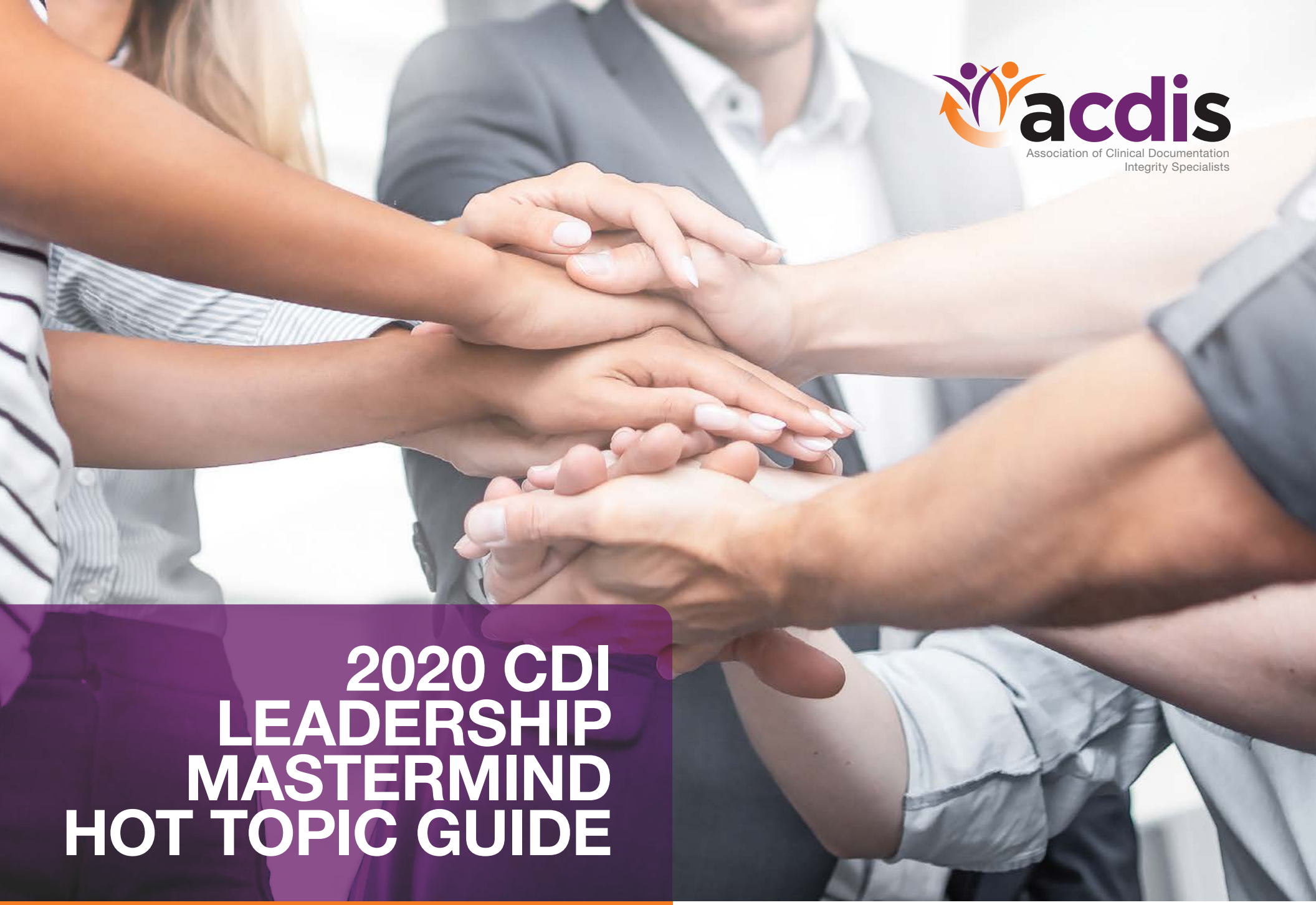

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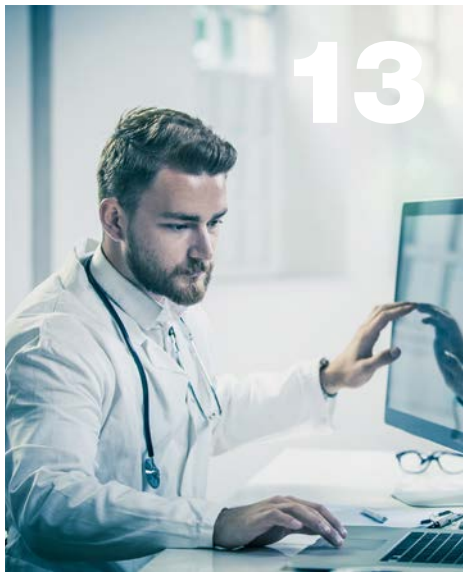


LETTER FROM THE EDITOR: LINNEA ARCHIBALD

CDI leaders find themselves involved in so many different projects. Advice on how to juggle it all can often be found by connecting with peers outside their organizations to collaborate, swap advice, and share challenges and successes. The ACDIS CDI Leadership Council serves the purpose of connecting leaders across the country for conversations about the hot topics in CDI and industry trends. But a smaller subset of the Council, launched in March 2020, provides participants with an opportunity for focused brainstorming and problem-solving.

This multi-topic resource, produced in partnership with 3M Health Information Systems, shares some takeaways from the first-ever CDI Leadership Council Mastermind group at the conclusion of its term. These conversations covered staff onboarding, managing and engaging remote staff, establishing and overseeing a retrospective review process, developing key performance indictors (KPI), incorporating denials management efforts, and determining what it means to have an advanced CDI program.

We hope that you'll read the resource fully, but also that you can navigate it and use it for focused guidance on topics central to your CDI program's needs.

STAFF ONBOARDING

A CDI leader's primary goal is to ensure that staff succeeds and feels empowered to grow wherever the CDI program may lead them. This empowerment starts with staff onboarding, providing a solid springboard for staff members' personal and professional growth and achievement.

For larger, multisite healthcare organizations, a standardized onboarding process ensures all CDI team members act in accordance with departmental policies and procedures. Having this process in place can also be extremely beneficial if an organization acquires new facilities that may have pre-existing programs.

"For us, the biggest step was to bring all the small groups together, so we act as one group. We're a system group and everybody reviews all hospitals instead of maintaining five distinct programs," says Leif Laframboise, RN, CCDS, CCS, manager of CDI at Yale New Haven (Connecticut) Health System. "We're one program and so we have unified processes."

"We require new hires regardless of whether they're brand-new to CDI or have experience to take the enterprise CDI skill assessment so that we can identify if they have any skill gaps that might need to be closed."

—Andrea Eastwood, RHIA, RHIT, director of clinical encounter and documentation excellence at Trinity Health in Livonia, Michigan

After hiring a new staff member, assess their current skill level and where they may need additional education, says Andrea Eastwood, RHIA, RHIT, director of clinical encounter and documentation excellence at Trinity Health in Livonia, Michigan. Each new staffer needs a little different information depending on their educational and professional background.

"We require new hires regardless of whether they're brand-new to CDI or have experience to take the enterprise CDI skill assessment so that we can identify if they have any skill gaps that might need to be closed," she says.

In addition to a standard assessment—usually comprised of multiple choice-type

“CDI leaders hiring and onboarding new staff in 2020 also faced the challenge of remote work due to the COVID-19 pandemic, eliminating the possibility of one-on-one, at-the-elbow training. Leveraging technologies available can help managers meet that challenge,

—Joann Ferguson, RN, MBA, vice president of revenue cycle at Henry Ford Medical Center in Detroit, Michigan

questions and scenarios—Mary Mastrandrea, RN, CCDS, system director of CDI/DRG appeals, at Catholic Health Services of Long Island in New York, suggests giving new staffers a mock chart to review and assess. This tests critical thinking skills and ability to identify missing or lackluster documentation. At the end of the onboarding process, that same assessment can show how far the individual has progressed and show any lingering gaps in education or process.

CDI leaders hiring and onboarding new staff in 2020 also faced the challenge of remote work due to the COVID-19 pandemic, eliminating the possibility of one-on-one, at-the-elbow training. Leveraging technologies available can help managers meet that challenge, says Joann Ferguson, RN, MBA, vice president of revenue cycle at Henry Ford Medical Center in Detroit, Michigan. Even before COVID, Ferguson learned to lean on technology for communication, allowing staffers to work at least partly from home.

“We historically brought people in the house for education for two weeks before redeploying them out [to work remotely],” she says. “Then we have always used Skype and other forms of communication to complete the orientation if people weren’t in the building. We don’t let the remote aspect stop us.”

The job of onboarding doesn’t end after the initial orientation period either, according to Ferguson. Leaders should ensure that staff receive regular education and monitoring to identify where educational gaps negatively affect their CDI reviews. Ferguson’s team conducts routine staff audits for a quality check. If an educator, the CDI lead, or manager notices lots of missed opportunities from one staff member, they focus education efforts directly.

At the end of the day, not only will a robust and ongoing staff orientation program enable staff members to perform record review effectively and autonomously, but it also enables them to explain the CDI program to physicians and improve engagement, which is vital to a successful program.

“We want everybody after they come off orientation to be able to speak to the ‘why’ of what we do,” says Laframboise. “That’s the biggest question we get from the providers.”

EDUCATING, ENGAGING, AND MANAGING REMOTE STAFF

While COVID-19 has forced most CDI teams into fully remote work on an accelerated timeline, under normal circumstances, leaders need to address a number of questions before choosing the remote options for their team members.

"There are struggles with remote work," says Teresa Hovater, RN, BSN, CCDS, inpatient CDI consultant with 3M Health Information Systems. "It's difficult to learn how to adapt when you're used to having someone that you can go check on, popping into your office, that face-to-face interaction, even just between team members. […] If you're sitting in a room with someone, it's a whole lot easier to read body language and know if they're paying attention and engaged. It's a lot harder when you're remote."

One of the major concerns is potential negative effect on physician engagement and education due to loss of direct, face-to-face interaction CDI staff traditionally leveraged. It's why many program leaders opt for a hybrid model that gives staff flexibility to work from home while emphasizing the need for personal interaction during onsite days.

In the current CDI landscape, especially for more mature programs that have established relationships with their physician staff or an onsite physician advisor to help with problematic providers, there are many more opportunities and benefits for remote work. Offering the option of remote work, according to Ferguson, shows your staff that you trust their commitment to their work enough to let them make a choice that fits their needs and desires.

"We do have 100% remote capabilities. Our associates are allowed to come onsite for training, regular work, internet outages, anything like that," she says. "Part of our culture is choice and allowing people to come into the office, but people can be 100% remote as well if they choose. They can do remote in the summer and come into the office in the winter if they want."

Of course, if a team member chooses to be remote (or the program is remotely staffed by design), a leader has to have policies and procedures in place to ensure the necessary work gets completed consistently, according to Abby Steelhammer, MBA, MHA, RN, director of clinical documentation excellence at Novant Health in Charlotte, North Carolina, who chose to leverage her organization's remote work policy for her own staff, rather than reinventing the wheel.

"Our policy is very broad," she says. "If we wanted to set up some department specific guidelines, we could, but we really have not found the need to do that."

If you do choose to create a specific policy for remote CDI staff, pay special attention to key performance indicators just as you would if staff were onsite, says Mastrandrea, and set up ways to monitor those metrics easily and regularly.

"We have a four-person data analytics team that created daily productivity spreadsheets that the managers can access via a shared drive," she says.

While the metrics are of vital importance for the health and wellbeing of the department and larger organizational goals, CDI leaders need to remember to connect with their staff members personally to ensure they're not isolated. Instant messaging tools and video conferencing apps have made this process much easier, but Steelhammer suggests booking dedicated meetings solely for the purpose of personal interaction.

"We're doing some creative things to try to make sure that we stay in touch with our workforce," she says. "One of our CDI managers set up a virtual lunch recently just to bring the team together and make sure they have that camaraderie."

"It's difficult to learn how to adapt when you're used to having someone that you can go check on, popping into your office, that face-to-face interaction, even just between team members. […] If you're sitting in a room with someone, it's a whole lot easier to read body language and know if they're paying attention and engaged. It's a lot harder when you're remote."

—Teresa Hovater, RN, BSN, CCDS, inpatient CDI consultant with 3M Health Information Systems

RETROSPECTIVE REVIEW PROCESS

While the conversations surrounding CDI expansion often center around alternative settings (outpatient, etc.) or new review avenues such as denials management or appeals, many programs have branched out into the world of retrospective reviews. These reviews can help ensure that any documentation in the chart added between the CDI specialist's last review and the patient's discharge gets accurately documented and coded, providing a fuller picture of the patient's story. While concurrent reviews still represent the best method of capturing realtime documentation before coding, a retrospective review process helps to close the gap on any lingering documentation deficiencies on the backend.

Building a post-coding (post-discharge), pre-bill retrospective review process requires collaboration with the coding team. Much like a DRG-reconciliation process, in which a CDI professional compares and reconciles their working DRG with the final coded DRG to ensure accuracy, the CDI and coding team members will each need to understand the process and which cases should be flagged for review.

"We have a non-linear process in that the cases will be reviewed, go to coding, and then when they're done coding, we have a series of flags to stop bills in coding and send the cases back to us for further review," Laframboise says. "We have a list of DRGs that we've determined have a high likelihood of opportunities, so those cases get sent back to use for a second-level review."

In addition to high-risk DRGs, Laframboise says their program also flags the short-stay cases that didn't have a concurrent CDI review and mortality cases where the severity of illness and risk of mortality scores were lower than a four and a four.

At Mastandrea's organization, they've also opted to give the CDI team members the chance to review cases before the bill drops, provide any changes, and send it back to coding for review. They'll also

review cases when the coding professional has questions about the documentation to ensure that all query opportunities were addressed before the coding is finalized.

Of course, adding *all* the cases to the retrospective review queue wouldn't be feasible on top of already full concurrent review buckets, so Steelhammer suggests coming up with a system to automatically select cases for additional reviews, much like using prioritization software for concurrent reviews. At her organization, they target cases for retrospective review based on length of stay and/or other previously identified opportunities/criteria typically associated with certain DRGs, procedures and/or quality indicators

Regardless of *how* a CDI leader decides to flag cases for retrospective review, they'll need to decide *who* is best suited to do them. One of the most common approaches is to establish a small team as a subset of the larger CDI department whose main responsibility is second-level retrospective reviews.

This smaller team offers a focused approach to the retrospective review process, Steelhammer says. Her team looks specifically at quality measures and mortality reviews, for example. They look for trends in quality reporting—specifically patient safety indicators (PSI)—and can pass that information along to the system's CDI educator to inform the rest of the team, effectively closing the loop between the concurrent and retrospective processes.

"For a while, we had a dedicated staff member [in order] to establish a process for second level reviews. Once we streamlined and were working with coding, we started rotating people through it,"

—Leif Laframboise, RN, CCDS, CCS, manager of CDI at Yale New Haven (Connecticut) Health System.

Though perhaps less conventional, Laframboise suggests having your staff members take turns doing retrospective reviews on a regular rotation. At his organization, 12 staff members at a time own the retrospective review process, with two people rotating off and onto the group each month, meaning each individual holds the position for six months. This ensures everyone understands the process from both the concurrent and retrospective perspectives.

"For a while, we had a dedicated staff member [in order] to establish a process for second level reviews. Once we streamlined and were working with coding, we started rotating people through it," he says. "It's a very different way to see a case and it's a great opportunity to change the scenery for your staff. […] Doing second level reviews helps them do better concurrent reviews."

KEY PERFORMANCE INDICATORS

Monitoring metrics and key performance indicators (KPI) helps program mangers determine the direction their department is headed, identify areas for expansion, and course correct along the way. Some of the common staff metrics include review rate, query rates, response rates, and query outcome rates. Establishing baselines and KPI categories that make sense for your unique organizational needs can be one of the most helpful exercises for managers, says Eastwood.

"We track the typical CDI metrics, such as an all-payer review rate and a Medicare review rate," she says. "We also set benchmarks where the rate will shade red, yellow, or green, depending on the rate that the site has. To be green for the all-payer, they have to have at least an 85% or higher review rate. For the Medicare review rate, though, we set a pretty high benchmark, so they have to be at or above 95% review rate to be green."

"Anything at the query rate that is higher than 40%, we shade pink because we're always a little curious to understand what might prompt such a high query rate that we would want to look at that and understand that better."

—Andrea Eastwood, RHIA, RHIT, director of clinical encounter and documentation excellence at Trinity Health in Livonia, Michigan

Eastwood's organization also has metrics for retrospective review rates and expects the all-payer rate to be around 15% or less and the Medicare rate to be 5% or less. They also monitor retrospective query rates to ensure the retrospective reviews are appropriate (since they often take more time than a traditional concurrent review), and physician response rate.

Some metrics, such as query rate, Eastwood cautions, can be misleading. While it's important to monitor these metrics, remember that a lot of things can affect the rate. Though a high or low outlier may not tell the *whole* story, it can help illustrate potential educational opportunities.

"There are a lot of things that can impact query rate," Eastwood says. "Anything at the query rate that is higher than 40%, we shade pink because we're always a little curious to understand what might prompt such a high query rate that we would want to look at that and understand that better."

Mastermind members also recommend tracking query outcomes to show the actual results of CDI efforts for the financial and quality measure health of the organization.

This rate should include indication of the times a CDI professional affects a case with their query efforts, even when it ends up downgrading the DRG to a lower paying bracket because these efforts help decrease denials in the long run and speak to the mission of CDI as ensuring the integrity of the medical record. Eastwood suggests calling it "revenue preservation" and even reporting DRG downgrades in a separate category that can be later compared to the denial rate (hopefully) decreasing over time.

Managers may be tempted to leave negative financial query outcomes out of the metrics, especially with pressures from the C-suite (particularly the chief financial officer) to constantly make a positive impact. Ferguson cautions that doing so wouldn't tell the whole story of CDI efforts and could inadvertently turn other outcomes into a manipulated equation.

"We report a total impact for the month, so there's negative in there," she says. "It's really that the impact is positive, minus the negative, to get the total."

Keeping a close eye on metrics also shows CDI leaders when they need to pivot efforts in relation to the broader healthcare landscape. As with every aspect of CDI, the COVID-19 pandemic affected metrics and made a mess of previous benchmarks beyond the control of CDI, Mastrandrea says.

"Our CMI was very high because of the respiratory failure associated with COVID, but that's dropping now," she

says. “Interestingly, our length of stay actually was very good during COVID because everybody was so focused on getting these patients out when they could.”

“We found that giving people their stats monthly made it so the metrics were their main motivator. Now, we provide them quarterly and emphasize that we want them to send necessary queries that add value to the record. […] Without interpretation, metrics don’t mean anything.”

—Leif Laframboise, RN, CCDS, CCS, manager of CDI at Yale New Haven (Connecticut) Health System

Now that they’ve seen the lower length of stay, Mastrandrea says that case management plans to focus efforts on keeping length of stay in the lower ranges. For example, they now have benchmarks for average length of stay for an uncomplicated coronary artery bypass graft and can work with physicians and case management to avoid that length of stay creeping up again.

A change in query rates and review rates as a result of dwindling census numbers can also open up opportunities for education, adds Steelhammer. In fact, the change has helped her identify ways she’d like to shift the department’s focus going forward as well, even beyond the public health emergency.

“Our query numbers have gone down during COVID, but we’ve exponentially increased our focus on education, and we’ll continue to do that,” she says. “Clearly metrics are going to change, but I think they actually changed for the better because we were already making a shift to be more proactive.”

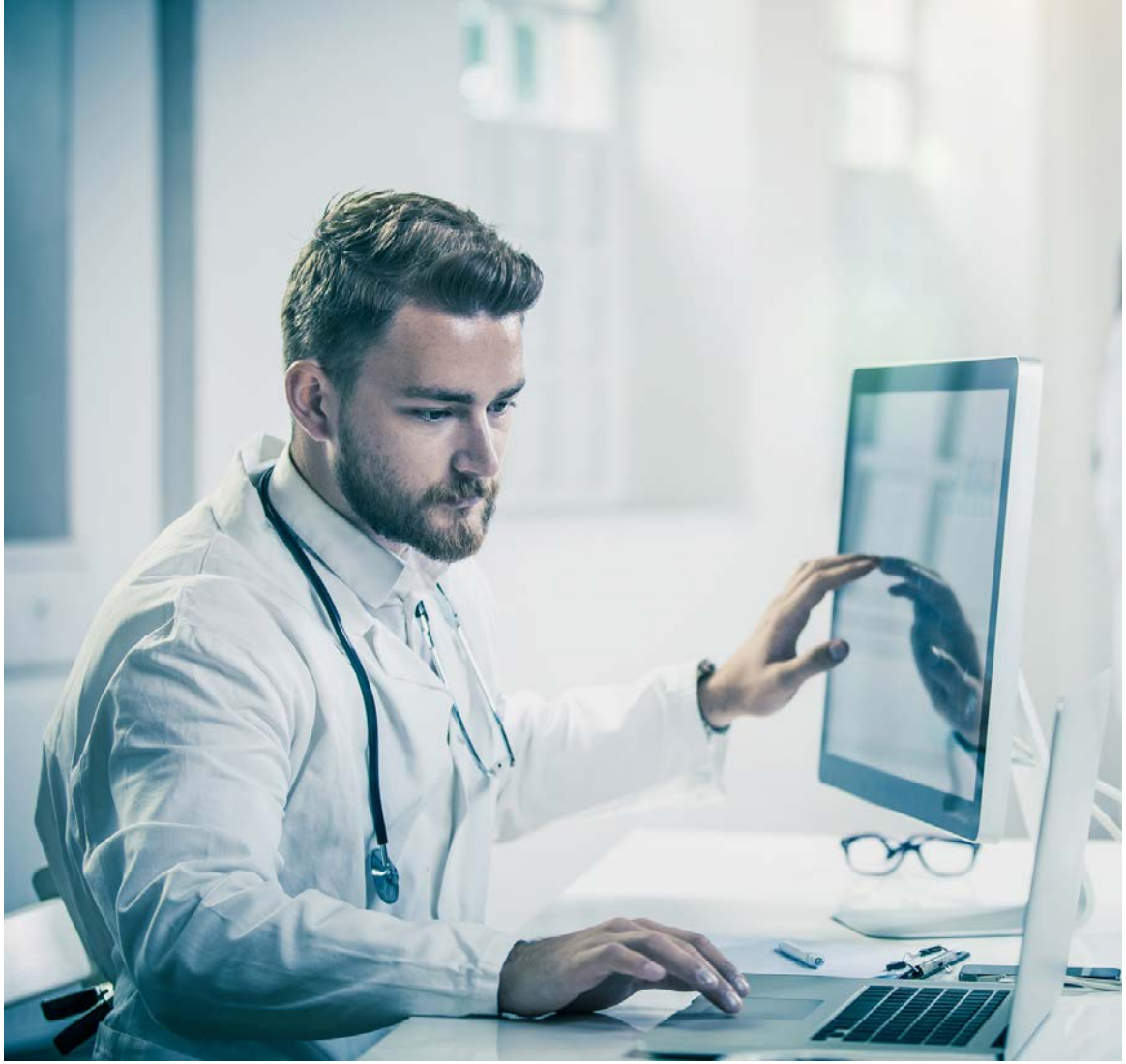
While always an important metric, the pandemic and the move to remote work has shone an even brighter light on the importance and nuances of productivity metrics, Ferguson says. For her organization, they’ve developed additional checks and balances within the productivity monitoring system to ensure team members are focusing on their work during work hours and identify any issues with the remote work environment.

“Our CDI specialist can see their productivity and can login any time. It shows idle computer time, it shows how much time they’re logged into each system. It shows initial case reviews, follow up reviews, etc., so they have access to all that all the time,” she says.

In conjunction with standard productivity, Eastwood suggests launching regular staff audits to ensure that team members are conducting quality reviews, regardless of the number they accomplished during their day.

Monitoring metrics—any staff metrics, really—can also open doors for individual one-on-one education, Laframboise says. Sharing metrics with staff at will, however, can open some issues and inspire the more competitive set to review quicker simply to hit higher productivity metrics, rather than focusing on quality reviews.

“We used to give staff their metrics monthly, but we actually ran into a problem with people trying to pad their stats,” he says. “We found that giving people their stats monthly made it so the metrics were their main motivator. Now, we provide them quarterly and emphasize that we want them to send necessary queries that add value to the record. […] Without interpretation, metrics don’t mean anything.”



CDI leaders are increasingly finding themselves pulled into the conversation surrounding denials management because, especially with the rise of clinical validation denials in recent years, often the denials originate from documentation concerns. Knowing what diagnoses are frequently denied can also help CDI professionals direct their reviews and shore up documentation on the front-end, thereby avoiding the denial altogether.

Getting involved, however, may take some leg work. For Amanda Palacios, RHIA, MPH, the system HIM director at Riverside Health System in Newport News, Virginia, even getting her hands on the data required some asking around.

"One of the first things I asked when I came on board was about our denials. Well, I was told we didn't have any, which I think everybody could probably agree that that couldn't have been a true statement," she says. "It took some time to figure what was going on and basically none of the DRG/CPT type denials have been managed for several years so we've been losing a lot of money around that and so I actually developed a new department. We're still trying to develop that department and hire good people."

Even from her early involvement, though, Palacios says they've seen success and been able to successfully decrease their denial rates and increase their overturn rates.

After establishing a solid denials management process at a single facility, Mastrandrea then expanded that process systemwide, which presented her with a large volume of denials and data to track. Now, she has four seasoned CDI specialists working DRG denials and four data analysts, "which is key to making the

program really work," says Mastrandrea. "I don't think you can have a good program unless you have a really good data analytics team."

The data analysts built a database from which they can run reports, which helps shape their efforts. The database includes:

- The case value (from the patient accounts department)
- The diagnosis denied
- The DRG billed
- The DRG proposed by the payer
- The modified DRG (if applicable)
- Reason for closing the case
- Due dates for each appeal level
- The strength of the appeal

Mastrandrea's team runs reports that include the amount of denials, the win rate, and top denial reasons. This is shared with utilization management, the organizational leadership, and individual CDI teams at their various hospitals. Their overturn rate (on appealed cases) is 80% and above, and they've uncovered additional education opportunities. Managers need to focus on both the positives and the negatives when addressing the data to show areas for improvement, according to Mastrandrea.

Prior to COVID, Mastrandrea and a CDI specialist from the denial team went onsite and provided examples of two wins and two losses, then reviewed other relevant CDI data. "The wins were just to demonstrate the importance of accurate documentation, and the losses to show people that there is further opportunity to clarify the documentation in the medical record," she says. Now this information will be presented remotely.

"We collaborate with our revenue cycle partners who have ultimate oversight and responsibility with the different areas of denials as well as compliance. […] We don't manage that process, but they pull us in as needed and we collaborate with an interdisciplinary team when we need to participate with appeals."

—Abby Steelhammer, MBA, MHA, RN, director of clinical documentation excellence at Novant Health in Charlotte, North Carolina

The data gives the team a path to streamline the denials and appeals process, too, she says. For example, after seeing a lot of sepsis denials and determining the same components existed in most appeals, Mastandrea's team developed sepsis appeal templates

"I liken CDI and coding at times to the offense and defense of the team. I think they get a little defensive sometimes about denials, which is understandable, but shouldn't be an absolute either."

—Leif Laframboise, RN, CCDS, CCS, manager of CDI at Yale New Haven (Connecticut) Health System

standardizing information (as well as customizable fields) to cut down on the time spent writing appeal letters.

In situations where the CDI team doesn't formally *own* the denials process, there are still opportunities to collaborate and learn from the teams that do, Steelhammer says. At her organization, the revenue cycle department oversees the denials management and appeals process, but leans on CDI when needed (for example, denials related to clinical validation).

"We collaborate with our revenue cycle partners who have ultimate oversight and responsibility with the different areas of denials as well as compliance. […] We don't manage that process, but they pull us in as needed and we collaborate with an interdisciplinary team when we need to participate with appeals," she says.

Steelhammer then takes the information gleaned back to the CDI team and provides education on top denied diagnoses to address any documentation gaps that frequently lead to denials. When CDI and denials management conversations stall or get stuck in department silos, CDI leaders can work to change the us-versus-them mindset, says Laframboise.

"Our denials department reports to coding. We've asked for feedback, we've asked for data, something that we can act upon, but we don't have anything formal lined up," says Laframboise. "I liken CDI and coding at times to the offense and defense of the team. I think they get a little defensive sometimes about denials, which is understandable, but shouldn't be an absolute either."

Denials data should be shared with CDI staff, coders, and physicians, too, Mastandrea says. Though physicians may be averse to talking about reimbursement, they likely want to know they (and their facility) gets credit for the work they do, she says. With financial shortfalls due to COVID-19, it's even more important that hospitals are paid for the care they provide. Shortfalls due to unnecessary denials may be the thing that gets their attention.

"Because a lot of facilities have lost a tremendous amount of money to COVID and not having their surgeries go as planned, they're now being hit with penalties," Mastrandrea says. "Now, all of a sudden, everybody's very interested in documentation in order to eliminate those penalties."

As programs mature, leaders often find themselves wondering what it *truly* means to have an advanced CDI program, regardless of its age. Outside of review focal points—which often vary from organization to organization—many CDI leaders increasingly look toward technological solutions to streamline processes.

Leaders need to evaluate those solutions and only adopt those well suited to organizational and programmatic needs, Steelhammer says. At her organization, they've launched an institute for artificial intelligence (AI) specifically to look at systemwide solutions.

"We're looking at solutions that can help, whether it's coming from a patient care perspective, a business perspective, acute, ambulatory, or specific to the medical group," she says. "Each and every year, we're adding new capabilities. Technology changes so quickly, I think you have to be agile around its assessment."

Leaders must continually evaluate the technology's success, its adaptability to CDI needs, and adjust as needed by working with their IT department or software vendor to optimize the program for their needs. For example, consider AI prompts within a speech recognition program, says Eastwood, who worked with their vendor to turn on only specificity prompts. "Some of the prompts we thought were maybe a little leading and could be construed as a query," she says. "We were very deliberate in our selection of what we turned on. We want to make sure that those automated prompts aren't leading."

Similarly, leaders need to realize that just because the technology has advanced and is streamlining certain processes, it doesn't mean that the role of the CDI professional has lessened, Steelhammer says. It's just changing and adapting to add the most value in the most efficient way possible.

"We felt like there was a lot of increased capability towards specificity, but then, if you were looking to capture full risk

adjustment as it relates to some of those quality considerations, the technology would not necessarily provide that," she says. "Technology wasn't going to close that gap."

"What we see with software is that it reads structure as opposed to language, which can't replace what we do," adds Laframboise. "Basically, CDI is reading what's not there, right? That's the purpose of the job. If it was already written, we wouldn't have the job."

While an AI solution may help provide greater specificity and pick up some of the low-hanging fruit, CDI specialists still need to lend their careful eye toward clinical validation during their own record review. The benefit of the software, of course, is that it does some of the lighter lifting for the CDI reviewer, allowing them to focus on the more complex clinical validation issues.

"We have so many payers with different clinical validation issues and different clinical indicators," Edwards says. "A dollar won today, that we can't keep, just costs us more in the long run."

Even with the pitfalls, technological solutions can help CDI professionals streamline their efforts, but it can't replace their vital work.

"It seems like we're incorporating new ideas and concepts each and every year, but we're not always taking work away," Steelhammer says. "We have to look for a tool that can truly complement our work and add value, while increasing efficiencies for our team."

Of course, getting approval for the new technology or even staff expansion to deal with increasing workloads can be a challenge for even the most business-savvy CDI leader. According to Laframboise, it's helpful to remember the priority of the group you're speaking to when crafting your presentation or business proposal. While all groups are concerned with return on investment (ROI), they may view things slightly differently. For example, C-suite leaders who sit more on the quality and patient care side of things (e.g., the chief medical officer), will be interested in how the technology will help improve quality ratings. Leaders on the financial side of things (e.g., the chief financial officer) will want to know how much money the solution will help the organization recoup.

"The big sell is always ROI. We do a report to the quality side and they think that money grows on trees. And then we also report to finance and they're afraid to plant trees," Laframboise says. "At the end of the day, I'm the one who has to write the business plan, so if want it, I have to work for it."

With any new technology comes the need for staff education to ensure they're prepared to leverage the solution to its fullest potential, Eastwood adds.

"If I could have a magic wand, I'd wish there was a way to tell if each CDI specialist is leveraging all of those

"We've been asking people that are interested to take the ACDIS CDI Apprenticeship class. That seemed to really help because it lets them know what the CDI job is about and gives them an idea whether they want to apply for the position."

—Mary Mastrandrea, RN, CCDS, system director of CDI/DRG appeals, at Catholic Health Services of Long Island in New York

[solutions] without having to get into over-the-shoulder observation of them," she says.

Some of the more mature staff members may feel especially challenged by the new technologies, Edwards says. If they've done CDI for a long time, they're used to the workflow and may adapt slower to something new than someone who learned the technology as part of their CDI onboarding process.

"Within the last five years, the CDI role has changed enough that [those in the role] 15-plus years are lost and we're having to do a lot of at-the-elbow support," Edwards says.

During the COVID-19 pandemic, leaders have also needed to leverage technology for physician and staff education and even, in some cases, onboarding staff remotely. While the remote onboarding is new, Mastrandrea says that they've long included an online learning component, even before a candidate is hired, as part of their interview screening process.

"We've been asking people that are interested to take the ACDIS CDI Apprenticeship class. That seemed to really help because it lets them know what the CDI job is about and gives them an idea whether they want to apply for the position," she says. Then, once the staff member is hired, they continue an online onboarding process, she says. "We use GoToMeeting so you both can get on the same chart together and go through a chart review."

Throughout the life of a program, monitoring KPIs can demonstrate which team members need extra help, but also where those potential program expansion opportunities may lay, Steelhammer says. Here, technology can also be of service to pull together complex reports and generate scorecards that are easily digestible and actionable for organizational leadership and the CDI team members themselves.

"We've been working on a revised scorecard. Some of those metrics are coming directly from Vizient, some of them are coming from a financial database, and then we use Microsoft Teams. We have a team that's dedicated to CDI data and analytics where we can pull in some of those visuals," Steelhammer says. "We're finally getting to a place where I really am very excited to have some of it completed, but it's still a work in progress."

Having that data at your fingertips helps guard your CDI team from any organizational cutbacks, too, Laframboise says. The combination of the financial and quality impacts paints a robust picture of a program's success. As programs mature and expand, don't lose sight of the benefit to the organization's bottom line, he says, because that's how you continue receiving the resources to expand and grow your team.

"CDI in our system now is seen as a necessary program. Whenever you're cutting something out, you're not cutting CDI. CDI is how you stop making cuts other places," he says. "We shouldn't run away from the financial impact. I think that's really important. You have to be comfortable telling that story."■