CDI Leadership Virtual Roundtable: Key Takeaways

Hospital and health system CDI managers, directors, and supervisor discuss virtual provider engagement, denials management, and productivity metrics and other key performance indicators.

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The role of a CDI leader is challenging and ever-changing with the needs of their department and their organization. While leaders' roles change and vary widely, they often include a focus on physician engagement and key performance indicator (KPI) trending and monitoring for the success of their programs.

In recent years, CDI departments have found themselves pulled into a variety of directions—from quality reviews, to outpatient expansions, to denials management. Whether proactively with clinical validation reviews or on the back end with appeal writing, denials management work represents one of the most popular new expansion areas for CDI departments of all sizes. As with any new initiative, the CDI leader sets the tone and leads the charge.

Recently, ACDIS gathered more than 30 CDI leaders for guided discussion on their day-to-day roles and responsibilities with a special focus on KPIs and productivity, denials management, and virtual physician engagement in light of the COVID-19 pandemic sending many CDI departments into 100% remote staffing models.

Following are highlights from each topic discussion that took place during the ACDIS CDI Leadership Virtual Roundtable, held November 13 and November 20.

VIRTUAL PHYSICIAN ENGAGEMENT

1 LEVERAGE EXISTING CROSS-DISCIPLINARY MEETINGS

One of the best ways to engage physicians and secure their buy-

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in for CDI efforts is to work with other departments and form a united front. While this approach works well when CDI staff has a physical presence onsite, it need not fall by the wayside in the virtual environment.

As with most endeavors, start with open communication. According to **Jennifer Boles, CPC, CRC,** system manager of ambulatory CDI at Baptist Health in Louisville, Kentucky, one of the best ways to get your foot in the door is just to share the CDI department's schedule with the department you want to collaborate with.

Many email systems allow users to create shared calendars that pull from multiple individuals or departments so that all users can see what's on the docket for a given day. Boles said they started by creating a combined quality and CDI calendar.

"When somebody gets their foot in the door, we ask for an additional five or 10 minutes when they go in," she said. "It saved the providers time too because they only had to meet at one time for all three departments."

Of course, CDI professionals have also traditionally leveraged rounds for physician education and engagement. With so many departments working remotely due to the COVID-19 pandemic, however, leaders may assume this avenue has closed.

Don't be so quick to dismiss it though, said **Andrea Eastwood, RHIA, BAS,** director of clinical encounter and documentation excellence at Trinity Health in Livonia, Michigan. While in-person rounds have indeed ended, there may be a way to take the conversation virtual.

"One of our sites have their CDI specialists attend virtual rounds," she said. "They weren't actually going from room to room because of COVID, so they scheduled them in a conference room and folks that were remote could attend virtually."

2 BE FLEXIBLE AND KIND

Though it can be frustrating to deal with resistant physicians, remember the stress they're currently under this year, roundtable participants said.

"A lot of this comes down to the relationships with our physicians," said **Katherine McFarland, MN, RN,** California/Texas director of CDI at Providence St. Joseph Health. "Giving them kudos, saying thank you for what they did for us, and having compassion for what they're going through. They're on the front lines and having to be with patients, and I think if we can all show that compassion, they're more apt to understand and participate in what we need to do."

Being understanding and showing compassion doesn't mean physicians get a free pass for ignoring or resisting CDI efforts though. Your compassion, however, can be the lens through which you see your interactions with them. Remember, attendees suggested, be flexible when communicating with burnt out physicians.

"You have to be willing to meet physicians wherever they are," said **Leif Laframboise, BSN, RN, CCS, CCDS,** manager of CDI at Yale New Haven (Connecticut) Health System. "If that's earlier, if it's late, if that's in a small group, large group, one-on-one—whatever it is—you have to meet them how they're comfortable."

Once you're in the room with them, start from a posture of a helper, suggested **Fran DeLisser, MSHI, BSN, RN,** CDI director at Bon Secours Mercy Health in Glen Allen, Virginia. When you start the conversation from that position, even the most hesitant physician is likely to warm to your education.

"We're trying to help them," DeLisser said. "I try to look at it like this: You're the doctor, you're saving lives. We're your angels and we just want to help you."

DENIALS MANAGEMENT

1 KEEP FIGHTING, BUILD TEMPLATES

Often, the task of denials management and appeal writing is a game of volumes: payers send a mountain of denials, sometimes all on a specific topic (e.g., malnutrition), knowing a hospital or system won't have the time or resources to fight those denials.

"If you think about the millions of dollars at stake, it's really is about finance," said Boles. "If you think of how many people will either not appeal—the payer automatically made that money back. Or for the amount of time it took for us to win the appeal, they got to sit on all that interest on that money."

According to **Joann Ferguson, BSN, RN, MBA,** vice president of revenue cycle at Henry Ford Health System in New Baltimore, Michigan, organizations that do choose to put resources behind the denials management or appeals process—whether housed in the CDI department or elsewhere—will reap the benefits of doing so.

"Payers hope you just won't appeal. We are very successful in writing appeal letters; it's generally around an 80%-85% success rate," she said. "It often takes multiple levels, so they're just hoping that you fall out of the process somewhere because it's so much work."

Of course, as with any new CDI initiative or project, the time and staffing component can be significant. This is where the use of templates for common denial targets will come in handy, Boles suggested. If you identify any particular trends in your denials, whether that be with a particular payer or diagnosis, make note of what sorts of things you're typically including in the appeal. Then, turn it into a template, just as you would with a query template for, say, malnutrition.

"We do a lot of template letters, especially when we're setting the same thing over and over again," Boles said. "We just change the patient information in it and send it off every day if you have to."

2 CLOSE THE FEEDBACK LOOP

Fighting the denials on the backend, of course, can be extremely successful, but it takes a lot of time and resources to do so. Because of this, roundtable attendees suggested closing the feedback loop with all relevant departments to put an end to repeat denials on the frontend.

While there's always talk of bringing the feedback to physician staff, **Renea Watson, MBA, RHIA,** senior director of CDI and coding compliance at Texas Health Resources in Dallas, Texas, suggested extending it to your own CDI and

coding staff too.

"We use the denials information for education for both the physicians and the staff. It provides feedback to the CDI staff if they potentially missed something or had opportunities in the query process," she said. "They also hand it over to coding because there could have been something missed there too."

Armed with the info, CDI and coding staff will be better equipped and tuned into potential documentation gaps that could lead to denials and can focus their query and education efforts accordingly.

When bringing the data to your physicians, focus on the denials received on their particular cases, suggested **Kaily Schmeling, RN,** CDI supervisor at Sanford Health Fargo (North Dakota). Not only can these discussions help you craft a winning appeal (since the physician who treated the patient has an intimate knowledge of the case), but it may also produce a little productive anger and inspire a change in documentation practices to avoid the same types of denials in the future.

"I bring the physicians the specific case and give it to them as a case study, talk through it with them, and discuss ways we can prevent the denials," said Schmeling. "It's been very helpful because they become invested in the process when they see their own denials and want to be involved in rectifying that if they can."

KPIS AND PRODUCTIVITY METRICS

1 MONITOR PRODUCTIVITY, COMMUNICATE EXPECTATIONS

Productivity expectations are not one-size-fits-all, according to roundtable participants. Factors such as a staff member's experience level and the depth of the review will impact the number of charts an average professional can get through in a day.

The CDI team at Essentia Health in Duluth, Minnesota, for example, is expected to complete 18-22 reviews per day, according to **Tracy Boldt, RN, BSN, CCDS, CDIP,** the system manager of CDI. Some staff members fall above that range, others just reach the minimum threshold, depending on their abilities. Leaders wishing to up their staff's productivity should look to their top performers for help, Boldt suggested.

"I took one of our very, very top performers and made her our educator for our CDI team. Why not take your top performer and turn her into your educator? Guess what? Now she's producing top performers. It just made a lot of sense to us," she said.

No matter what standard you set for your department, however, make sure you're communicating those expectations to your staff members at every step of their development, said **Jessica Risner, BSN, RN,** CDI director at Banner Health in Phoenix, Arizona.

Once a CDI staff member "graduates" their orientation process, Banner holds them to a productivity rate of 10 new and 10 rereviews per day, but they've given time to mature into that with expectations communicated clearly along the way.

"Our orientation process is a year. We do a slow ramp up to make sure that the foundation is there. When you hit six new reviews per day, we kind of plateau you for a few months. We make sure everything is good. We do lots of audits, and then we increase you," Risner said. "And at the 12-month mark, you should be at 10 new and 10 rereviews."

Even after a staff member has matured, leaders should continue to monitor their metrics, communicate expectations, and adjust things on an individual level if needed, said **Deborah Jones, MSN, RN,** director of CDI at Brigham and Woman's Hospital in Boston.

"My staff's individual goal is a 50% query rate, and they see about eight new cases a day," said Jones. "But if you fall below the query rate three months in a row, then we drop your review rate down until you get back to the goal."

2 ACCOUNT FOR ALL RESPONSIBILITIES AND ADJUST

As a CDI program grows and takes on more responsibilities, expanding its review focus beyond the CC/MCC capture for financial impact, productivity metrics become more slippery.

Leaders have the difficult job of determining where their staff uses their time. Though many CDI software solutions can help leaders monitor staff time, they won't account for work that takes place outside the record review process, such as educational activities.

Rhoda Galang, RHIA, CDIP, corporate CDI manager at Scripps Health in San Diego, California, suggested that leaders develop a tool to help track those duties and identify any issues that are stopping staff from meeting their metrics.

"We developed an Excel productivity spreadsheet that staff have to populate every day at the end of the day," she said. "It measures the productive and the non-productive hours and then it also has a space for comments to explain. For instance, if they have an hour of non-productive time, what was that about? Was it education, or training, or meetings? Or was their system down?"

If you notice repeated issues that are hindering staff meeting their metrics, leaders should adjust accordingly. For example, when Laframboise saw that his staff were overwhelmed on Mondays with cases from the weekend and were unable to hit their 100% review goal, he decided to change the schedules to better distribute the workload.

"We have people working scheduled weekends," he said. "Everyone acknowledges that Monday mornings are tough, but now when people get their assignment on Monday morning, it's Sunday admissions instead of Fridays. That weekend coverage really helps a lot. Monday just feels like another day instead of the weight that it normally is."

Ultimately, the goal of a CDI leader is two-fold, participants agreed: Leaders set expectations for their staff and then enable them to succeed. Sometimes that requires adjustments and a recognition that staff members are human too and may have bad days, especially now during the COVID-19 era.

"Everybody can have a bad day here and there," said **Peggy Paddock, RN, CPC, CDIP, CCDS, CCS,** division manager of CDI at OSF Healthcare St. Francis Medical center in Peoria, Illinois. "We have to be flexible with that and realize all the things happening in people's lives right now."

ACDIS is the nation's only association dedicated to the unique needs of the CDI profession. It conducts roundtables and exchanges like that described above to share ideas, solutions, and insights among CDI professionals. Please visit www.acdis.org to learn more.