Catapulting case management and CDI coordination

A physician admits a patient with dementia, yet provides no further definitive diagnosis. The CDI specialist recognizes the scenario as similar to a case reviewed the week before, so she reaches out to the case management (CM) team to see whether they have additional insight. The CDI specialist believes the dementia is due to the elderly patient’s inability to self-medicate appropriately, so CDI and CM bring the case back to the physician, who agrees and documents the additional information in the medical record. That documentation, in turn, enables the case management staff to recommend alternative discharge plans, including greater supervision of the patient’s medication intake.

That’s just one example of how beneficial open lines of communication between the CDI and CM teams can be. And while most CDI programs report to HIM, the 2016 CDI Salary Survey shows nearly 15% of the more than 1,000 respondents report to CM. There’s a synergy there, to be sure, but those managing CM and CDI programs warn against too much overlap and emphasize the need for collaboration, communication, and caution.

As the ICD-10-CM/PCS implementation date neared, Ashworth won support for additional CDI staff members and leveraged their efforts on educating physicians about documentation needs, increasing her staff to nine and adding a dedicated manager over each team.

In the beginning, CDI efforts were “a work in progress,” Ashworth says. CDI staff thought management only cared about CM issues, and the CM felt management focused more on CDI concerns. CM staff thought CDI nurses focused only on record reviews for optimizing coding data, while CDI thought CM only looked

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Julie Anne Tardi, RN, CCDS

Ashworth, BNS, MSHA, CM director there. Ashworth felt the program had plateaued after about three years; she knew it needed changes but wasn’t sure what exactly needed to be done.

The CDI program at Jackson Madison County General Hospital began in 2008 with five staff members and a manager who oversaw both CDI and CM efforts, says Debbie
at length of stay (LOS) and inpatient admission criteria. They only saw the slim line of what they thought the other team’s principal function to be and “couldn’t see how it worked together,” Ashworth says.

“Getting people to understand their contributions to the bigger picture is one challenge I struggle with,” says Anna Winkowski, who worked in outpatient CM in Chicago when CHRISTUS St. Frances Cabrini Hospital in Alexandria, Louisiana, offered her a job two years ago as manager of its CM and CDI department.

Back at Jackson Madison County General Hospital, each team now has the support of additional staff and direct managers. The teams hold monthly departmental meetings that provide an overview of everyone’s efforts. They reinforce the need to bring documentation deficiencies forward to the appropriate individuals as needed. The CM team asks CDI to help with physician education on repeat documentation concerns. The CDI team contributes information that might help ensure the accuracy of the LOS, as well as reviewing records for present on admission, hospital-acquired conditions, and other areas of overlap.

“The days of ‘this is my job and I don’t care what you do’ are over,” says Ashworth. “In healthcare, everything depends on everyone else. Be it transport or dietary or coding or case management or CDI, every bitty piece that everyone does matters. Being able to hear what each other does and how it matters helps us all.”

Marriage woes

When CM and CDI work collaboratively, the potential for improved patient outcomes increases, agrees Julie Ann Tardi, RN, CCDS, CDI specialist with Nthrive, based in Alpharetta, Georgia.

Consider the following scenario. A physician admits an elderly woman and places her on a ventilator. The CM staff reviews the record but doesn’t pursue any additional reviews or inquiries because the patient meets medical necessity for an inpatient admission according to InterQual protocols. The CDI reviewer, however, queries the physician because the documentation doesn’t include any codable diagnosis. Such situations illustrate the need for case managers and CDI staff to work closely together, says Tardi. The CM team can see the whole picture clinically and understand what’s going on with that patient, yet without specific documentation of whether the patient came to the ED in respiratory failure or whether the ventilator was related to an elective intubation, the coders cannot accurately depict the care provided.

In her previous role as director of CM and CDI at a Florida-based hospital, Tardi’s team started off relatively small with 12 staff members, but she helped grow it to a robust team of nearly 40 staff members encompassing both CDI and CM. “Traditionally, all these departments are divorced from each other—siloed. We needed to get some recognition of the interconnectedness of these groups for the sake of the patients,” she says.

It wasn’t easy. “Some staff had been in these roles for many years and were married to the way they traditionally did things,” says Tardi. Advancements in payment reform, however, are pushing organizations to look past checklist methods of assessing patient admissions and adopt broader considerations related to clinical validation, medical record documentation support, readmission reduction efforts, and present on admission indicators, among other items.

“It’s no longer a simple cookbook recipe that case managers can follow step-by-step,” Tardi says, but a collaborative, critical assessment of the patient’s conditions, medical record documentation, and regulations governing patient care and assessment.

“The common denominator is change,” says Tardi. “Change and clinical thinking, critical thinking, regardless of department.”

Shared priorities

Take another example from Jenny Prescia, MSN, RN, ACM, CCDS, NE-BC, director of case management at Northwestern Lake Forest (Illinois) Hospital. In a casual conversation with a CM staff member, a physician reveals telling an abusive spouse not to hit his wife anymore. Unfortunately, that conversation with CM took place a week after the physician saw the spouse’s wife in the ED. The physician never documented the abuse and hadn’t brought CM into the loop. Such
anecdotes represent one reason Prescia believes CDI and CM teams need to work closely together. Had the CDI specialist noticed evidence of the abuse in the medical record and brought it to CM’s and/or social workers’ attention, the team may have been able to secure more appropriate discharge planning or helped the patient obtain outpatient support services or housing.

“We can change patient outcomes,” she says.

Prescia actually oversees CM, CDI, recovery auditor and denials management, social services, and outpatient orders management, among other items. One of the benefits of working in a small hospital (Lake Forest has just over 200 beds), she says, is that “I know everything about everything.”

Although CDI and CM teams at Lake Forest traditionally shared duties, Prescia says neither team seemed to excel or even progress with related efforts. “We weren’t getting anywhere on physician education,” she says. “I knew we needed to do something.”

In January 2016, Prescia separated CDI from CM and refocused efforts on traditional responsibilities associated with each department. Within six months of making the move, the team improved the case-mix index to 6%, getting it to within 80% of national norms.

“We hadn’t realized how surface-level our CDI efforts had been until we separated the duties,” says Prescia.

Both teams continue to collaborate on LOS and transition planning. Because CDI staff enter the working DRG into the EHR, they can also provide thoughtful insight to the CM team about what conditions the physician may be treating and alert CM staff if outstanding queries could improve the expected LOS or affect discharge planning. Conversely, the CM team can use the EHR to run reports highlighting which patients passed their expected LOS and bring those cases to the CDI team for review if necessary.

At St. Frances, Winkowski’s CDI team bounced around from department to department, first in CM and then in quality, where staff were expected to help with core measure reviews. Its current iteration, back under CM, employed formal CDI training (two staff members attended a CDI Boot Camp session in New Orleans), and while staff initially reviewed records principally to identify CC/MCC capture and reviewed only DRG payers, they now review all payers and help CM with LOS concerns.

“Specificity of the documentation plays a huge part in obtaining an accurate LOS expectation,” she says. “That specificity could be simply laterality or Gram-negative versus Gram-positive pneumonia, but each detail matters.”

CDI staff review records by hospital unit and join other hospital disciplines during daily “huddles” or rounds. “We have a really good relationship across the departments,” says Winkowski. “Each team also serves as subject expert for each other, and CM staff knows if something is going on they can ask the CDI staff to look at the record.”

Like Ashworth, Winkowski has a CDI program coordinator who tracks productivity and identifies areas of additional opportunity and education for her staff. Overall, Winkowski manages nine CM staff, six social workers, three utilization review nurses, four CDI staff members, and three patient intake staff.

“It’s a good group of women,” she says. “I really enjoy their personality, collectively. Every morning I stop by and say hi, and if I’m feeling sad they pick my spirits up.”

While Rudy Braccili Jr., MBA, CPA, CRCE, executive director of revenue cycle services at Boca Raton (Louisiana) Regional Hospital, hasn’t combined CM and CDI at his facility, he’s heard of more and more hospital bringing their teams a bit closer together. At Boca Raton, CDI staff review core measures along with hospital-acquired conditions, while medical necessity reviews to ensure appropriate inpatient admissions remain under the purview of the CM team, he told ICD-10 Monitor during its September 19 Talk Ten Tuesday web broadcast.

Braccili’s CDI team is “looking for the reality of what happened and making sure it gets documented,” he says. Those considering tighter relationships between CM and CDI need to “measure each of your CDI program goals to see what’s right for your hospital.”