all those words that didn’t turn into letters and numbers [healthcare codes] just fade away,” Telisky said.

Since quality is core to Albany Medical Center’s mission, Telisky and the team then dig into publicly reported quality data such as information found on the Leapfrog Group, the Hospital and Physician Compare websites, U.S. News & World Report, and elsewhere. Armed with various data elements, Telisky can then move from generalized trends down to coding and documentation implications for specific patients and specific physicians.

“That’s when I begin to see opportunity,” she explained. “Why is it that every year, X diagnosis is higher in our hospitals than it is in other comparable facilities?” Of course, she added, the challenge for her organization is a bit cyclical. “Training begins to feel like Groundhog Day because you have new residents every year. But we have to go there; we have to provide this education.”

It’s not uncommon for Telisky to be detained by the physician staff after an educational session, she explained. “I can’t tell you how many times I’ve been invited to talk to physicians for a 10–20-minute discussion and ended up staying an hour or more.”

Telisky encourages CDI programs to “foster healthy competition among physicians. Keep it positive and elevate the energy,” she said. “Avoid negativity or negative language and use words that focus on opportunities. Opportunities are exciting, energizing.”

Since she is a practicing physician in Albany Medical Center’s emergency department, Telisky understands the challenges working providers face. Armed with a master’s degree in healthcare business administration, however, she also understands the administrative side of the American healthcare system.

**Editor’s Note:** Telisky is the CDI physician advisor at Albany Medical Center and presented at the September 2020 ACDIS Curtain Call event. Contact her at teliska@amc.edu.

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**Foster healthy competition among physicians. Keep it positive and elevate the energy. Avoid negativity or negative language and use words that focus on opportunities. Opportunities are exciting, energizing.**

Ashley Telisky, DO, MBA

Yet, she admits her education provides her with just enough knowledge to understand where to begin to unearth additional information, reminding attendees that “many people at the table may not have had that opportunity. Many doctors don’t ever have that opportunity. Understanding the administrative side helps me be a better doctor. Working on the clinical side in the ED makes me a better administrator. You have to be patient, calm, and clear in explaining not only the what but the why. If there is no margin, there is no mission. But in all honesty, the margin follows if we adhere to our mission to care thoroughly for our patients.” 🕉️

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Most CDI programs came into being with the primary focus of financial improvement and reimbursement accuracy: capturing CCs/MCCs to shift the MS-DRG placement to one with a higher relative weight. The impacts of these efforts were straightforward to demonstrate, and highlighting a return on investment (ROI) was as simple as showing the DRG shifts associated with CDI activities.

As payment methodologies have begun to pivot away from strictly fee-for-service to pay-for-performance, CDI efforts have shifted focus too. Measuring the CDI impact and ROI related to quality concerns, however, is much more complex than strictly monitoring financial performance.

“Most CDI programs came into being with the primary focus of financial improvement and reimbursement accuracy: capturing CCs/MCCs to shift the MS-DRG placement to one with a higher relative weight. The impacts of these efforts were straightforward to demonstrate, and highlighting a return on investment (ROI) was as simple as showing the DRG shifts associated with CDI activities. As payment methodologies have begun to pivot away from strictly fee-for-service to pay-for-performance, CDI efforts have shifted focus too. Measuring the CDI impact and ROI related to quality concerns, however, is much more complex than strictly monitoring financial performance. Right now, we report out the LOS [length of stay] index (observed/expected ratio), a mortality index, ROM [risk of mortality], and SOI [severity of illness],” Anyika says. “We still track and use DRGs, but we focus more on our quality scores. We’re a cancer center and have a critically ill patient population with multiple chronic conditions. Because of this, our patients generally stay longer, so our CDI reviews are more intensive because we need to ensure that anything which happens during admission is captured and accurately documented by the provider.”

According to Anyika, when the mortality index (observed/expected mortality ratio) is less than 1, that’s a success for Sloan Kettering. “If a patient is scheduled for chemotherapy and they suddenly get admitted with pneumonia, for example, we may still need to administer the chemo when they’re stable and during the same...
admission. The patient may have associated pancytopenia which may need transfusion. The patient may get transfused,” Anyika says. “All these will invariably lead to a longer LOS for the patient. We always have to explain the medical necessity for this LOS, and this can only be optimally achieved when accurate and codable documentation is completed by the provider.”

The sure way to obtain accurate expected LOS is to ensure that the patient’s additional and applicable diagnoses/conditions are accurately documented in the record from the beginning of the stay through discharge. When this happens, the providers derive the optimal expected LOS available to care for their patients.

“If we can get this vital information documented as the events occur, then we can justify a longer LOS for the patients when this happens,” she says. “It’s so important that if there are any questions or ambiguity in documentation, the CDI specialists query for clarification.”

Tracking mortality metrics, public rankings

Often, the mortality index information offers a straightforward entry point for proving a quality-related ROI, agrees Jones. This is largely because the observed to expected (O/E) ratio can be trended over time to see the effect of your focused CDI mortality reviews.

Simply put, an O/E rate of greater than 1 means that more patients died than were expected. When the O/E rate is too high, it either indicates that the hospital didn’t take care of their patients well, which led to their untimely deaths, or that the documentation didn’t show how sick (and at risk of death) the patients really were.

“[CDI efforts] can’t do anything really to change the observed, but you can make that denominator bigger for the expected,” Jones says.

Brigham and Women’s uses Vizient to extrapolate the expected mortality rates and calculate the O/E ratio. Then, the CDI team can use that data to home in on particular diagnoses that are heavily weighted across different methodologies and used by payers for risk adjustment.

“Those particular diagnoses we’ve found are coagulopathy, weight loss, and fluid and electrolyte imbalance, so we have particular goals for capture rates for those,” says Jones.

It’s important, according to Jones, to look at your quality metrics (such as your O/E ratio) in relation to your peers for benchmarking purposes. This will help you understand where you may need to improve further to be competitive. At Brigham and Women’s, Jones partnered with a quality analyst to do a focused review of their quality data.

“We took a look at the U.S. News top 20 hospital report, since we are included in that,” says Jones. “That’s where we figured out who our peers were and compared to see where there was the most opportunity for improvement.”

Using the U.S. News & World Report list to show the quality success of their CDI program has won the support of organizational leadership, says Jones.

“Although it doesn’t have direct [financial] ROI attached to it, we can say that the work we’re doing improved the expected mortality and in turn will improve O/E that will then increase our ranking,” she says.

In addition to outside quality ranking reports, Anyika suggests CDI leaders leverage their existing technology or employ the help of outside services to generate reports for the department showing its quality impact. At Memorial Sloan Kettering, the CDI team leverages their CDI technology for mortality tracking and the risk adjustment calculator offered through Vizient, which also offers a level of predictive analysis for their future efforts.

“We use the tool to determine possible diagnoses that may improve the quality outcomes for the patients,” she says.

Reporting, sharing data

While the aggregated CDI ROI data may be valuable for a CDI leader to see and pass along to organizational leadership, Jones suggests giving each CDI specialist access to their query impact data. This allows leaders to develop benchmark expectations, gives CDI specialists an idea where they stand, and shows staff members the impact they’re making for the organization.
“At this point, it’s only reported as an aggregate, although I do measure the number of individual queries that a CDI specialist sends that are quality or severity based,” says Jones. “Each person has a goal of a 35% query rate for severity and quality-type queries.”

Beyond the CDI staff, quality ROI data should be passed along to organizational leadership and decision-makers so that the true value of CDI efforts related to quality reviews can be recognized. Which leaders need the data, however, will depend on your organizational priorities and departmental reporting structure.

For example, though they review many of the same metrics, Anyika and Jones share their data with different organizational entities.

“In my facility, the quality ROI reports are looked at by the HIM director, the deputy physician in chief, and the finance department,” says Anyika.

Jones adds that, depending on whom you’re sharing the data with, you may need to customize the reports accordingly. Not every group or individual wants (or needs) to see every data point.

“A few people lay eyeballs on it, and so the information in the report will change depending on who is looking at it,” she says. “We have a CDI steering committee that has representation from all leadership, and they’re getting the highest level of overview of that information. Then, at that point, it gets tailored down a bit more depending on the audience. If I’m reporting it to just my leaders, it would contain the information that they’re focusing on or the metrics they want to see.”

**Leveraging quality for physician engagement**

While it may not have a concrete financial ROI attached to it, one of the hallmarks of quality review success is improved physician engagement, which will ultimately help all aspects of CDI work, Jones says.

“Every year for the past three years, we meet with each service line and show them their individual quality ranking and how we think they have improved their documentation, but also how they can improve their expected mortality and severity rankings,” she says. “That has been a total game changer.”

Now, when Jones approaches the department chairs and service line chiefs, they immediately want to know what they can do to improve their mortality rates. Their enthusiasm ultimately works its way down to the other physicians in the department.

“It’s really been a top-down approach with engagement rather than going to them individually,” she says. “The level of engagement has drastically improved.”

Conversely, while improved physician engagement indicates that CDI efforts related to quality reviews may be working well, a dip in quality-associated metrics may indicate the CDI team needs to offer additional physician education, Anyika says. While some education opportunities are unique to the physician in question, leaders should monitor their metric performance for regular, predictable changes that could offer context around any decline.

“We are a teaching hospital, so we find that the metrics might drop when there is an influx of new residents, fellows, nurse practitioners, and physician assistants. As documentation improves, those metrics get better,” she says.

Monitoring metrics by service line may also offer avenues for focused education, Anyika says. For example, when she noticed that a specific service line’s physicians had longer LOS and mortality indexes, Anyika did a focused audit of their charts. Her audit revealed that some of the physicians were not documenting the patients’ associated conditions, such as malnutrition and pancytopenia—these would have improved the LOS and mortality indexes. As a result of these findings, she was able to offer focused education to that service line and later reported better results.

“We’ve found that [quality reviews have] helped us open doors for provider engagement,” says Jones. “When you’re approaching them from the aspect of quality and how it will affect their quality scores, they respond much better to that than trying to get them engaged for reimbursement purposes.”
Driving meaningful improvement for healthcare quality scores

by Allen Frady, RN, BSN, CCS, CRC, CCDS

Over the last eight years, small pockets of the healthcare industry have been adapting an organizational culture that had its origins in mission-critical endeavors. These efforts mostly surround things such as clinical care processes and patient safety failures—and rightly so as the stakes are high in these areas. As the effectiveness of these strategies is proven, these organizational culture traits may start to spill over into operational areas that are less “life and death,” but still mission critical.

I have no doubt that hospital operations outside of direct clinical processes may see great benefit from these same cultural shifts and workflow reallocations, derived from the five traits of high reliability. According to the Agency for Healthcare Research and Quality, these five traits are:

1. Preoccupation with failure
2. Reluctance to simplify
3. Sensitivity to operations
4. Deferece to expertise
5. Commitment to resilience

What better place to start that transition than in the arena of hospital quality assurance and tracking? In my column, I’ll explore how these concepts could be put to use in transforming and right-sizing the denominator in your observed to expected (O:E) ratio for quality outcomes, which is an inevitable next step from the ongoing application to the numerator. Documentation and programs designed to improve documentation need to embrace forward-thinking change: moving away from oversimplified process modifications to top-down cultural and operational change.

Today, many chief medical officers and chief medical information officers are focusing on improving CMS star ratings. As a byproduct of this trend, providers are changing their perception and use of CDI programs. The traditional mandate of a CDI department is to “improve the documentation.” Can a CDI program accomplish other tasks that bring value to an organization? The question we as CDI specialists are often presented with is how we might better utilize and repurpose the expertise housed in the CDI department for new projects.

CMS star rating calculations

Before we explore process and change management, let’s talk about CMS star ratings. CMS uses its Five-Star Quality Rating System to measure the experiences Medicare beneficiaries have with their health plan and healthcare system. Health plans are rated on a scale of one to five stars, with five being the highest. These ratings are then published on the Medicare Plan Finder. As of 2019, the CMS star ratings are calculated by first selecting the measures (the selection criteria are applied quarterly). The second step is grouping the measures, which is similar to the Hospital Value-Based Purchasing model and the existing display on the Hospital Compare website. Measures fall into the following groups:

- Mortality
- Safety of care
- Readmissions
- Patient experience
- Effectiveness of care
- Timeliness of care
- Efficient use of imaging

The third step is to calculate the group score using a latent variable model for each group. After the individual group scores are calculated, a summary score gets generated (called the “hospital summary score”). This
summary score is a policy-based weighted average of available hospital group scores.

The next step is applying the reporting threshold (the hospital must report three measures in at least three measure groups and one outcome group) before finally calculating the star ratings.

For more information about star ratings and the process by which they are calculated, visit the CMS website.

**CDI department challenges**

The current approach to quality, coding, and CDI involves inconsistent methodologies, definitions, and predictability. Existing methods and vendors all use different criteria specification files, applied at different time intervals with different scoring systems.

Traditional CDI work has mostly focused on optimizing the risk of mortality (ROM) within the 3M software. This makes sense because the CDI team and coders can view the scoring directly within their 3M encoder. Many, if not most facilities employ a closed loop where fatalities that are scored at a ROM of less than 4 receive a secondary review to make sure no reportable risk factors were omitted. If the ROM score assigned by 3M is a 4, then the coding and CDI departments submit the claims for final billing and move on.

Unfortunately, focusing on 3M’s ROM alone does not translate well into improved quality scores for other metrics and will not translate well into improved CMS star ratings. Even when facilities use a proxy that closely resembles the CMS systems, they may find significant discrepancies. You can have a low ROM score with a high CMS mortality index, or vice versa.

Several factors impact this situation, such as inadequate addressing present on admission status and/or delaying a status change to hospice care until deep into the post-admission time period. The most common problems industrywide are:

- **Present on admission status**: Abrupt changes in patient status often result in uncounted risk adjustment diagnoses that trigger a ROM of 4 in 3M.

- **Missed conditions**: Conditions that are suspected but not worked up or treated result in the absence of risk-adjusting conditions in the denominator, despite the fact they are likely present in the patient.

- **Lack of specificity**: Conditions that are reported using outdated language don’t provide risk adjustment inherent to the patient’s true status.

- **Inconsistent documentation**: Conditions noted in the discharge summary or progress notes may be omitted in the ICD-10 codes when there is confusing or contradictory documentation among providers or when the summary isn’t reviewed.

- **Sepsis cohort**: Aggressive sepsis query activity may inadvertently shift some patients into the sepsis mortality cohort unnecessarily (i.e., when the findings attributed to sepsis are easily explained by an already named process).

- **Atypical condition capture**: Conditions not normally associated with traditional inpatient severity metrics may not be captured, failing to adjust the denominator.

- **Resolved conditions**: Conditions that resolve in the ED or shortly thereafter and/or are not mentioned elsewhere in the record may go unreported and fail to adjust the denominator.

**Importance for the organization**

CMS quality scores are now driving two major performance impactors.

1. Patient traffic into your facility or system
2. CMS pay–for–performance value incentive payments

Allen Frady, RN, BSN, CCS, CRC, CCDS
Using the CMS Compare sites, patients can look up your facility and benchmark it against alternative facilities in the area. Depending on their payer network, they may make their final provider choice based on these scores. This consumer-driven healthcare market is rapidly transitioning toward transparency, and these market selection forces are only going to grow with time.

A survey of the problems makes one thing painfully clear: Star ratings cannot be fixed by looking at coding accuracy or documentation patterns in a vacuum. Ad-hoc, quick-fix solutions within your EHR will net modest gains at best. Trying to nail down a simple solution rapidly in a vacuum will hinder you, rather than help you, in achieving beneficial quality scores.

To improve quality scores, a complex top-down management strategy must be employed in order to prevent continuous quality failures at every step in the process. For this, we will examine some of the behaviors associated with highly reliable systems and extrapolate those behaviors that apply to coding and CDI work. You can employ several principles of high reliability, not just in your clinical processes of care and patient hospitality, but also in the processes driving the denominators to the right size of the O:E ratios for accurate scoring.

Provider education

To start with, physician leaders need to be at the table and help lead the charge to facilitate physician buy-in. These should be respected by practicing doctors who work on or lead the frontline care delivery.

Meaningful data should drive behavior, and CDI efforts are well served when they align physician goals to the larger facility goals and ask how the efforts translate to better care delivery.

First, you must decide which quality measures matter, determine their specifications and definitions, and provide the logic for the measures selected. Next, subdivide the information into data that we can do something about and data we have no control over. For example, we can’t impact a patient’s age, income, healthcare accessibility, sex, race, or transfer origin location.

As soon as they’re identified, eliminate as many documentation or care delivery “workarounds” as possible. All barriers to clear clinical processes and effective risk factor capture need to be brought up by the frontline staff, and solutions should be developed in partnership with the CDI, coding, and quality teams. Foster a culture of safety and encourage frontline workers to bring problems to the table, rather than constantly working around issues and operating in shades of gray.

Multiple staff creating workarounds within the EHR or simply making whatever selections are fastest will only multiply your failure points. Root cause analysis and ongoing process improvement will also be nearly impossible.

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

Multiple staff creating workarounds within the EHR or simply making whatever selections are fastest will only multiply your failure points. Root cause analysis and ongoing process improvement will also be nearly impossible.

When it comes to provider education, first further define the key clinical elements that should receive attention for the metrics that have been selected. Ask yourself:

- What exact diagnoses are we addressing?
- What risk factors are more pertinent?
- What do the standards indicate as best practice?
- How should we document variances when we disagree with or fail to meet those goals?

Make sure to deliver the data to the correct physicians who are driving clinical processes of care, documentation, and risk factor capture. In today’s landscape, the attribution may be more about a team of providers rather than a single provider. To gain traction, we will often need to address this as a team responsibility. Instead of looking at individual providers, analyze what went wrong as a team and then discuss the solution as a team. This leads to accountability for all providers. Everyone’s processes and outcomes need to be held to the same standard of accountability.
Addressing physician behavior requires full transparency and honesty. Make sure to deliver feedback in a timely manner—it’s more productive to talk about what happened last week than about what happened a year ago. Bring the full process into focus—the good, the bad, and the ugly alike.

The CDI lead in combination with the frontline staff must drive continuous real-time problem solving, perfecting the standardization and performing root cause analysis of failures on a continuous basis. As the program matures, continue to ask the following questions:

- What is working well?
- What is not working well?
- Why are things not working well?
- What needs to be done to fix it?

**CDI/coding managers**

The CDI and coding manager will need complete buy-in and understanding to become subject matter experts and understand what is working and what is not working.

First, use standardized metrics for right-sizing the O:E denominators and determine which diagnoses have real impact and under what circumstances. Second, develop policies and procedures for reviews and queries of an expanded list of existing risk factors. The direct manager/lead coder should provide real-time education to staff performing the work and establish a reporting structure and dashboarding procedures.

During the course of education, CDI specialists and coders need to learn:

- Who executes change?
- Who gets educated?
- Who has the accountability?
- Why are we doing this?
- How are we doing this?
- How will we track and follow up to sustain performance post roll out?

Anticipate things going wrong with the process or within the data. Develop a plan for further review procedures and root cause analysis, and establish escalation policies to the lead coder and to the physician advisor(s).

**Administration**

Up to 80% of team leads’ or first-line managers’ time should be devoted to coaching, educating, reviewing, and problem-solving the program rather than attending meetings all day. There should be a higher level of specificity about the role of coding and CDI in relation to these quality metrics, both on the front line and at the middle management level. Make sure the correct peer-to-peer discussions, staffing ratios, and education are happening.

Before oversimplifying and rapidly putting solutions into place, first understand the root cause, the frequency, the impacts, and the workability of the solutions. Avoid trying to piecemeal your way to a five-star rating. Defer to the subject matter experts. Listen to and act upon the information the experts and frontline staff offer as they have the best insight into why problems are occurring.

When issues arise, make sure you have a proper escalation plan in place. Interlocking accountability is necessary so that breakdowns anywhere in the system can get escalated. Here’s an example of where various issues may go:

- Unclear documentation goes to a physician advisor
- Poor coding goes to the coding educator or lead
- Poorly written or missed queries go to the CDI manager
- Lack of staffing to accomplish the goal goes to administration

Make sure all points of failure are ultimately receiving evaluation, escalation, and execution by leadership. Most importantly, make a commitment to move away from a fragmented approach to quality consisting of intermittent and poorly monitored one-off projects.
CMS

According to CMS, a new star rating methodology is on the way that will simplify the calculations and create increased transparency. Under the new methodology, CMS will evaluate five measures (as opposed to seven currently):

- Mortality
- Safety of care
- Readmissions
- Patient experience
- Timely and effective care

This is a move to a simple average methodology to calculate group scores instead of the statistical latent variable model currently employed. CMS will further standardize measure group scores so that they are comparable and more transparent between categories.

Once these changes take effect, hospitals will be required to report three measures from three groups. One of the reported groups must be either the mortality or safety of care group. Additionally, according to CMS, critical access hospitals and Veterans Administration (VA) hospitals will be included. (For more information on CDI in VA hospitals, read the article on p. X.)

Due to reporting and payer guidelines surrounding the inpatient and outpatient prospective payment systems, claims data may not always represent the true severity of the clinical data. This happens because claims reporting is still largely based on the work of the provider rather than the capturing of the patient's clinical profile. This may create discrepancies between the definitions of the quality department and those of the CDI and coding department. Don’t shy away from this. Instead, communicate and address issues with full transparency through education and revised policies and procedures.

Finally, mobilize your physician leadership and participate. Research the issues and write to CMS during the March and September comment periods on the proposed rules. Determine what makes sense and is working and, conversely, what fails clinical logic and/or is broken.

The discrepancy in reporting and coding guidance from various piecemeal CMS communication streams create easily identifiable contradictions in CMS’ instructions to facilities. This is something that we really need to pressure CMS to reconcile in the near future. 🌟

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Th hough the adoption of outpatient CDI has been growing steadily over the years, it’s not always easy to prove the return on investment (ROI) for such efforts. While there will likely be struggles such as gaining buy-in from the C-suite and providers, developing an appropriate documentation system, and proving the worth of the program, an outpatient CDI program brings many benefits to an organization. From implementation to maturation, outpatient CDI programs are well served to communicate these benefits to organizational leadership for continued support.

By Carolyn Riel

"We were pretty lucky that in our facility, leadership was already fully behind and pushing for the outpatient program," says Jennifer Boles, CPC, CRC, coding liaison and educator with Baptist Health in Louisville, Kentucky. “They really wanted to look into ambulatory and outpatient CDI, but just because we had that initial buy-in doesn’t mean getting things off the ground was easy.”

Baptist Health encountered “every hurdle that you can imagine” when first implementing their outpatient CDI program. “It was at first a struggle to gain leadership buy-in, not for implementing the outpatient program, but to see the need for focusing resources on reimbursement,” Boles says, as well as the added hurdle of getting providers to do one extra documentation step along the way.

“I had to work with and reeducate folks in compliance, the coders, and inform them of why they needed diagnosis codes and not just evaluation and management (E/M).” Boles says. “Payers would say, ‘We don’t care about E/M, but we need the diagnosis.’ It was really a lot of reeducating everyone.”

Amidst all the challenges, IT implementation proved the most difficult. “We didn’t have any kind of data or IT way to track anything;
everything was manual,” Boles says. Though there have been advances over the years, there aren’t many outpatient-focused vendor solutions on the market that suited Baptist’s needs, and most that did exist would have been far too expensive, Boles says. “If you put out 500,000 claims a month, you aren’t going to be able to afford a product that is paid by claim.”

In addition to the dearth of available solutions, Boles says she often found her IT requests pitted against the inpatient requests and vying for priority.

“Every new build you do in IT is a struggle because it competes with the inpatient side,” she says. “There’s that competition of which is more important and who should get the resources to get it done.”

To overcome this competition, Boles suggests that CDI leaders avoid comparing the success of their outpatient program to that of their inpatient program; instead, focus on showing outpatient CDI’s importance as a separate entity.

“Start by getting that buy-in from leaders, then buy-in from providers, and then down to other departments as well,” she says. “Share your priority list of when you need to get things done, and even though it’s not easy, be patient to know when it’s your turn.”

As the program has matured, the Baptist team has focused on a number of metrics to prove their success. On a provider basis, Boles looks at service line chart review and diagnosis review goals per provider and tracks the Hierarchical Condition Category (HCC) capture rates.

Boles also tracks risk adjustment factor (RAF) scores from CMS year-to-year as a way of monitoring metrics. “The reason why we track provider documentation as well as RAF scores is because providers who submit a claim on the patient are impacting the patient’s RAF score,” says Boles. “The provider’s patient average RAF score may be low, but are actually doing really well with their documentation. The provider’s patient population might not be as sick [if the RAF is low and the documentation is correct]; it makes a difference.”

**Tracking financial success**

“There are lots of little nuances of struggles that you might face with proving the worth of your outpatient program,” Boles says. “For example, HCC capture falls into so many different categories of an organization and it might already be counted towards another area of revenue. It’s really hard to cut out your chunk of an impact on an HCC.”

To help overcome the parsing issue, Boles suggests focusing on how outpatient CDI has impacted specific projects instead of only looking for the revenue-tied impacts of the program.

“If there is something specific to an HCC like a commercial payer project that pays for that HCC not being tied to another location, we can look at that and know exactly how much we contributed to that by closing out,” she says. “We also look at specific CPT® codes that work towards HCC codes, such as a wellness visit, and we can then say that because we focus on wellness visits, it’s an easy way to tie our efforts to that HCC—because you know if you raise the amount of annual wellness visits, that’s a direct impact from outpatient CDI.”

In addition to HCC capture and coding accuracy, Boles says the facility has seen marked success with their RAF scores over time as well, which is another important metric to prove your outpatient CDI program’s ROI.

“We saw an 11% increase in our RAF score since starting the outpatient program, and that was the largest success,” says Boles.

While it’s great to see those wins within the CDI department and report them to organizational leadership, Boles says the successes only continue coming if you share the progress with your providers.

“We’d go to the providers and say what our RAF score was in 2018 and how it’s increased to now,” says Boles. “They see that impact there and want to continue to improve it.”

**Tracking success beyond reimbursement**

While the financial ROI of an outpatient CDI program helps keep the lights on, Boles says the true point of success for a program is seeing providers begin to understand the importance of documentation. This payoff won’t come quickly—it’s taken three years at Baptist—but it’s well worth the wait, she says.
Since the program launched, Boles says they’ve been able to see the impact of physician buy-in on their metric performance. For example, providers from the primary care service line have been receiving RAF scores 20%–30% higher as a group year-over-year in addition to the 11% increase in payer RAF scores.

“You really need to make sure people understand what you are doing and what tools you’re building to help them,” says Boles. “Make sure they know why it’s important and make sure you have tactics and a plan.”

To gain this all-important buy-in, Boles suggests meeting with all possible stakeholders to share the importance and impact of outpatient CDI. While this may involve scheduling meetings yourself, leaders should be open to attending meetings as well to be the outpatient CDI voice at the table. For organizations with both inpatient and outpatient CDI teams, make sure both teams have a presence at departmental meetings.

For example, Boles attended a quality meeting a few years ago focused on heart failure. There was a committee formed on the hospital side to better document heart failure cases, and all the inpatient CDI specialists were involved, “but no one had thought of the outpatient and ambulatory effect on that,” Boles says. Without the outpatient component, however, the documentation could be incomplete, and it could lead to negative impacts on mortality measures, Boles says.

“You have to capture that information 90 days before or 30 days after discharge, and if you don’t have that ambulatory data or know that’s a requirement, then all of that valuable data disappears or doesn’t count for what it should. Things will be missing that could help close out mortality measurements,” she says.

Ultimately, painting a picture of outpatient CDI success isn’t just about proving a financial ROI; it’s about painting the full picture of a patient’s health, and that includes their outpatient visits.

“We have to capture everything the entire time they’re being cared for,” says Boles. “Outpatient helps show the before and after, not just when they hit the hospital doors.”

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**OVERCOMING COVID-19-RELATED CHALLENGES**

In addition to the run-of-the-mill struggles outpatient CDI departments face, the COVID-19 pandemic has brought a whole new set of difficulties. For example, HCCs can only be captured during face-to-face visits or telehealth visits that include both audio and video. “There are some people who don’t have the ability to do video,” Boles says.

With the increased prevalence of telehealth visits, the Baptist team knew they’d need to find a solution to ensure the HCCs were captured and reported properly. With the help of their IT department, they were able to build encounter types in their EHR system to note whether the telehealth visit included video.

The fix didn’t stop with the IT update, though. According to Boles, any updates need to include a physician education component to truly make a difference.

“We’re doing a lot of payer reviews right now, so I’ll look at a chart and say, ‘Oh, we captured the diagnosis code,’ but then see that it was just a telephone visit, so the code doesn’t count,” she says. “We’ve had to do a lot of education to make sure that the providers know this HCC capture rule.”

While the update and education grew out of a challenge, it’s ultimately helped improve the overall HCC performance for the organization.

“We’ve actually had more outpatient encounters this year and captured more HCCs because of this education; the visits have just been in a different setting,” Boles says.
GUEST COLUMN

CDI the VA way

by Merle Zuel, RN, CCDS, and Tammy Heffner, BSN, RN, CCRN, CCDS

According to the VA website, the Veterans Administration (VA) provides care at 1,255 healthcare facilities, including 170 VA medical centers and 1,074 outpatient sites of varying complexity, serving more than 9 million enrolled veterans. This makes the VA the largest integrated healthcare system in the United States, yet the role of CDI in the VA context is rapidly evolving and developing. It’s an exciting time to be a CDI professional.

Over the past year, things have been rapidly improving as more nurses have joined the VA in a CDI advisor role. Development and rapid expansion of the CDI program within the VA healthcare system has led to a significant number of open CDI positions across the country.

The VA is making leaps and bounds with their efforts to catch up to the private sector’s sophisticated approach to CDI while doing things “The VA Way.” The VA’s Cerner EHR modernization project is happening in phases and the technology is improving, yet many of the VA’s open CDI positions remain unfilled. The answer may be as simple as the unique structure and roles laid out by the VA CDI program guide.

The role of the CDI RN advisor in the VA is much like that of a physician advisor/physician champion in the private sector, with a proactive collaborative approach to physician engagement and education. The pool of qualified candidates is greatly reduced by restricting the role of the RN to that of an advisor, rather than the traditional CDI specialist role. Ongoing education, clinical collaboration, and analysis of documentation impact all fall to the CDI RN advisor. While this may seem unconventional or counterintuitive, it offers an excellent division of labor in the VA setting.

The CDI RN advisor is used in a clinical collaborative role with providers. The CDI guide created by the national VA HIMs office does not allow the RN advisor to send queries, which can be a frustrating adjustment for CDI professionals with RN backgrounds coming from other private sector healthcare organizations. New CDI RN advisors coming to the VA with previous CDI specialist experience will have to adjust their expectations for their role.

At the VA, the HIM/coding team or the CDI specialist owns the task of sending queries. Educating providers regarding how the written record will be interpreted and coded shapes how the final record appears and helps close gaps in documentation prior to coding. The work of the CDI RN advisor is more akin to query prevention with the clinical goal of creating an accurate, specific record of care.

With our current EHR system, when our providers document, there is no convenient dropdown menu or prompt and click system that automatically adds information. The use of abbreviations, shorthand, and copy and paste serve to erode the diagnostic specificity and severity of illness. The RN CDI advisor has the responsibility of discussing the semantics of manual diagnosis documentation and the need for specificity. The RN functions in a clinical collaborative manner with the provider to ensure accuracy and to assist with knowledge of ICD-10-CM requirements for specificity. The RN is
not responsible for querying or coding the record. This is the key to achieving sustainable results in an electronic EHR system that requires the provider to write out each diagnosis.

Most providers receive little to no education about the specificity requirements in ICD-10 CM, but they are very amenable to collaborating on the accuracy of the final record. The CDI RN advisor role can be described as proactive clinical validation. If the CDI RN advisor sees a condition that is clearly supported by the clinical indicators but not specified to the level of detail needed for accurate coding, they can address it in real time, clinician to clinician, and get the record clarified.

The clinical manifestations and indicators of various diagnoses are the same no matter the setting or health-care system. If every CDI professional aims to create an accurate record, the quality metrics and revenue will also be accurate. That should be the guiding principle.

**Service-related conditions, coding nuances**

Unlike private sector healthcare organizations, the VA also sees service-related connections to medical conditions. Veterans are assigned to priority groups based on several factors such as length and time of service, combat duty, known exposures and trauma, rated disability levels, and service-connected disability. Treatment of service-connected conditions is typically covered, but many veterans have a significant number of comorbidities that are not expressly service-connected. In these cases, third-party bills are generated if the veteran has insurance, and the same standards that apply to the private sector apply to the VA.

Recovery auditors try to work their magic on all claims, and if the documentation does not support treatment for a diagnosis, they will deny the claim. Many veterans have copayment obligations for their care, and they will be obligated to pay those copayments in the event the insurance denies the claim. In an ideal world, it should not be the patient’s responsibility to pay the bill if a claim is denied due to the health system’s poor documentation practices.

The VA also has specific subsets of acronyms and coding quirks, including their own coding guidelines. There is also a unique funding structure, Veterans Equitable Resource Allocation (VERA), that is only found in the VA. It is the only health system in the United States that is funded partially by congressional appropriations. Quality measures are analyzed using the Strategic Analytics for Improvement and Learning (SAIL) reporting, which mirrors CMS’ framework with even more emphasis on mental health and social determinants of health.

In fact, the VA is quite progressive when it comes to providing a continuum of whole-health education and treatments.

It is an honor and privilege to collaborate across our healthcare system as we strive to ensure the data integrity of the care we provide to veterans. The only real way to learn the system—"The VA Way"—is by joining the team.

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Analyst roles highlight the value of CDI

By Carolyn Riel

As the CDI profession has grown, so has the diversity of job titles represented in the profession. Like many industries, with maturation comes specialization. CDI analyst positions (sometimes called informaticists or systems specialists) are one such role that has arisen thanks to the ever-increasing need for data analytics and metric monitoring. These professionals don’t conduct traditional record reviews, but instead focus purely on CDI and coding data and how it relates to the overall picture of the organization. In general, CDI analysts’ primary roles fall into two main categories:

- Data analytics and presentation
- Technology and systems support

“I think analyst positions look much different than your traditional CDI specialist, and having people in those roles is really changing the focus of CDI,” says Robin Jones, RN, BSN, MHA/Ed, CCDS, regional director of CDI in the West Florida division of AdventHealth in Tampa, Florida. “CDI used to be so much about nickels and dimes, but now it’s about quality metrics, so it’s much more in depth than it used to be, and people in these analyst roles really show that value of CDI.”

Analytics and tech support

One thing CDI analysts agree upon is that their role does not have a tidy “average day” agenda; everything depends on the needs of the department.

“Today I started with reviewing quarterly provider notes to make sure they are meeting what our policies and procedures say that they should,” says Phyllis Stevenson, MSN, RN, CCDS, CDI informaticist at Allen Hospital in Waterloo, Iowa. “Other days if there are updates either for the computer, an application, or updates for Epic, I have to disseminate that information out, and I also find out what is changing through our Epic Change Review.”

Stevenson also acts as the “device person” and takes calls from physicians if they are having issues with their documentation because she knows the nuances
of what needs to be done for their workflow and to reduce “note bloat.”

In some cases, the analyst’s two primary responsibilities—data analysis and technology support—change based on the time of month or year, says Beth Simms, BSN, RN, CCDS, CDI systems specialist at Banner Health in Phoenix, Arizona. For example, the end of the month, quarter, or year is prime time for data reporting, and the information technology (IT) side of things may fall to the wayside till those reports are completed.

“It depends on the time of year; maybe I’ll be working on end-of-month reports or quarterly reports,” Simms says. “Other days I could be working with vendors if there’s an update coming, or I could be working on a special report request from the organization stakeholders. […] If there are any IT changes that have happened, I have to go in and make sure that the workflow is all updated.”

Once she’s reviewed any changes in the EHR or other software system, Simms then assesses the impact it may have on the organization’s business and works with the vendors and internal IT department to ensure the changes take effect smoothly.

“We kept finding new places for her to provide support,” says Jessica Risner, BSN, RN, CCDS, CDI director and Simms’ supervisor at Banner Health. “CDI really is a technology and data-based department. For a CDI department and/or staff to thrive, they must have technological literacy. Beth’s role ensures we keep oversight and understanding of our applications and data.”

According to Simms, she’s found that the two pieces of her role are increasingly intertwined.

 “[I’ve noticed that I needed] to find the additional programs and resources out there that really showed us what we didn’t know or areas of our data we weren’t tapping into,” she says. “It’s really changed focus to being able to get the full scope of where all the data goes and where it comes from.”

On the data side of things, one of the major benefits Simms brings to the team as the designated analyst is the ability to take a deep, time-consuming dive into metrics to identify patterns and areas for improvement. While a CDI supervisor, manager, or director may be pulled in several directions, analysts can offer a focused look at the department’s metrics and pass along relevant findings to the key decision-makers.

“We have so many [50] data points, and we take the stakeholders’ requests for specific data into consideration,” says Risner. “A lot of our KPI [key performance indicator] data is tailored to a specific audience. The revenue cycle departments heads want to see a higher-level overview, where the quality director might want more detailed information like how many reviews were done and which were a PSI 11.”

While Simms does a lot of the analytics work, Banner Health also has an independent analytics department with one person specifically assigned to CDI. “The gentleman from the analytics department will pull the data for us each month into spreadsheets, and then
You can’t just jump to the end of the story. Notes should start the moment the patient is seen [in an outpatient setting], not ahead of time because the clinic is busy and they’re trying to get a head start on their documentation, because then something might be missed during the exam. The note needs to be the entire story, from start to finish.

When monitoring physician documentation, Stevenson says you will find which clinicians are doing a “fabulous job” with painting the entire picture of the patient, and which clinicians are submitting notes that are not up to par. Stevenson’s findings go straight to the medical staff office and then get passed along to the review board.

“It really lets the facility keep an eye on those physicians who seem to be problematic with delivering an appropriate note. We aren’t just checking to make sure they’re appropriate diagnostically, but appropriate with the full note,” she says. “Monitoring this documentation allows us to see which physicians might need a little more help with this.”

Jones agrees that the data analysis work often leads to physician education opportunities. If the analyst sees something “off” in the data, they have the opportunity to dig deeper and uncover the real issues.

“Let’s say in January we pull a report and see that the pneumonia DRGs are 12% less than the previous month,” she says. “We know that November through April is the height of pneumonia, sepsis, and flu time of year, so that number should not be down. My first reaction is to look for inside reasons as to why that might have dropped—for example, if in January we added five new people to the facility.”

When a discrepancy such as low pneumonia rates arises, the
analyst pulls data for all the charts with that diagnosis for the relevant time period to see if there are any patterns, and if the underlying reason for a data change is because of new faculty. Sometimes the analysis may even illuminate additional education or query opportunities.

“We really try to look at something and recognize if it isn’t right, then troubleshoot out from there,” Jones says.

**Staff onboarding**

While data and technology may be the centerpiece of most analysts’ work, many also play a role in staff onboarding, according to Risner.

“[Simms] also helps a lot with onboarding,” she says. “She works with our IT equipment team to ensure equipment bundles are ordered, shipped, and delivered to our new hires. She also has a huge role in their orientation and teaching them the lay of the land.”

When a new staff member starts at Banner Health, Simms is the one to show them how their Microsoft Outlook® and Teams® systems work to communicate with their coworkers, how to set up the EHR and coding software, and how to navigate the facility’s intranet site.

“So much of CDI relies on technology now, so having those skills to be proficient with it is a necessity, and you need someone to teach the staff how to do it,” says Risner.

Risner says that Simms’ role in training staff to use technology well has made a noticeable impact on their department. “Some of them didn’t even know how to put up an ‘out of office’ response in their email,” she says. “[Simms’] role really helps bridge the gap with technology and gives them the confidence with using the software.”

**Role evolution**

As CDI continues to expand its footprint, it’s likely the role of an analyst will become even more central to a successful program. Without the data backing new endeavors, it’s impossible to know where to focus resources for the biggest impact.

“We never really stop looking at any data point or monitoring anything, only add new ones,” Risner says. “We’ve started really looking at quality metrics, like expected mortality numbers and how we can support those through queries. It may not seem at the beginning of monitoring that there’s an impact being made, but when we get the quarterly quality reports you can see those changes.”

CDI analyst roles have also evolved when it comes to the way they interact with the data they pull. Instead of simply generating reports and passing them along to CDI leaders for interpretation, Jones says that many analysts are now expected to do that interpretation themselves and explain what the data means for the department and the organization.

“CDI analysts on all different levels are now constantly being called to prove the worth of their organizations,” Jones says. “CDI used to be this little corner shop of the hospital that people only knew because they got lots of money. CDI isn’t like that anymore; they’re on the floor going to multidisciplinary rounds, interacting with everyone on the healthcare team from nurses and doctors to dietitians.”

With continued expansion, the analyst’s roles will continue to intersect with other departments, meaning those filling these roles need to be comfortable interacting with their colleagues across departmental lines.

“Sometimes we own a lot of data, but we aren’t the owner of all the data,” Risner says. “An analyst needs that good relationship with the quality department so they can share what they are seeing, and the analyst can bring that back to CDI. Or the same thing can be said about the denials department, because CDI influenced denials trends, so you need that relationship to understand how your team influenced those metrics.”

“Analysts have to be able to tie these things all together and have to analyze the data, not just for CDI but for wound care,” adds Jones. “They have to analyze all of this information and stop whatever the problem is. […] If you don’t have an analyst and someone who can pull data together so that you can

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Phyllis Stevenson, MSN, RN, CCDS

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troubleshoot any issues, you’re putting your organization at risk for not being shown in the light that it should be.”

At the end of the day, the future of CDI could move in a variety of directions—from deeper quality reviews, to denials management, to outpatient expansion, and more—so CDI analysts need to be prepared for the unknown and ready to jump in with both feet, Stevenson says.

“We have something in our mind of what we’re going to be doing, but that’s not all we do,” she says. “There are so many parts and pieces to it, so make sure you’re ready to work with the team and brainstorm.”

**COVID-19 AND ANALYTICS**

As it did with every aspect of CDI work, the COVID-19 pandemic changed the way CDI analysts worked and what they needed to monitor. On a dime, many CDI analysts found themselves tasked with monitoring documentation metrics specific to COVID-19.

For example, “we had to make sure we were ordering COVID tests prior to the patients being admitted, making sure there was PPE [personal protective equipment], and changes to our Epic program for a COVID banner on the storyboard so we knew who was positive and who wasn’t,” says Stevenson.

Additionally, on the outpatient side of things, the pandemic accelerated the expansion into telehealth services for Allen Hospital, Stevenson says, which made the technology piece of her role even more important.

“This really changed the way we did things because we had doctors who were still working but couldn’t do surgeries, so that affected our metrics. And learning telehealth systems was really new for us; we had to do so much work with technology and devices,” she says.

Beyond the internal technology needs, Stevenson says the analysts found themselves suddenly working in patient-facing technology support roles.

“We even started using Zoom® for a bit. It was a way to help patients see their loved ones when they were in the hospitals,” Stevenson says. “I remember the first time we got it set up, it was heart wrenching. The person who was there was so ill, they didn’t know if he would make it or not, so we had to set up three separate Zoom calls for him on a device so his family could talk with him before anything happened.”

Thankfully, in that case, the patient rallied and recovered with a long line of hospital staff lining the hallways and cheering for him, because he got to go home.

At Brigham & Women’s, the change was inevitable simply because of the volume of COVID-19 patients compared to other admissions. “Over 50% of our charts are COVID patients, so that’s really changed the way our CDI staff and analysts work,” Jones says.

Now, the analysts look at those who died from the coronavirus, noticing any comorbidities, and really pay attention to the medical baggage people bring to the hospital that makes them more susceptible, Jones says.

“For me, it’s made us more cognizant of the different aspects COVID throws at us,” she says. “It made us change our level of reviews when you get these patients that are here for three days and are looking better, then after five days will deteriorate.”

Figuring out what needed to be documented in these charts was a learning curve, Jones says. “If you aren’t getting the DRG and comorbidities right, it’ll show on your reports,” she says. “When COVID first hit, our quality metrics weren’t good because we were not documenting correctly, but we’ve seen now through communicating with physicians and educating them that there has been a huge improvement in our metrics.”
Visit the ACDIS website to find out what events are coming up in your area!
Productivity metric success: Be flexible, communicate openly

by Linnea Archibald

Productivity expectations are a tricky topic, often talked about in nonspecific terms that leave those trying to set benchmarks for their department lost in the mist. While productivity metric expectations should be based on departmental and organizational considerations, these metrics are still important for leaders to track so they can ensure staff members are meeting goals and identify areas that might need improvement.

While previous ACDIS surveys have yet to illuminate a standard number of record reviews that will work for every department in every circumstance, there are several considerations and practices leaders can leverage to set realistic goals.

Account for nontraditional work

One of the biggest factors in setting and reaching productivity expectations is the number of “extracurricular” projects CDI staff members have on their plates. The CDI footprint has expanded over the years to include more complex review types, many of which take more time than traditional CC/MCC capture.

“When I first started [with my organization] six years ago, I started as a member on the CDI team, and we were pretty much looking for CC/MCCs and would write a severity query here or there,” says Deb Jones, MSN, RN, CCDS, director of CDI at Brigham and Women’s Hospital in Boston. “Over time, that has changed. Now, the CDI specialists are looking at the principal diagnosis, CC/MCCs,
SOI/ROM, clinical validation, and Vizient and Elixhauser indicators. It’s a lot more work than what they were doing a few years back.”

By nature, each of those in-depth reviews often take substantially longer than a “traditional” CC/MCC capture review. This means that as CDI staff take on more complex reviews, it’s likely their number of charts per day will dip. Leaders, in turn, may need to adjust their expectations and/or increase staffing to accommodate the added workload while still reaching all the charts that need reviews.

Of course, anyone working in the CDI world can attest that the job is rarely eight hours a day of straight chart reviews. Many CDI professionals also spend time providing physician education—either formally or informally on an as-needed basis—or tackling other types of reviews such as mortality or second-level pre-bill reviews. These tasks will likely eat into their day-to-day chart review productivity.

According to Rhoda Galang, RHIA, CDIP, systemwide CDI corporate manager with Scripps Health in San Diego, California, it’s important to track CDI specialists’ additional tasks to understand where their time is going each day. Galang’s team tracks their extra duties in their productivity database spreadsheet alongside their chart review productivity, which means she can look at it at any time and see what’s going on.

“I see their comments on the productivity database. I do trend them. If there’s someone who’s consistently under 10 reviews per day, there needs to be some reason recorded on the productivity database,” she says. “It could be education, meetings, system issues. I should have enough reasons before I sit down with them to understand and help them in whatever fashion they might need help.”

The CDI team at Essentia Health in Duluth, Minnesota, also keeps track of their additional duties, according to Tracy Boldt, RN, BSN, CCDS, CDIP, manager of CDI at Essentia Health.

“We keep track of all the other responsibilities they have to do on a separate spreadsheet, and they’re expected to do educational activities,” Boldt says. “Each staff member keeps track of their hours every day and make notes about what they were doing. Instead of me micromanaging, I can just look at the team tracking tool.”

While these extra activities may dip into staff members’ chart review productivity numbers from time to time, Jones says these same activities are what keep staff members engaged in their work. Rather than doing straight reviews all day, other duties such as education or special projects offer variety and professional satisfaction to staff members. To account for the busy workloads, Jones suggests putting “administrative” tasks into staff’s expectations from the beginning and carving out time to accomplish non-chart review tasks. This way, staff members don’t have to feel guilty or pressured for spending time on these pursuits.

“Pretty much everyone on the team has some other project that they’re working on. I think that’s important too: They’re not just staring at a screen for eight hours reviewing cases,” she says. “Every five weeks, they get an administrative day where they can use it to clean up any cases that are hanging out on their list, any committee work, etc.”

Investigate technology

Technological solutions can be useful to improve productivity metrics, helping prioritize work queues and even taking care of some of the “low-hanging fruit” queries automatically, freeing up CDI specialists’ time for more complex review types and educational opportunities. However, a solution that does not suit your organization’s needs can be more trouble than it’s worth and ultimately hurt the CDI staff’s metric performance.

“The tool definitely matters,” Jones says. “It is such a can of worms, including at our organization, and it’s probably that way for everybody.”
One of the first things to look at when evaluating technology’s impact on CDI workflows is the number of systems required to accomplish CDI work, according to Shelby Humphreys, RHIA, CCDS, director of coding and CDI at Vidant Health in Greenville, North Carolina. After stepping into her role, she immediately looked into the department’s technology use and began to streamline.

“When I first had the opportunity to work with the CDI team at Vidant, I took an interest in current state workflows and began to work with the team to learn more and consider potential for efficiency gains where possible,” she says. “At any point, one CDI specialist during one review could be traveling through three to four solutions or workflows to get through one case.”

Now, the CDI team at Vidant is working toward a unified technological solution to ensure CDI’s work is streamlined and as efficient as possible. Plus, limiting the number of solutions in play lowers the learning curve for new specialists, who’d otherwise have to grapple with new technology on top of being completely green to the CDI world.

In fact, the ropes of CDI technology can be a big hurdle for new staff to clear. Galang says that, while her organization is implementing new CDI solutions, they welcomed new staff in the in-between time and have had to bring them up to speed using all-manual processes. This lack of technology can negatively impact productivity. “Our new CDI staff are dealing with a very manual process right now since we’re sunsetting the current CDI system,” she says. In addition, the manual process can lead to some degree of human error that causes data inconsistencies. For example, if the CDI specialist doesn’t select the right checkbox, it may say they haven’t reviewed any records. “I just ran a report, and it says there were zero reviews, but it was just that they didn’t check one box. So, now I have to trace back to see what they missed.”

Regardless of whether the staff member is new or experienced, or if the CDI solution is new to the organization or not, monitoring and addressing technological hiccups helps staff consistently meet their expectations and keeps them from getting frustrated, Boldt says.

“[Our auditor educator] makes sure they’re using their EHR and the CAC tool the most effectively. Sometimes it’s just that they used their tools inefficiently. Sometimes it’s as simple as saving some clicks.”

**Monitor, address shortfalls**

Regardless of the expectations, leaders need to monitor performance over time to identify any issues with individual staff members’ performance. According to Jones, it’s helpful to take a broad one-month viewpoint when assessing metric performance and then average it to a per-day number. Everyone has days where they won’t meet their minimum productivity numbers due to other responsibilities or technical difficulties, so taking the monthly average will provide a realistic number.

However, even a bad month, according to Jones, may not be indicative of underlying issues. Instead, trend over a longer period of time. For example, if you notice a staff member dipping below the minimum expectations, trend their performance over a couple months to see if the dip was an isolated incident. If the issue persists, take it to the staff member and address it on an individual basis.

“There have been instances where we’ve had to provide additional training or support, lower their productivity (usually down to four or so), and then slowly bring them back up to eight to 10 as their performance improves,” says Jones. “We encourage peer reviews, so if a CDI specialist has dropped down, we encourage them to find someone they can buddy with.”

Galang also monitors on a monthly basis, looking for trends in
the specialists’ data to identify any areas for improvement. If she does notice a dip, she can refer back to the tracking documents to see what could have been affecting productivity before going to the staff member to discuss their performance.

“If they dip lower than 10 reviews, we do monitor that,” she says. “Sometimes I understand why it’s less than 10. For example, maybe they ended up getting all the mortality reviews. There’s often a good reason why, and it’s always captured on their CDI database. They update it every day and then upload it so I can see the trends.”

Outside of reviewing the tracking documents, Humphreys recommends an informal sit-down with the underperforming staff member to discuss their workload and identify any areas where they may need help or education. At Vidant, the CDI manager handles these discussions on a monthly basis.

“Our CDI manager performs monthly audits and one-to-one reviews with each CDI specialist. It might just be to touch base, or it could be a focused determination of a developmental plan to improve their skill sets. She takes a different approach with each individual,” she says. “The one-on-one meeting is basically a fact-finding mission, and then from there, she can create a plan for the next few weeks to get back to the normal or improved levels.”

No matter what the spreadsheets or conversation reveals, it’s crucial to follow up to ensure the education or action has improved the staff member’s metrics, Boldt adds. The first productivity intervention should open the door to future conversations to ensure the problems are addressed successfully.

“If I notice someone’s not meeting their metrics, I’ll reach out to our CDI educator to seek information regarding the CDI specialist’s recent audit,” says Boldt. “Often times the staff are happy to meet with the educator to ensure they are doing well as well as provide tips and efficiencies for their daily work. We check back in Increments of three, six, and 12 months to ensure consistency and the team is meeting expectations.”

**Adjust expectations**

As new duties are added to CDI’s often overflowing plate and reviews get more and more complicated, CDI leaders need to consider adjusting their expectations to more realistic, achievable numbers. It’s also always helpful to have a range of expected reviews so that staff have some flexibility.

“We require eight to 10 new reviews per day,” Jones says. “We came to that number, and it has decreased over time. It was 10, but as the responsibilities increased, we’ve reduced that. We do find it’s closer to eight on average per day than 10.”

When expectations are too high, you may risk burning out staff members as well, Humphreys says. While productivity metrics are valuable to ensure the CDI department reviews the records they need to, they aren’t the end-all-be-all of CDI success. When they’re treated as such, it’s natural for even the best staff to feel discouraged, and they may end up leaving the department for greener pastures where they feel they can succeed.

“We had some folks who were discouraged in their roles and on paper we might have had some real concerns, but when you actually sat down and dug into their opportunities, they were doing well,” says Humphreys. “Now, we focus more on the quality of the CDI reviewer’s time spent reviewing, rather than the volume of reviews and queries. We want to make sure the queries are actually worthwhile.”

Expectations need to be adjusted for new or inexperienced staff members as well as those who’ve been with the department for a long time. Most CDI professionals say it takes at least six months to feel some level of comfort in a CDI role, so expecting those newbies to reach full productivity expectations too quickly sets them up for failure.

“Our new staff members aren’t expected to hit their production for a full year,” Boldt says. “If we have to implement with contract staffing while they get up and running to ensure the work is completed as expected, we will do it. […] There’s no reason to pressure them. You’ll lose your staff that way. Keep them, feed them, help them continue to grow.”
NOTE FROM THE ASSOCIATE EDITORIAL DIRECTOR

COVID-19 concerns continue to affect CDI efforts

by Melissa Varnavas

By the end of January 2021, the total number of deaths associated with the pandemic neared 450,000, according to John Hopkins Coronavirus tracker. That’s the official count. Most in healthcare understand that numerous patients, particularly in the early days of the disease’s spread, passed away due to complications from the virus or exacerbated preexisting conditions, and a lack of definition around documentation requirements related to the virus means potentially legions more COVID-19 deaths have gone uncounted.

Nearly half a million deaths over the course of the year. A grim milestone. News reports attempt to put such losses into context, telling viewers it means more people are dying each day from COVID-19 than the two leading causes of mortality, heart disease and cancer. The Journal of the American Medical Association, observed that the daily COVID-19 death toll was “equivalent to the September 11, 2001, attacks, which claimed 2,988 lives, occurring every 1.5 days.”

The enormity of our collective loss grows larger still when we consider the social and financial implications. Lockdowns led to business closures. Closures led to bankruptcies, unemployment, and food insecurity the likes of which the nation hasn’t seen since the Great Depression. That’s not hyperbole—it’s reality.

In the healthcare field, elective surgeries were canceled or postponed, limiting patient and staff exposure in an attempt to stop the spread of the disease. This, in turn, led to estimated financial losses of millions, according to a recent CDI Strategies article. Meanwhile, many organizations struggled to staff emergency departments and ICUs as the spread of the disease caused massive increases to hospital censuses.

CDI programs were affected too. And yet, numerous ACDIS surveys throughout 2020 illustrated not only COVID-19’s detrimental effects, but also the innovation, even the heroism of CDI staff. On February 11, ACDIS Director Brian Murphy along with CDI program directors at three organizations held a free webinar, “ACDIS Insights: The second surge impact of COVID-19 on CDI,” where they reviewed the results of a survey aimed at uncovering the effects of the most recent spike in cases.

According to the survey, nearly 70% of the 200-plus respondents said COVID-19 “somewhat” or “significantly” affected their organization’s surgical cases in the last two to three months (from November to January, essentially). Some 80% said their facility’s census increased during the same time frame.

When census numbers fell, many faced furloughs, reduced hours, or even layoffs. When COVID-19 cases increased, particularly in hard-hit areas of the country, some with clinical professional backgrounds were asked to return to nursing units to help care for patients or field calls for COVID-19 care from a panicked public.

Some 18% of respondents in the survey indicated their staff had been redeployed, another 18% indicated they’d been asked to take time off, and 11% had furloughs.

Thankfully, 35% indicated their department was conducting CDI business as usual. Only 7% indicated they’d had layoffs, and only 5% had pay reductions.

The biggest cost-cutting steps affecting CDI programs came in the form of trimming education, consulting, and other offerings, according to the survey.

The recently released 2020 CDI Salary Survey results illustrated similar trends, with less than 65% of the more than 1,000 respondents indicating they’d earned a raise within the last 12 months—a drop of more than 10% year-over-year (78.59% reported earning a raise in 2019 survey). In addition to the overall cuts, 57.08% of respondents reported working more than 40 hours per week in 2020, but only 8.54% reported receiving additional pay for that overtime work.
Reductions in other non-salary job perks were common in 2020, too, with respondents noting reductions in budgets for travel (35.65%), continuing education (28.70%), meals and entertainment (holiday parties, etc.) (28.70%), hours (24.30%), retirement plan matches (19.36%), and incentive bonus programs (15.22%). Of the 22.43% who answered “other,” a large portion reported temporary furloughs, layoffs, sick time cuts (an especially difficult benefit to lose during a pandemic), and being transferred from CDI efforts to direct patient care.

That’s what happened with Brianna Brown, BSN, RN-BC, CDI manager at Stormont Vail Health in Topeka, Kansas, and her team, according to the Salary Survey. Some staff had to redeploy to direct patient care, and Brown shifted the remaining team’s responsibilities to make up for the added work. Yet, by monitoring CDI metrics, she proved the program was an essential part of the organization’s fiscal integrity.

Those able to astutely monitor metrics seemed equally able to argue the case for CDI programs’ importance. At least one other positive outcome came for those looking to remote reviews as a work-life balance opportunity—an increasing trend for CDI specialists over the past few years due to electronic health record advancements. Remote capabilities have improved significantly over the past five years, as have security protocols and individual organizations’ capabilities related to at-home work policies and procedures.

In the spring of 2020, as the world awoke to the realities of the pandemic, only 14% of respondents to an ACDIS poll at the time indicated they were still working on-site. That fluctuated significantly throughout 2020 as some teams came back to the facility full time and others began to move to a part-time or permanent work-from-home solution for their teams. Now, according to the survey discussed on February 11, 15% plan to stay 100% remote, 12% plan to implement a hybrid on-site/remote staffing model, 16% plan to remain in a hybrid state, and 24% remain uncertain as to what the future holds. Only 3% indicated they were planning a 100% return to on-site CDI staff.

Despite the pandemic setbacks, CDI professionals had some positive news from the 2020 Salary Survey. The largest portion of survey respondents—20.04%—reported making $80,000–$89,999, up from 18.61% in 2019. Additionally, a greater percentage of respondents than in any other ACDIS salary survey reported earning $100,000 or more per year: 37%, up from 32.99% in 2019 and 28.15% in 2018. That’s a trend not necessarily seen in other professions, or even in other healthcare jobs.

Of course, the public health emergency lasted (and is lasting) much longer than many initially hoped. The future remains uncertain and perhaps more frightening than ever, with the vaccine rollout increasing across the country and people praying they’ll be next on the list to receive it.

Like so many in the healthcare industry, CDI professionals have served as heroes in continuing their daily record review efforts, an effort that remains crucial as the world attempts not only to get a handle on the pandemic but to understand COVID-19’s long-term effects. They’ve answered when called to serve further, redoubled their investment in their program’s core mission—the overall integrity of the medical record—and stood ready to defend that effort when necessary.

We’ve never been prouder of those working in the field, never been prouder of our CDI community, and never been prouder of the privilege of being able to serve it.

Editor’s note: Varnavas is the associate editorial director of ACDIS. Contact her at mvarnavas@acdis.org.
In one of my posts on the ACDIS Blog, I made an analogy of utilization management (UM) being like those relatives you never really talk about, the ones you have to invite to Thanksgiving dinner for Grandma’s sake but pray the airline tickets are too expensive for them to show up. Of course, that was written in April of last year, before we knew that this past Thanksgiving, and Christmas, and Chanukah, and Kwanzaa, and Diwali, Grandma wasn’t having anyone over for turkey and stuffing.

I could have been one of those people for whom the holiday invites are few and insincere. When I originally interviewed down here in Jacksonville, it was for a UM position. But there was also an option to help develop an adult CDI program as physician advisor, to supplement the continuing excellence of Douglas Campbell, MD, FAAP, MHA, on our pediatric side. And CDI is so much more fun than UM. The entire job of UM is like the instructions on a bottle of shampoo: Chart review. Meet criteria. Argue. Lather. Rinse. Repeat.

While the scope of work may differ, in many places there is at least an institutional relationship between CDI and UM. Here at Baptist, we’re in the same division within the revenue cycle. While we have separate physician advisors for CDI and UM, in other places the same clinician fulfills both roles. But regardless of shared advisors or shared departmental structures, UM and CDI workstreams still tend to stay in their own silos. Maybe that should change.

In this edition of the Research Corner, we’ll take a look at a project on the subject of CDI and UM collaboration. Then we’ll pivot and reflect a bit on self-care.

Collaborating with case management/UM: CDI review of observation patients to ensure proper status

Kerry Termaat, BSN, RN, supervisor of CDI at ProHealth Care in Waukesha, Wisconsin

Most of us know that the majority of work for the UM team lies in justifying patient status. Should the patient be admitted to observation or as an inpatient, and what specific factors about the case establish the need for inpatient care and prolonged lengths of stay? UM often uses preestablished lists of criteria associated with a diagnosis to designate appropriate patient status. A patient with pneumonia might meet inpatient criteria if they have hypoxia, but might not if they simply have a fever and an elevated white blood cell count.

But what UM may not understand in their pursuit of inpatient criteria is that the diagnosis itself, independent of criteria, can help justify inpatient status and longer hospital stays. As we know, better specificity of principal diagnosis and the addition of CCs/MCCs often move cases into DRG groups with higher measures of illness severity and arithmetic mean length of stay. It would follow that if CDI specialists could review observation cases, they might find documentation opportunities that could add justification for the longer inpatient stay.

Before we go any further, a quick note about “midnights.” Inpatient status is characterized by a hospital stay of two or more “midnights,” while stays of one “midnight” or less are considered observation admits. This is different than staying only one day. An observation admission could theoretically stay 47 hours and 58 minutes, from 12:01 a.m. on Friday to 11:59 p.m. on Saturday, and still meet the “less-than-two-midnight” criteria for observation status. (In this context, Medicare
and other payers view an “observation” admission and an “outpatient” visit in the same light.)

In this project, the CDI team was asked to review the records of observation patients who stayed in the hospital for two midnights or more. Cases were evaluated for missed documentation or additional opportunities for documentation that might justify an inpatient stay. Reviews were conducted by experienced CDI staff and were limited in scope, focused not on the comprehensive medical record but on diagnoses and conditions most likely to justify an inpatient stay. When an admission record met this standard, the case was referred back to case management for final reconciliation. When a record needed a query to meet inpatient criteria, the case was referred for UM follow-up with the query pending.

The project began with review of observation cases that stayed two or more midnights; it was later expanded to include all patients in observation status staying one midnight or more. Overall, the total number of cases reviewed during the study period was 2,383; 254 (10.6%) of records were felt to have documentation consistent with inpatient criteria and were referred back to case management for reevaluation. Of this group, inpatient status was confirmed in 179 cases (70%), with a total estimated financial impact of $1.33 million.

There are a few outstanding questions. One wonders why the leadership felt that CDI needed to do a second review of the UM records. That’s certainly a compliment to the CDI team, but what was lacking in the UM effort? There’s also an open concern about the return on investment (ROI). It’s unknown how much staff time and effort it took to achieve these results. The data shows that only 7.5% of the records reviewed were eventually converted to inpatient status, and while there was a gain of $7,400 per case converted to inpatient status, if we extrapolate that out to encompass the entire block of nearly 2,400 charts reviewed, it represents a return of $556 per record seen. Whether that’s an efficient use of CDI time and resources compared with the return per case for more traditional CDI efforts is a question that an individual program would need to decide for itself.

This work has helped direct my conversations with our UM cousins about ways to use the CDI evaluation and query process to augment their efforts. I’ll also be taking a closer look at our ROI per record reviewed to better evaluate our productivity and efficacy. As a big advocate of expanding the footprint of CDI throughout the organization to demonstrate ever-increasing value from our work, I’m delighted that this abstract helps pave the way.

Practice a pause: Take care of you

Imelda Gerard, BSN, RN, CCM, CDI specialist at Banner Health in Phoenix, Arizona.

While this issue of the CDI Journal publishes on April Fool’s Day, there’s nothing foolish about taking time for yourself. This is even truer these days as it’s harder to draw lines between the office and home. As long as we went to the office, there was a sharp demarcation between the different facets of our lives. For most of us, that barrier no longer exists, and it’s crucial to not let working from home and living at home become the same thing.

In this project, CDI meetings featured a series of non-impact exercises (the Mukunda Stiles Joint Freeing Series, for those of you keeping score) and a guided meditation. Having learned these techniques in the larger session, participants would then be able to adapt them for use on their own. Attendees at these sessions reported that they felt more at ease in the workplace after the intervention. It would seem reasonable to assume that an employee who is more at ease is less anxious and fatigued, and likely more productive as well. As more of us now work from home and our personal and professional lives are increasingly enmeshed, it’s even more important to take those moments to pause, stretch, and reflect.

Personally, I started doing yoga about two years ago. I like it a lot. I feel more relaxed, less stiff, and better able to sleep after a session. I also think that if I keep this up, I’ll have better balance and less chance of a hip fracture in 20 years. (Code S72.0, fracture of head and neck of femur.) I’ve even done goat yoga, about which I can say it’s mostly goat.
The only problem with yoga is that I have an internal monologue with it. I'm certain this is a result of working in healthcare. So early on in the hour, when we're moving our shoulders, hips, and ankles in big circles, the instructor tells us that the pops and cracks we hear are “releasing energy.” Outside, I maintain a calm, placid, yogi-like expression of focus. Inside I'm arguing. “It’s not energy. It’s arthritis. I’m 58 and things crack and pop, and now that I think about it, I moan when I get up from the recliner because my knees hurt. I’m old. OLD! Maybe my kid’s right that I should start ordering off the senior menu.”

There’s another exercise where we keep our arms parallel to the floor for so long it starts to hurt. The instructor calls this “energy flowing to your core.” I call it lactic acidosis. (Code E87.2, acidosis.)

I talk to myself about the poses, too. I get why things are called “cat” or “cow” or “cobra” or “downward dog”; I can see something looking like that. But things like “tadpole” or “pigeon” don’t look like any tadpole or pigeon that’s ever crossed my field of view. It can always be worse, however, as I’m reminded by “happy baby.” This is where you lie on your back, grab your feet, and pull them as far out to the side as you can. While this may well be a sign of a happy baby, as an adult it suggests a very different message.

On the other hand, yoga can be diagnostic. There’s a spinal twist where you lay on the floor with arms outstretched and turn your body completely to one side while your head moves fully in the opposite direction. When I do this, and my body is twisted to the right with my head turned left, I get paresthesias in my left thumb, index finger, and middle finger. So, I already know where my radiculopathy will be. (Code M54.12, radiculopathy, cervical region.)

As the author says, practice a pause. Take time for yourself. It’s important. Just be sure to live in the moment and don’t argue. 🌞

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One of the main aspects of the CDI role is provider education. But unlike query impacts—both financial and quality related—proving an ROI for educational efforts can be exceptionally difficult. There are no quality scores or rankings, no DRG changes, no concrete numbers. Instead, CDI professionals must rely on the improvements in provider documentation to tell the story of their educational impact.

For example, according to Nancy Skaw, RHIT, CCS-P, CCDS-O, CDI specialist at Mayo Clinic in Eau Claire, Wisconsin, giving providers coding education to help them understand documentation requirements can’t be measured in dollars and cents, but it will help providers buy into the CDI process and more willingly participate in CDI initiatives.

“We have to help educate providers; we can’t just make them do [better documentation],” she says. “For me, I do coding education, and we have to remember they didn’t go to school to be coders, but we still have to educate them on those basic coding rules so they can get credit for the care they’re providing to patients.”

Monitoring provider education ROI

According to Skaw, the most important component for tracking provider education efforts accurately is having the appropriate digital tracking tool.

“Dr. Manz [James Manz, MD, CCDS, CCDS-O] did a lot of work for us from taking us from manual reporting on education to digital. With the tools he helped set up, we can see if the codes are HCC or risk adjusted, if a benchmark of 75% of action on diagnosis was met, and a lot of other metrics as well,” Skaw says. “The back-end coders review the charts of visits that were provider documented, and the metrics set in place really shows us if their documentation is improving or not.”

Within their tool, the CDI team has assigned various education ROI metrics so they can track the progress over time as they provide education, Skaw says. For example, the tool tracks the percentage of times a provider takes action on a suggested code. Skaw can then export that data and see whether their education surrounding the topic has had an effect.

“Dr. Manz created these access tools, we input the data, and he was able to pull our metrics.
we ran reports manually, and this is just a much more efficient way of doing it,” Skaw says.

Beyond using digital tools, when tracking provider education improvements, it’s helpful to focus on a particularly problematic diagnosis that has required a lot of CDI education. According to Skaw, their team has narrowed in on diabetes.

“If they aren’t on board, you obviously aren’t going to have very good metrics,” Skaw says. “Dr. Manz really helped with explaining the importance to providers. You have to first gain their respect and let them know that the new process is there to help and not hurt them, and that these tools are in place to simplify their processes.”

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Nancy Skaw, RHIT, CCS-P, CCDS-O

“We look at the percentage of non-complicated codes versus complicated codes,” she says. “Many diabetics have a lot of complications, and often we find that providers will document them but don’t always bill for it.”

As the providers receive education on diabetes documentation and coding, the metrics should improve, with fewer missed opportunities to capture complications, she says.

Provider buy-in

Ultimately, whether your education provides an ROI largely depends on whether your providers buy into the CDI process and absorb your education. In many cases, enlisting the support of another provider for some peer-to-peer education may be the ticket to success.

In addition to peer-to-peer efforts, giving providers access to their own data (and the data of their region or organizational group) may help bring them on board. Mayo shares the education ROI metrics in aggregate, but they also break the metrics down regionally by state and group to see where opportunities lie. All providers have access to the intranet site to see every metric at their leisure.

“As CDI, we bring their updated metrics monthly where we go through personal and clinical counterparts and compare,” Skaw says. “We’ll use the digital tools to look at data, such as with the diabetic cases if the coder had to remove things because it wasn’t supported, then we work with the providers and help them get better with their documentation.”

When you notice a provider who needs a lot of improvement, approach them kindly so you don’t alienate them and create an enemy. “When I work with them, I don’t say, ‘That’s wrong.’ I say, ‘You did a good job, but next time do a bit more of this,’ ” Skaw says.

Once a provider has bought into the CDI process and there are fewer opportunities for improvement, Skaw suggests keeping meetings with them simply to touch base rather than providing specific education. This maintains a good rapport with the providers and shows them that the CDI team is there to be a resource, not an additional burden.

“I’ll ask them how they are and anything they’re struggling with, and sometimes it’s really just a venting session for them,” she says. “If this is the case, I’ll just thank them for all of the hard work they’ve been doing with COVID-19, and if they sound busy, I’ll just thank them and let them go.”

No matter where you start on your provider education journey, remember that things won’t change overnight. Gaining lasting provider buy-in and positive educational ROI takes time.

“Don’t give up,” says Skaw. “We’re all struggled at times, and I’ve always said it’s baby steps and the slow turtle that wins the race. Reevaluate and see what’s working and what’s not, then tweak accordingly.” 🌟
Got data?

by Trey La Charité, MD, FACP, SFHM, CCS, CCDS

So, your organization has a CDI program. How do you know if it’s any good? What positive impact is it having on your facility? Is it achieving everything it can? These questions can be answered only if you have performance data to review. Many organizations were astute enough to identify, delineate, and obtain the appropriate performance metrics from the very beginning. Others added them later through interactions with consultants, educational conferences (like ACDIS), or other seasoned CDI programs. Some CDI programs, however, still struggle to demonstrate that there is value in what they do. If you find your program in the third group, I hope this article will help you initiate the discussion with administration about the information you need to take your program to the next level.

In my institution, the performance data for our 13-year program has been a bit rudimentary. Some might consider our data collection abilities prehistoric at best. Since inception, this program has collected just three pieces of data: case-mix index (CMI), CC capture rate, and MCC capture rate. Any other information about the program is extrapolated; at best, it’s an educated guess.

Why do no other data collection abilities or performance benchmarks exist to measure our results? Simple: Our program, like many others, was developed in the chief financial officer’s (CFO) office. Therefore, the starting and sole goal of this program was to increase the CMI. While this program has long since moved away from its initial financial focus, we have done so without the benefit of improved program monitoring. Soon we will be moving from the dark ages to a robust CDI solution. With this in sight, what data should I be collecting and monitoring? Though certainly not an exhaustive list, here are some things we should all try to capture.

1. ROI for query efforts

Let’s start by identifying some additional financial data that might be missing: return on investment (ROI). If you cannot prove an ROI to a CFO, what good is your program? Fortunately, most CFOs interpret the CMI as a direct surrogate for the ROI. They think that if the CMI is up, so is the ROI. Therefore, if you have achieved a higher CMI, your program is presumably doing well.

As simple as this sounds, this is not a two-way street. Your CFO will only accept specific ROI dollar amounts when approached for more full-time employees (FTE) or other desired resources. You will be expected to show that you could earn X more money for Y more chart reviews. Therefore, you need to know two things:

1. The average number of queries written per month, and
2. The average increased dollar amount that results from each positively answered query

This data is not easily obtained, and there are many mitigating circumstances (such as the performance of surgical procedures) that may alter the results. There are many CDI software products that will gather and track this data, but they are not free. Although you can obtain this information the old-fashioned way (i.e., enter it into an Excel® or Access®-type data file for every query), this requires manual effort, and productivity losses will ultimately erode the necessary diligence to make this method consistently viable. We started with this approach in our program and then quickly abandoned it so we could increase the number of charts reviewed.

2. Staff productivity

You need to be able to assess the productivity of your individual reviewers. For each reviewer, you need to know the number of charts reviewed per day, including the number of new charts versus those previously examined. Additionally, you should track the number of queries submitted per chart review as well as the
number of positively answered queries. This information yields focused insight into individual reviewer productivity, allowing both praise and intervention when necessary. Furthermore, this information can then be aggregated and submitted to administration for reporting purposes, giving total numbers of charts reviewed, queries submitted, and queries positively answered per day, week, month, etc.

Knowing the value of an FTE in your program gives you the leverage to argue for each new hire. Once again, there are IT solutions available, but they come at a cost. My organization initially relied on self-reporting of these metrics but succumbed to the previously mentioned productivity pressures. Ultimately, we settled on the percentage of inpatient hospitalizations concurrently reviewed as our surrogate marker for these productivity metrics. Although a rather opaque measure, reviewing just above 90% of all inpatient admissions to achieve and maintain a CMI that is consistently three and a half tenths higher than our beginning benchmark is all we have been able to report.

3. Questions and feedback

Pay close attention to the questions asked of and the responses received from your medical staff, as this may be the strongest indicator of your program’s success. Knowing the topics repeatedly asked of your providers highlights what subject deficiencies exist and where your educational efforts should be directed. Likewise, if one service line has a significantly lower positive query response rate than the rest, it’s time for a conversation with the leader of that service line. If one individual or entire service line never answers their queries, it might be prudent to escalate that to administration. If an individual or service line always has the concurrent query turned into a post-discharge query, what can be done to improve their response times?

With this information, you can determine the medical staff’s engagement with your CDI efforts. Without it, I must rely on my concurrent reviewer’s subjective sense of where the problems reside. It should come as no surprise that doctors want to see data, not perceptions, when their performance is being questioned.

Your providers’ response patterns will also reflect how effective each individual concurrent reviewer is with your medical staff. For example, if one concurrent reviewer submits the most queries per chart review but has a lower-than-average positively answered query rate, you might draw an unfavorable conclusion. Alternatively, is the concurrent reviewer who has the lowest number of queries submitted per chart but the highest positively answered query rate better? What if all your reviewers have the same average query submission rate, but one has a 20% higher positive query answer rate?

Issues like these can only be discovered and addressed if you have access to this kind of data. Here, I can tell you we have a 100% query response rate and we run about an 86% positive query answer rate (i.e., the answer the query writer was seeking and expected, sometimes called the query agreement rate). But which reviewer is the most effective? What, specifically, does that employee do that should be emulated by the other reviewers? Unfortunately, all I have are guesses with no proof. To get a handle on your CDI program’s true effectiveness, obtaining this information may be the place to start.

4. Observed to expected metrics

I suggest you routinely monitor your organization’s reported observed to expected (O:E) metrics. In its elemental form, an O:E ratio is defined as the number of times something happened divided by the number of times something was supposed to happen. A ratio above 1.0 is a problem because something is happening more often than was expected. Obviously, exactly at or below 1.0 is always the desired outcome.
O:E ratios are applied to many things in medicine, such as AHRQ’s Patient Safety Indicators (PSI). The significant O:E ratio with which your administration is likely most concerned is the overall mortality rate. No one wants an overall O:E mortality rate above 1.0, as the interpretation is that your facility or organization has more patients die than it should. While none of the models that report an organization’s results in O:E ratios are perfect, it is likely that your organization routinely employs one of them to track and improve patient care outcomes.

As I remind our medical staff, the “O” in any O:E ratio reflects the actual medical care they provide. The size of the “O” results from all those years of medical training they endured and the continual quality improvement efforts they expend in seemingly endless meetings. The size of the “E,” however, is derived solely from their documentation. After reviewing this, I ask the medical staff which of the two values they think is easier to improve. Invariably, they recognize that influencing the “O” is the constant, long-term goal of what they do every day as a medical professional. In other words, it is quite labor-intensive and moves slowly. The “E,” however, is relatively simple to impact and responds quickly to a few additional keystrokes in the EHR. Clearly spelled out like this, they will get it. The bottom line is that the more effective your CDI program is, the lower the O:E ratio should be.

Unfortunately, CDI program performance metrics can be difficult to obtain if your facility or organization does not have the technological infrastructure to provide them. Collecting the needed information through manual record review can be constructive but is likely prohibitively labor intensive and totally infeasible if your patient volume is high. Some organizations can tell you down to the query how much impact they have on the finances, denial rates, severity of illness/risk of mortality scores, hospital-acquired conditions, PSIs, O:E ratios, etc. Most of us, however, are not so fortunate.

We need data. If your CDI program exists in a data deficit, it’s time to broach the issue with administration for two reasons. First, they might already have some of the data you need through their knowledge of and contacts in your organization. Second, you can confidently produce a performance metric wish list that demonstrates where you want to take your CDI program. Obviously, in my opinion, this conversation can only result in positive progress.

Editor’s note: La Charité is a hospitalist at the University of Tennessee Medical Center at Knoxville, a clinical assistant professor, and the medical director of UTMC’s CDI program. He is a past member of the ACDIS Advisory Board and the author of three books. La Charité’s comments and opinions do not reflect necessarily those of UTMC, ACDIS, or its Advisory Board. To reach La Charité, email him at Clachari@utmck.edu.
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ACDIS: What did you do before entering the CDI field?

Sninchak: I spent 17 years of my nursing career working at the bedside in the acute care setting. Most of those years were in the neurological ICU, stepdown, and regular adult unit.

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

Sninchak: In 2014, Novant began the process of EHR integration. I traveled to assist physicians and advanced practice providers with their transition to physician order entry. After performing the physician super user role for three months, I realized I loved teaching the tips and tricks for making documentation easier. I explained the EHR functions and documentation steps with as little disruption to workflow as possible. The patient was always first, the computer second.

One particular shift—one of the first shifts where everything was in the computer—I was shadowing a doctor, and together we were running a patient to the ICU. Just as he went through the double doors to the unit, I said, “Did you transfer her in the system?”

He stopped and said, “I don’t know. You tell me.” He was completely frustrated. That experience taught me that clinical expertise and documentation requirements were no longer separate, and that, as much as we would like to act independently at times, things had changed.

There was no going back. The patient had to be transferred in the computer to “exist” in her new location. The medication machine was not going to open until it knew her name. Orders for all diagnostic testing would have to be entered into the computer. It was a startling realization. I imagined each doctor, nurse practitioner, or physician assistant was going to need someone running along with them, and I knew that wasn’t going to be the case. Our providers would need ongoing updates and support to maintain safety and quality of care during the transition.

I wanted to continue being a resource and someone that could remove barriers with information. At the time, the only similar role I knew of was an EHR physician training role. I decided to check internal job postings and I typed the word “documentation” into the search box. A CDI specialist position popped up. I’d never heard of the role or the CDI program. A quick Google search led me to ACDIS and the resources I needed to learn more.

A few weeks later I met our director, Abby Steelhammer, and manager, Shannon Champion. Their passion for CDI inspired me. 2021 will be my sixth year in CDI, and it just keeps getting better and better!

ACDIS: What has been your biggest challenge?

Sninchak: I think my biggest challenge was stepping into a new role for CDI. The dedicated educator role was new for the profession and our organization. I became the educator for a team of 26 professionals, some with eight to 10 years of CDI experience under their belt. At the time, I had less than two years of CDI experience. It was a crash course in figuring out first what my sources would be to answer complex questions. ACDIS was at the top of the list, followed by CMS. I spent many hours and weekends reading on the ACDIS and CMS website. (Yes, the CMS website!)

An equal challenge was designing a role that would add value to the program and help to give the team even more confidence in their daily practice. That involved a lot of assessment of baseline knowledge, learning styles, and creating education wish lists that team contributed to over several months. Putting in that time in the
beginning has made all of our education efforts more successful over the years.

ACDIS: What has been your biggest reward?

Sninchak: Finding a way to be a specialized nurse after so many years at the bedside was a surprise and gift. It is rewarding to discover a profession that combines all of the nursing profession abilities and interests, from clinical analysis to creating education solutions. It was also realizing that education is my true calling and how fulfilled you can be when you find the right fit.

I trained with our team for the CCDS by leading a study group. I worked with our coding partners to study and prepare for the CCDS and went back to school in 2018 for my master’s in education to improve my own practice and help the team create and design effective education. Our team has grown with me, and they’ve taught me how important it is to make sure we have the needed tools and knowledge.

ACDIS: How has the field changed since you began working in CDI?

Sninchak: In 2015, the CDI program and roles were less understood by the acute care teams. We had plenty of room for increased physician engagement. The sense at that time was that CDI would probably “go away” and many physicians listened politely while considering the program temporary.

Fast forward to 2020 and we are highly connected and part of the treatment team. Collaboration through Microsoft Teams® and Zoom® video chats are the norm. There has been a significant shift into more data analysis and better education design and content planning. Education foundations like learner motivation and increased learning transfer are rising to the top to make every interaction count. Careful planning is important and having an educator and/or education focused program is essential to success.

One example of this is reduced turnover. Since 2016, we have added seven full-time employees with 100% retention. I believe that speaks directly to the thoughtful education support, roles, and training as planned by our program director.

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

Sninchak: I have always been impressed by Laurie Prescott and her educator approach to improving documentation. Sometimes we skip over basic teaching principles that work. For example: repetition. Her advice and strategy have helped me in my role as educator.
I also share ACDIS white papers in team meetings and while orienting new CDI specialists. Whether the topic is Hierarchical Condition Categories or clinical validation or how to conduct a medical record review, the white papers are very useful when we are discussing CDI topics. We love the organization and format!

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

**Sninchak:** I’ve attended three ACDIS conferences: Vegas, San Antonio, and Orlando. In addition, I was honored to present in person in 2019 and virtually in 2020.

My favorite conference memory, hands down, was presenting with M.E. VanGelder in 2019 in Orlando. It was giving the presentation itself, but it was also meeting educators from around the country and talking about the challenges and strategies of the role. M.E. and I met through the ACDIS conference app in 2017 and launched the ACDIS Educator Networking Chapter soon after. 2019 was our first time speaking nationally. We shared the importance of the educator role and value-based healthcare and how it can help guide program success.

After the presentation, we had two lines of people asking questions. The room was full of wonderful energy and excitement about the CDI educator role and CDI profession. They stayed with us asking questions throughout the entire networking break that followed our speaking time slot. Experiences like this show how encouraging CDI professionals are and how much we love to help each other and share tips for success.

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

**Sninchak:** Show up with a service-oriented mindset and end each day with gratitude for lessons learned.

There is very little that you can accomplish alone in CDI (if anything). Be open to making new connections and friends in CDI. I think it would be very difficult to understand this profession or succeed without a support system of both experienced and new clinical documentation specialists.
ACDIS: If you could have any other job, what would it be?

Sninchak: I would operate a tiny mobile library and travel all around a favorite island, talking with people and making book recommendations.

ACDIS: What was your first job?

Sninchak: I worked at a local drug store (Revco). Those were different times! I would memorize my regular customers’ cigarette and candy favorites. Most purchases were strange combinations of prescriptions, vitamins, cigarettes, and beer. Often people were unable to afford their medication and asked to put them on hold for a later pickup. This was probably one of my first realizations that healthcare was a struggle for many.

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

- **Vacation spots:** Bald Head Island, North Carolina, is our family’s favorite place to vacation. It’s very peaceful and secluded there. The island is a turtle sanctuary, and no cars are allowed, so you travel around by golf cart or bike. It’s a great place to see the Milky Way in the sky. Every four or five years, I take a big trip with my best friend from nursing school. We push our limits and overcome fears like heights, propeller planes, and train schedules. In 2019, we experienced the Northern Lights in Iceland and braved some glacier climbing!
- **Hobbies:** Travel, reading, and shell collecting.
- **Non-alcoholic beverage:** I’m from North Carolina, so saying anything other than sweet tea would be wrong. Sweet tea.
- **Foods:** Shrimp and grits.
- **Activities:** Swimming, walking, and sleep!

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

Sninchak: My husband and I have seven children together. Before COVID, we traveled as often as possible. During the pandemic, we’ve been staying home and spending time together, watching our favorite TV shows or movies, relaxing with our two dogs (Yoshi and Luna). I say relaxing, but Yoshi is a husky mix, so we also spend a lot of time chasing her.

ACDIS: Is there anything else you’d like to add?

Sninchak: Be yourself. I would describe myself as corny and at times overly optimistic, and I haven’t tried to tone that down at all! I think those qualities have made me a better educator. So much of what we do is serious and rightly so, but in learning new documentation requirements and developing education as a team, it’s important to trust in your education process and have fun. I make sure that everyone is comfortable asking questions and that they’re not worrying about whether or not they should have already known the answer. We frequently remind each other in meetings that if you have a question, then someone else on the team probably has the same question or could use a little more detail. This is a point of view that helps us all learn together. 🌟

Editor’s note: Interested in being featured in a future Meet a Member column? Contact ACDIS Editor Carolyn Riel (criel@acdis.org) today!