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2021 MASTERMIND HOT TOPIC GUIDE: PART 2

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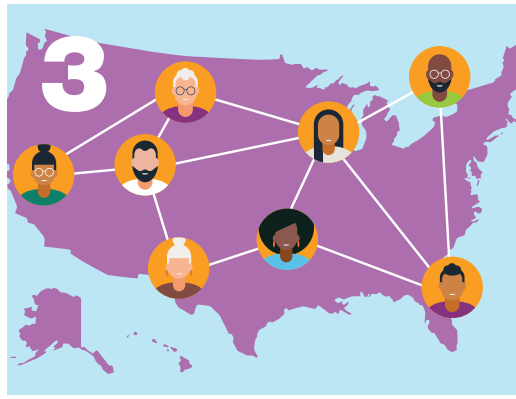

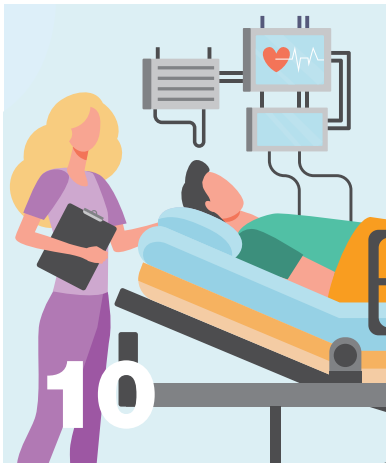

2021 MASTERMIND HOT TOPIC GUIDE: PART 2

The ACDIS CDI Leadership Council serves the purpose of connecting leaders across the country for conversations about the hot topics and industry trends in CDI. A smaller subset of the Council, the Mastermind group, provides participants with an opportunity for focused brainstorming and problem-solving. The Mastermind members participate on the group for one year, covering a wide range of topics during hour-long meetings. Readers can find takeaways on CDI/coding relationship building, internal staff quality assurance, and outpatient CDI expansion from the first half of the term in part 1 of this hot topic guide series.

This second multi-topic report, produced in partnership with 3M Health Information Systems, shares takeaways from the second half of the 2020/2021 CDI Leadership Council Mastermind term, including a three-hour in-person meeting at the 2021 CDI Leadership Exchange. These conversations cover a range of leadership topics, from computer-assisted physician documentation (CAPD) technology to CDI impact and key performance indicators (KPI), avoiding scope creep, and navigating payer sepsis criteria.

Gone are the days when CDI professionals reviewed paper charts and sent physical queries, and the industry has come a long way from rudimentary electronic health records (EHR). Now, many leaders have a wealth of artificial intelligence (AI) solutions at the ready to complement and support CDI's work and reduce administrative burden. While computer-assisted coding (CAC) products have been on the market for some time, CAPD products are relatively new on the CDI scene and many leaders find themselves in the beginning stages of implementation projects.

While some CDI leaders may advocate for additional technology, **Karen DiMeglio, RN, CCDS, CPC,** CDI director at Lifespan in Providence, Rhode Island, says the proposal for a CAPD product instead came from her information systems (IS) department.

"They had gone to a conference and came back and felt like this is something that would really help our providers. At the time, provider burnout was high on everyone's mind," she says. "We also really wanted to make sure that every hospital was capturing the appropriate revenue. They knew it's based on documentation, so they felt like it was a good choice."

Though a new CAPD tool was attractive to the IS department and organizational leadership because it promised to decrease documentation burden and shore up revenue, DiMeglio says that CDI's primary goal should always be the integrity of the documentation. Therefore, any product implemented needs to be reliable, compliant, and useful for both the providers and the CDI team. To ensure these goals were met, CDI leaders should take the implementation process one step at a time.

"When you're rolling out new technology, incrementally is the way to do it," says **Michael Rant, RHIA,** manager, industry relations U.S. and Canada, at 3M Health Information Systems in Murray, Utah. "Even when you're talking to the physicians about a new technology, give

it some time and phase it in thoughtfully so you can make sure it works how you expect it to."

For Lifespan's implementation, they chose to begin with a six-month study period before rolling the product out to all providers. During this period, a volunteer group of providers piloted the program to gain insight into its functionality and any opportunities for improvement. This study period allowed DiMeglio (and colleagues from the IS, coding, and organizational leadership teams) to monitor the use of the solution and the resulting metrics.

Because of potential hiccups, DiMeglio also suggests leaders work with the vendor to turn the solution on in "silent mode" prior to roll out. This way, you can see what triggers the CAPD to prompt the physician and ensure that you're comfortable with the sensitivity of those triggers. Ultimately, this process helped the Lifespan team decide to initially limit the diagnoses the CAPD will focus on to only five:

- Acute blood loss anemia
- Pancytopenia
- Malnutrition
- Encephalopathy
- Acute respiratory failure

"The company had a list of diagnoses that it can prompt the provider on, so I fed that information back to our physician advisor and that helped us decide what diagnoses were too high risk, had too much room for error, to let the software handle," she says.

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Even with hiccups during the "silent mode" phase and the study period, DiMeglio says they did see some substantial positive outcomes as well, including decreases in certain common CDI queries (e.g., chronic heart failure), freeing up the CDI team to focus on more complex documentation issues and provider education. This is really the true goal of a CAPD product, according to **Alison Bowlick, RN, CCDS, MHA, CRCR,** AVP of CDI at Ensemble Health Partners in Cincinnati, Ohio.

"This is ultimately a benefit and aid to the CDI specialists so they can dig deeper into the cases instead of focusing on the low-hanging fruit," she says.

Ultimately, removing those queries from CDI's plate may shift the role of a CDI professional toward a greater focus on education, DiMeglio says, which will change the way CDI leaders look at performance metrics. It won't, however, remove the need for CDI professionals altogether.

"While our primary role has always been to review and query, maybe our primary role will eventually change to review and education," she says.

"It's like the CAC," adds **Lee Anne Landon, RN, CCDS, CCM,** CDI manager at HonorHealth in Phoenix, Arizona. "It hasn't decreased our need for coders."

PROVING IMPACT, KPIs

One of the largest portions of any CDI leader's job centers around collecting, analyzing, and reporting data to prove the efficacy of the program and illuminate areas for potential growth. As healthcare reimbursement has shifted from a fee-for-service model to pay-for-performance, leaders' jobs have gotten more complicated when it comes to proving CDI's worth.

"Last year, we built 17 new reports so that we can give the CFOs the full picture," says **Dawn Diven, BSN, RN, CCDS, CDIP, CCDS-O,** enterprise CDI system director at WVU Medicine in West Virginia. "The first thing out of their mouths is always 'what's the ROI?' And it's a valid question. We as leaders do need to know the answer to that."

While the financial piece will likely always be a focus for your C-suite team, it's also helpful to keep a finger on the pulse of other organizational focal points and align your metrics accordingly, says **Carrie Willmer, RN, CCDS, CDIP,** director of CDI at SCL Health in Broomfield, Colorado. When SCL Health began emphasizing length of stay in the last year, Willmer took the opportunity to align CDI's metrics accordingly to show how her department could impact the organization's goals.

"This year we've been successful in calculating the geometric length of stay shift associated with our queries, which closely mimics the line graph demonstrating our financial impact. Being able to speak the language and align with the organization focus has been really helpful," she says. "It shouldn't surprise me because of our financial impact, but we brought in 400 days last month. That's over a year! It's been a huge perspective shift."

"Your KPIs are going to depend on your organization goals and also which departments you've broken down silos with and work with," echoes Diven. "We work with quality; we work with care management—we work with several different departments—so what can we bring to the table that supports them?"

While all that data helps to paint a more robust and accurate picture of the CDI program's value, getting that data can be a challenge. Additionally, it can be tricky to relay that information to organizational stakeholders in a meaningful way. Landon suggests leaders provide commentary about how their efforts as a department have prevented denials and quality measure penalties down the line. It doesn't have a direct, immediate dollar amount tied to it, but it is making a difference to the bottom line.

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the third and fourth CC or MCC so you're preventing that denial. It's getting that risk adjustment so that your readmission and mortality rates look the way they're supposed to," she says. "We need to recognize that a query doesn't have to have a direct [financial] impact on the case to be impactful."

In addition to pointing out any non-financial impact KPIs, **Jo Brautigam, RN, BSN, CCDS,** CDI manager at Roper St. Francis Health in Charleston, South Carolina, also suggests that leaders explain the difference between your CDI reports and those coming from other departments or an outside vendor. Though they're all showing you *part* of the story, they're not going to be exactly the same, which could spur questions from your leadership.

"We're contracted with 3M for three of our hospitals, but we still do reviews at a fourth hospital because it is still a hospital in our system," she says. "When I present my KPI data, I have to specify that mine is four hospitals, all payers, etc. and it will therefore be different from 3M's data."

Regardless of how many sources of data you can pull from, Bowlick suggests leaders choose and stick to one ultimate source of truth for their data. This way, your presentations will be consistent month over month, and you'll be able to easily compare the data over time.

"Being able to rely on one source of truth is really important," she says. "It may not mirror everything at the system level depending on what you're looking at and when you pull the report, but this is my time to tell my department's story."

NARROWING FOCUS, AVOIDING SCOPE CREEP

In most cases, CDI has long ago proved their value to an organization and, seeing the positive impact the department can have, it can be tempting to get involved in an overwhelming amount of projects. The problem, as many leaders know, is that this attitude can easily lead to a CDI department that's stretched too thin.

"Scope creep is a big pain point," says **Patty King-Musser, DNP, BSN, RN,** senior director of CDI at Geisinger Health System based in Danville, Pennsylvania. "I'm very big on making connections with other departments because of the support that CDI can provide, but once you do that, then they can start to see you as their employees. Trying to make sure you maintain those boundaries is very challenging. We want to be supportive and help drive overall success, but we're a limited resource."

Setting boundaries early in any collaborative project helps ensure the CDI team doesn't lose track of its mission and slowly transition to doing other departments' jobs, Brautigam says. For example, when the two-midnight rule was first launched, her CDI specialists were asked to help ensure the documentation aligned with the new requirement. Before getting involved, Brautigam made sure to define the lines of what would be CDI's role and what would be handled by other departments.

"As part of the health system we belong to, we have to help each other with our expertise. Just be aware, there will be a next ask, because 'the CDI [specialists] are already in the chart.' We can limit it, but if we say flat out no, that's going to label us as inflexible and if we need help

in the future, it won't be there," she says. "Set up a process, do your bit, and then walk away from it."

Remember that CDI isn't necessarily coming to save the day on a given initiative and handle the whole thing on their own, Landon says. Lean on your peers in other departments and seek to form a truly collaborative relationship. This will go a long way in preventing stretching your team too thinly.

"Make sure you're working collaboratively, which means the other departments have to do their part," Landon says. "If you want us to work with you, you have to work too."

The clear divisions of labor and delineation of boundaries also needs to extend to your metrics. Yes, CDI can help with quality projects, for example, but ultimately the quality department still needs to be responsible for their own metrics.

"Let other departments own their own KPIs," Bowlick says. "We can still show how we're supporting other departments, but it's ultimately their data."

Though many CDI departments may find themselves pulled in new directions, some departments may view CDI's help as a threat, Diven warns. From their perspective, it could be seen as CDI coming to fix their mistakes or take away their jobs. When this misunderstanding occurs, CDI leaders should work to diffuse any tension and approach the relationship from a place of humility.

"We're not here to take away your job—you're really great at your job," Diven says. "I'm not here to point fingers at anyone, I'm here to learn. We just want to get better at what we do."

When CDI does begin working on "non-traditional" CDI projects (e.g., denials management, quality reviews, etc.), leaders should factor those efforts into the productivity expectations to ensure staff members aren't getting penalized for taking on new projects.

"We've factored in the extra projects into productivity, so it all counts," says Diven. "Whether you're reviewing concurrently or retrospectively for quality, mortality, whatever, it all counts."

In addition to helping advance organizational goals, CDI's involvement in various projects can open professional development possibilities for staff members, helping to ensure long-term job satisfaction and career growth.

"I see a lot of this as an opportunity for staff development," Willmer says. "We can't be Jack of all trades, because then we'll be master of none, but what we've done is build project teams. […] It's been so interesting to see how we can crosspollinate interest with expertise."

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There are certain diagnoses that seem to be a thorn in the side of every CDI program—malnutrition, respiratory failure, and encephalopathy to start—but none top the list as frequently as sepsis. A large part of the issue from a CDI perspective is that there's not a universally accepted set of criteria used by all parties, for organizations and payers alike. In fact, it's become a common practice for payers to target sepsis claims because of this very criteria confusion.

Though it won't completely stem the tide of denials, many CDI program have worked with their organizational leadership and physician staff to write organizational sepsis criteria upon which to query and fight denials. The work shouldn't end there, however, according to King-Musser.

"What the facility needs to do is come up with standard criteria for those commonly denied diagnoses," she says. "And then you need to take the definitions back to the insurance companies at contract time. […] This is bigger than coding and CDI. This needs to be supported at a higher level."

Since some payers (such as UnitedHealthcare and Cigna) have publicly embraced sepsis-3, your appeals won't make much headway without that crucial contract negotiating piece, Diven says.

"We have a systemwide sepsis committee because not only are my CDI team members confused, but the physicians are confused too," she says. "Ultimately, we need to get into the contract discussion because I don't know what we've agreed to. We can fight until the cows come home, but if you've already signed something, we're done."

While clearly defendable, Willmer also warns that even if you weren't *technically* contracted to use sepsis-3 criteria at the time, some payers may try to deny cases dating from sepsis-3's publication under the guise of it being the payer's "official" criteria set.

"You can't hold us to criteria retrospectively that was never communicated to us," she says. "We're getting hit from all angles and it's discouraging."

If you're not involved with the contracting piece, the CDI team can still make a difference through the query process.

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For the sake of compliance, organizations shouldn't document strictly to follow the payers' whims (especially since different payers hold to different criteria) or down-code to avoid a potential denial.

"Technically, we are in a contract with UnitedHealthcare and we are supposed to give them back all this money because it didn't meet sepsis-3, but on the other hand, we have to code compliantly based on the physician's documentation," says Willmer.

Instead of coding non-compliantly and ignoring clear physician documentation, CDI professionals should do what they always have: Review the record and query to ensure the documentation is thorough, complete, and clear. That way, if a denial does arise, the organization will be in better shape to fight it.

"What CDI does is if the documentation meets sepsis-2 and it's valid, we leave it alone," says Brautigam. "If it looks like there's sepsis and we're going to query to get it in the chart, we will incorporate with sepsis-2 and sepsis-3 criteria on our query. […] Ultimately, we have to take what they document."

"If we have any additional organ dysfunction, we always ask them if they can make the link to the sepsis," echoes Landon. "We'll take sepsis-2 because that's what our organization has decided, but we'll query for the link if we can."

While this practice will help ensure the documentation is as airtight as possible, it's still likely your organization will see denials if the case doesn't meet sepsis-3 criteria simply because it's a more strenuous criteria set to meet and defend. The criteria were not developed to be used in payment determinations, however. It was created to determine risk of mortality for severely ill patients in the intensive care unit (ICU). Identifying a patient as septic *before* they have organ failure is good patient care and doctors should get credit for that care, regardless of it meeting sepsis-3 or sepsis-2.

"It's a patient care issue ultimately. I don't want to be dismissed from the ED until I have organ dysfunction because I didn't meet sepsis-3," Diven says.

"It's advantageous to the payer for us to do good quality care and that care comes from early identification," adds Willmer. "They want to have their cake and eat it too." ■