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Association of Clinical Documentation Integrity Specialists

MEANINGFUL DATA, CLEAR MESSAGING, AND SUCCESSFUL RELATIONSHIPS NECESSARY INGREDIENTS TO CONVEY VALUE OF CDI

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The Participants

Sheri Blanchard, RN, MSN, FNP-BC, CCDS, CCS,
corporate director of CDI for Orlando Health in Orlando, Florida. Orlando Health includes 10 facilities and approximately 55 CDI staff. She is a member of the ACDIS Advisory Board.

Deb Jones, MSN, RN,
director of CDI for Brigham and Women's Hospital in Boston, Massachusetts. Brigham and Women's is an 800-bed academic medical center and also includes 150-bed Faulkner Hospital, a community hospital. She has 19 CDI specialists across both campuses and a team leader. The team reports to quality and covers most payers. She is a member of the ACDIS Leadership Council.

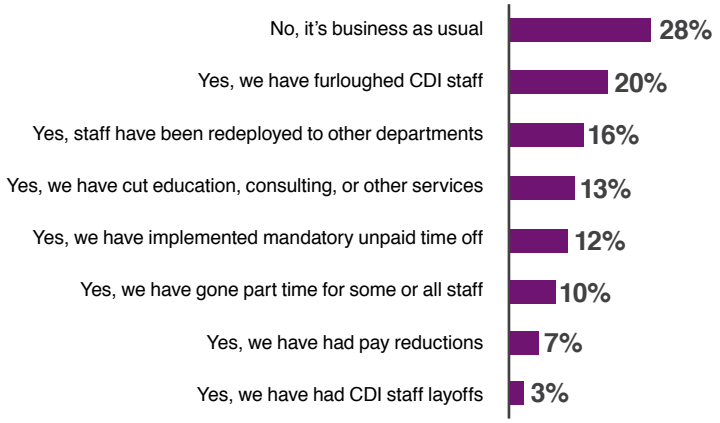
Emily Emmons, MSN, RN, CCDS,
regional director of CDI for Kaiser Permanente Northern California Region in Oakland, California. This region includes 21 inpatient facilities and 4,500 acute care beds. The CDI team includes 17 CDI specialists, three managers, and a senior business process analyst. She is a member of the ACDIS Advisory Board.

Leif Laframboise, BSN, RN, CCS, CCDS,
manager of CDI for Yale New Haven Health System in New Haven, Connecticut. Yale New Haven consists of five hospitals across seven campuses covering 2,500 beds. The program consists of 55 frontline CDI staff, covering all payers, and a leadership team of six CDI professionals. He is a member of the ACDIS Leadership Council.

LEADERSHIP RESEARCH SURVEY SHOWS DEFINITIVE SHIFT TO INTEGRITY-FOCUSED OVER FINANCIALLY DRIVEN CDI PROGRAMS

COVID-19 has wreaked havoc on healthcare systems, and CDI departments have suffered from the fallout. An ACDIS survey conducted in June in the aftermath of the initial outbreak showed that many were hit with furloughs, salary reductions, and in some cases layoffs.

Has your CDI department been impacted by organizational cost-saving measures?



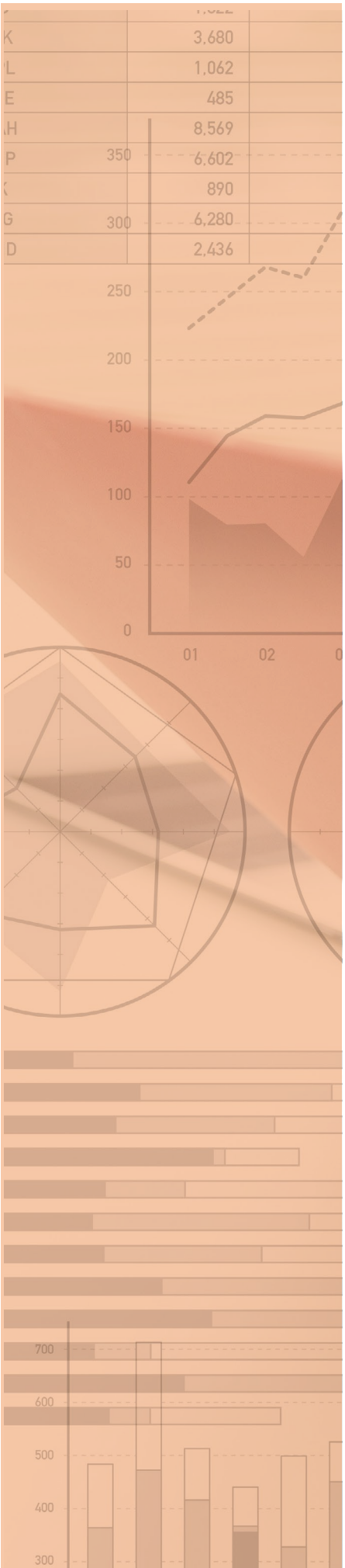
But many organizations' CDI departments survived relatively unscathed, even those in hard-hit areas where their peers suffered disproportionately. Looking into the "why" behind this phenomenon, it seems that the best-faring CDI departments deliver clear value to their organization and have a clear channel to communicate that value to hospital administration. When they did suffer setbacks, these CDI departments were able to bounce back quicker, because they had an effective communication strategy and great relationships with organizational administration.

This paper shares stories from CDI teams who've weathered the pandemic and offers proven principles and recommended best practices on communicating the value of your CDI department. While this paper was precipitated by COVID-19 and its associated fallout, the strategies discussed apply regardless of circumstance. Value should always be on the minds of CDI leaders in their day-to-day operations and communications.

Impactful reports and regular communication

High-quality data, regular reporting, and messages tailored to the audience are musts in the effective communication of CDI value.

Orlando (Florida) Health's CDI team reports directly to revenue management, but it communicates regularly with all the major players, including finance, hospital presidents, and CFOs. On a daily basis it reports



the following metrics, generated from its hospital database/information warehouse:

- CC/MCC capture rates
- Observation/inpatient conversion
- Payer mix
- Severity of illness (SOI)/risk of mortality (ROM)
- Top DRGs and DRG mix

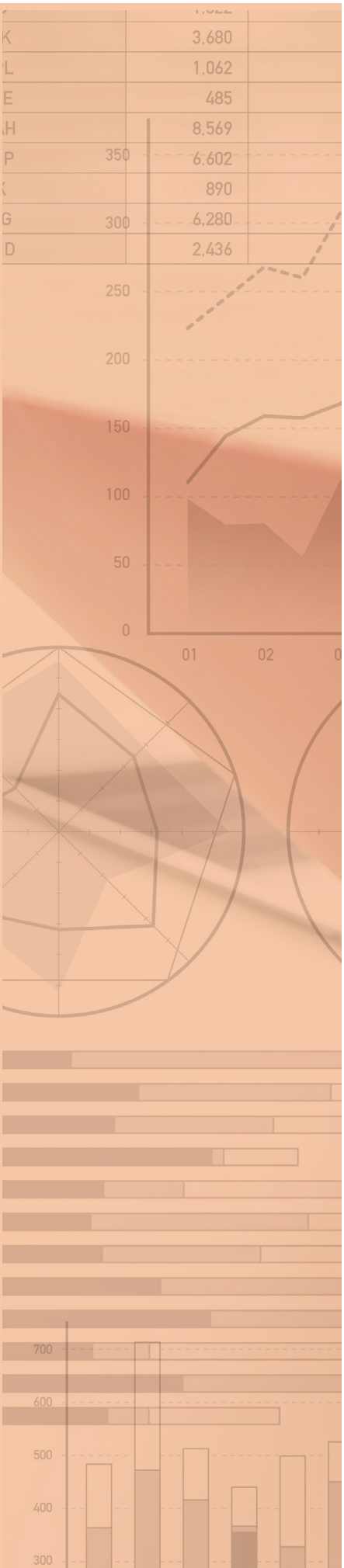
On a monthly basis Orlando Health reports CDI's case-mix index (CMI) impact (i.e., cases that a CDI reviewer touched and made a DRG or SOI impact through clarification), and individual CDI metrics including review rate, physician response and agree rate, query rate, and query percentage. This is done with a vendor application.

Orlando Health also meets with hospital CFOs monthly to discuss financial variations. For example, a recent high-CMI month stemmed from the hospital performing a high number of tracheostomies, not from direct CDI intervention, while a month with low-weighted DRG was the result of many observation patients flipping to inpatient while not being acutely ill. Both were unique circumstances in which numbers alone did not tell the story.

"The key piece for us has been that communication and those reports, and making sure they (administration) know who we are, what we do, the value that we bring, and showcasing—especially now with COVID—that every dollar matters," says **Sheri Blanchard, RN, MSN, FNP-BC, CCDS, CCS,** corporate director of CDI for Orlando Health. "When I first started (with clinical documentation excellence at Ohio State in the early 2000s) we were down in the basement, there was no windows, you were lucky if anyone knew who you were. Now we just continue to push out and be in the forefront."

That work to take the lead and grab the spotlight has paid off handsomely for CDI departments over the past decade, opening doors and revealing new opportunities. "As CDI programs continue to demonstrate value to their organization, they are often sought out to help solve other organizational documentation challenges. Their scope is constantly shifting," says **Diana Ortiz, JD, RN,** marketing manager at 3M Health Information Systems in Murray, UT.

Kaiser Permanente's focus is on improvement of quality metrics and strong physician relationships. Physicians comprise one medical group per region, and have a strong voice and stake in the well-being of the system.



"They're very engaged, and we're very fortunate in that aspect," says **Emily Emmons, MSN, RN, CCDS,** regional director of CDI for Kaiser Permanente's Northern California Region in Oakland, California.

Because of that relationship, Kaiser tends to focus on metrics that interest the physicians and assist with physician performance. These include the following:

- Physician response rate and physician escalation rate, and percentage of CDI queries that require subsequent coding queries. This demonstrates CDI's value in ensuring coding and chart accuracy.
- Query compliance and missed opportunities rates, which demonstrates a commitment to valid, high-quality queries.
- Impactful queries, which are queries that impact patient safety outcomes, public reporting, and research.

But Kaiser's CDI department is also recognized as revenue-generating and reports though revenue cycle, which includes coding, CDI, and HIM. Financial metrics are always available when needed.

At Brigham and Women's Hospital in Boston, CDI reports to the department of quality and safety and shares metrics across multiple departments. Its principal method for communicating metrics to leadership is a quarterly CDI steering committee. In attendance are the CQO, CFO, CMO, chief compliance officer, VP of quality, and other department heads.

Deb Jones, MSN, RN, director of CDI for Brigham and Women's, is a believer in showing the money. "It's not the only metric we show, but it's a great way in the door to open the ears of senior leadership and hook them in," she says. "In my experience, once you have that support, then all of the other initiatives you're trying to do will have increased support."

One of her favorite metrics is chart impact rate, which is the amount of impacting queries that were agreed upon by the provider over the total discharges. The denominator can be any metric or population being measured: severity or quality impact, CC/MCC capture, and others. This allows

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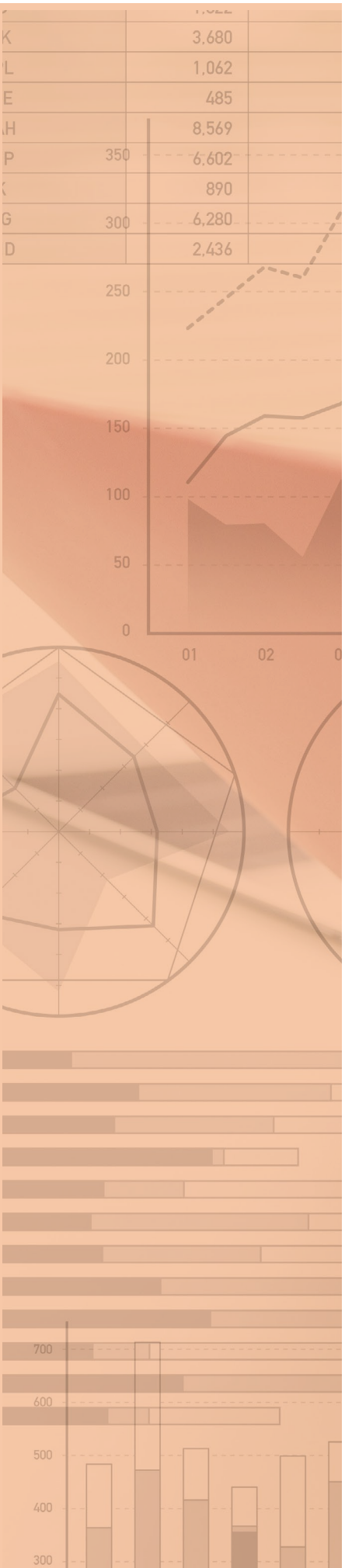


Jones to avoid running through query rates, response rates, and review rates when she's taking the valuable time of so many high-level administrators. Chart impact rate covers all these.

"When we're in these meetings with CFOs, CQOs, and CMOs, their time is very valuable, and I've found they really just want to get to the bottom line," she says. "That metric has been proven to answer all their questions in one metric."

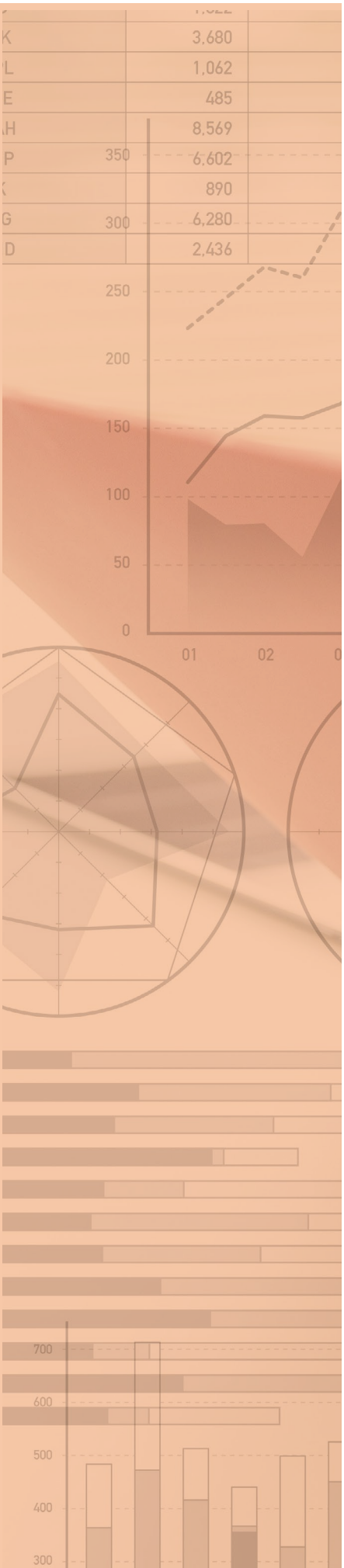
Ortiz agrees on the plethora of metrics and the need for focus. "The measurement of chart impact has expanded over time beyond financial, to include APR-DRGs reflected in SOI/ROM, AHRQ's exclusions, clinical validation, HCCs, and more," she says. "So there are many ways to impact a chart."

But although she's aiming for the bottom line at these meetings, Jones doesn't want to just perform a dry run of metrics—she also seeks to tell a story. So before she gets to metrics, she talks about goings-on in the department, growth, and new initiatives.

Yale New Haven (Connecticut) Health System's CDI team reports to two departments, including finance and the CMO. Like Jones, **Leif Laframboise, BSN, RN, CCS, CCDS,** manager of CDI for Yale New Haven Health System, tailors discussions for his audience. "We try to avoid that feeling of reporting structure and 'this is a leader and we're presenting,' and we focus more on a discussion about what's working and what's not, and what impact we're seeing."

The end result of those personal conversations and demonstrated value has been program growth. When Laframboise started, he was one of 12 CDI specialists; the Yale New Haven Health System now boasts 55 CDI review staff and six leaders. That growth came from demonstrating to finance (in as much detail as they could bear) the ROI of a single FTE. It's a long discussion that could be years in the making, and requires much relationship building along the way.

"That growth doesn't come from nowhere; you really have to demonstrate value to be able to say that these positions are necessary," he says. "It's a PR campaign. When I show that value, it's not going to be a rough guess, it's a real calculation based on each individual's performance and what it will cost us not to rehire. At the same time, there are going to be people who aren't interested in the financial impacts."



Telling the story: Art of communication

CDI professionals must become comfortable not just working with data, but interpreting it and telling engaging stories to explain what the data means. For example, CMI fluctuations are not always the result of CDI efforts, but a CDI director should be able to explain these fluctuations and what is and is not under CDI control.

"When evaluating CMI, normalization is crucial to account for major volume shifts," Ortiz says. "It is especially important in 2020 to factor in the impact of COVID-19 on CMI."

"We don't own CMI, but we certainly champion it," Laframboise says. "That was very obvious through the COVID period where we saw rising CMIs, and then we hear finance reporting that we're in really significantly stressful times financially. Explaining that story to people who only see CMI as a number is important. When you understand the pieces, the pieces are more important than the number."

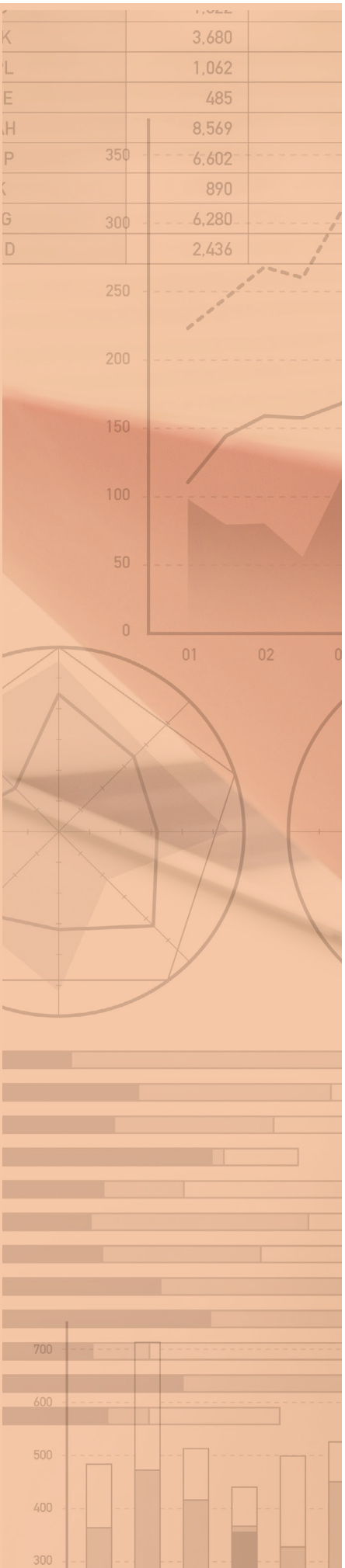
Laframboise says effective communication of data also entails honesty, not spin. For example, he's heard many organizations boast of a 95% query response rate. But a little examination under the hood reveals that the initial query was sent to a provider who didn't answer, then a second physician who also did not answer, and finally a third who did answer—an actual 33% response rate.

"If we're really being honest, we know that [95% response rate] is not exactly true," he says. The good news is that the 33% response represents a big opportunity for improvement.

Since the COVID-19 pandemic, platforms like Zoom® and Microsoft Teams® have largely replaced face-to-face meetings, but conversations haven't stopped. Jones, for example, has a monthly 1:1 with her manager, the VP of quality, using video conferencing.

In some respects, the rapid adoption of these platforms has facilitated more communication. Video calls can circumvent hard-to-follow email chains, for example. They also have removed some of the camera-shyness of prior days. Pre-COVID, Jones might host a meeting in a conference room, with most attendees remote and only connecting via audio.

"You weren't seeing anybody's faces; you're sitting in a conference room alone and reporting out metrics," she says. "The virtual communication and being able to see people has really brought more conversational communication back to these types of meetings."



> **The key is to listen, and inquire, and explore, and once you identify what their goals and their needs are, then you can move forward and build that relationship. This business is just like any other business; it's all about relationships. The more you connect with people and the more people you connect with and provide meaningful information for them—not for you, for them—the better the relationships you build.**
> —Emily Emmons, MSN, RN, CCDS, regional director of CDI for Kaiser Permanente Northern California Region in Oakland, California

Kaiser's CDI staff was already operating 100% remote prior to COVID-19, so the outbreak did not have any material effects on communication. But staff were not using the video function before the pandemic; now, they get together in video huddles.

The art of CDI communication entails tailoring the message based on audience, and not dragging out the message any longer than needed for busy administrators and physicians. Laframboise, for example—a former surgical ICU nurse with a history of dealing with trauma surgeons in the middle of a night shift—uses a very different approach when talking to the chief medical officer vs. finance.

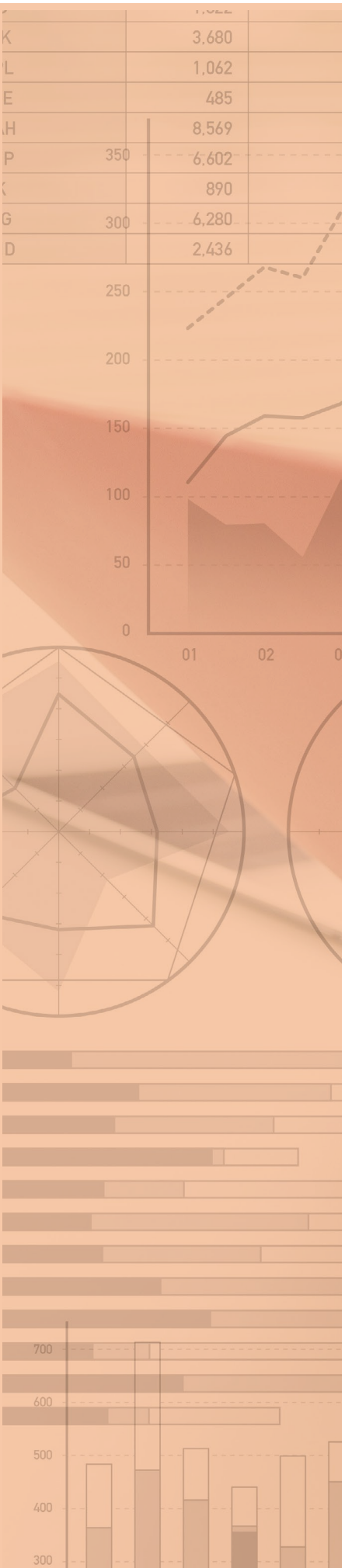
If there is a commonality between the two groups, it's that both want to know they are a priority, and both deserve a concise, clear message.

"I very early learned in my career that you need to start making sense right away—we need to get down to brass tacks and make sure we're communicating something that is meaningful and with the detail they need to be able to act," he says. "Understanding the needs of the person you are communicating to is a really important part of communication. The burden is on me—it's not on you to understand what I mean, it's on me to communicate what I mean."

Both sides are working toward the same goal, which is bettering the organization and the health of its patients. "At the end of the day we're all on the same team, whether we're coding or CDI or the CQO," Blanchard adds.

That level of communication requires a degree of vulnerability that CDI leaders must get comfortable with. It also may mean changing common CDI review priorities.

"You have to know what your audience needs and wants, and what their concerns are, and you can't know that unless you ask," adds Emmons. "The key is to listen, and inquire, and explore, and once you identify what



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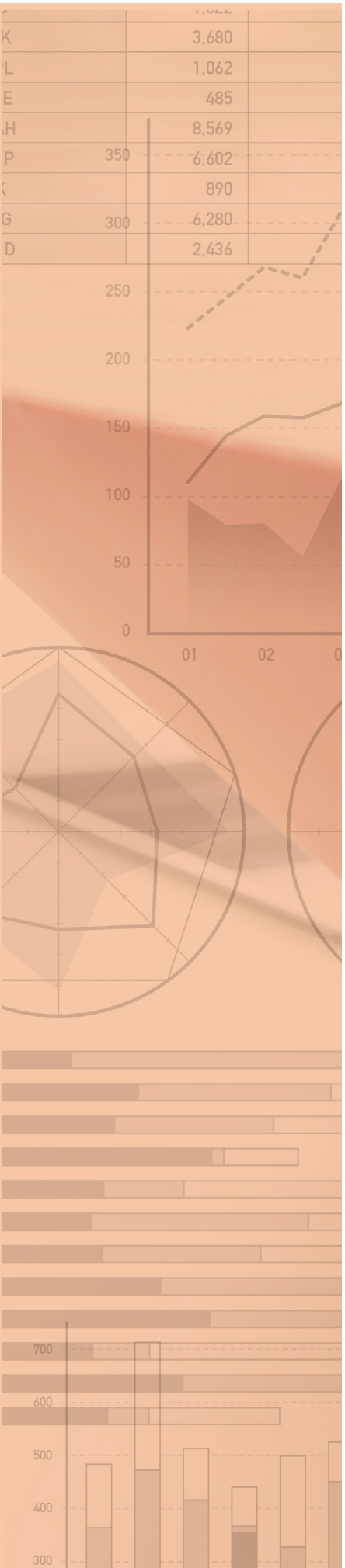
Jones, who says that by nature she is somewhat introverted, notes that communicating with hospital administration is not always easy and was something that she struggled with earlier in her career. She offers the following suggestions for those who might be experiencing similar challenges:

- Communicate honestly and thoroughly to gain respect. One you have the respect of hospital administration, the information you share will be more meaningful and resonate with your audience.
- Know your topic and get in front of any issues. "My worst fear is that a CMO or CFO or someone will call me and say, 'Why didn't I know about this?' I always want to be up front and make sure that I never have to play catchup on anything," she says.
- Solicit and accept feedback. Ask if the information being shared is meaningful, and tweak methods based on the comments you receive.

What to avoid

Following are some common errors for CDI leaders to avoid when communicating with administration.

- **Asking for dollars that don't exist without demonstrating ROI.** For example, staffing requests often have to be included in future budget planning, and they are unlikely to be approved if the proposal does not contain strong data projections that demonstrate the potential ROI of the new staff. And double (or triple) check to make sure the supporting data is accurate. "You want to make sure all of the impact data, everything that you present, is accurate the first time, that you've verified it and validated it before you put it in front of someone who really cares about data," Emmons says. "Senior leaders and executives, they care about data. They want you to interpret it and analyze it for them, and they want you to tell the story, but once they see that your data is not accurate, you lose your credibility."
- **Reading slides and regurgitating data without explaining the why.** Instead, share the story about what the data means. For example, a review rate might be meaningless to a CFO or CQO, so take the time to explain why it's important. "You'll lose interest pretty quickly if



you're just sharing graphs that are not meaningful to your audience," Jones says. "Share the story."

- **Not making the case for needed resources.** "Another error to avoid is failure to communicate the business case for technologies or services to help your organization achieve quicker results," notes Ortiz. "Does technology enable something to be done more efficiently, and if so what are the barriers to adoption? What will make results scalable across growing organizations?"
- **Ending a meeting without saying what's next.** If you fail to do this, hospital leaders will be bound to ask. Be proactive and forward-thinking in your message.
- **Being afraid to make mistakes.** There is no single all-encompassing playbook for CDI success. The industry is evolving rapidly, payment methodologies and codes change, and events like COVID-19 can't be predicted. You need to dig in and "make that first step in the dark," Laframboise says. "No one is going to lay it out for you, and if you're waiting for the step-by-step guide, you're falling behind. Missteps are learning points, and we change direction a little."