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2022 MASTERMIND HOT TOPIC GUIDE: PART 2

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The ACDIS CDI Leadership Council connects 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 in the group for one year, covering a wide range of topics during hourlong meetings. Readers can find takeaways on internal staff audits, CDI scope creep, and clinical validation from the first half of the term in Part 1 of this series.

This second multitopic report, produced in partnership with 3M Health Information Systems, shares takeaways from the second half of the 2021/2022 CDI Leadership Council Mastermind term, including a three-hour in-person meeting at the 2022 CDI Leadership Exchange. These conversations cover a range of leadership topics, from CDI quality involvement to balancing priorities, denials management, and thoughtful leadership principles.

QUALITY INVOLVEMENT

CDI involvement in quality reviews represents a necessary facet of CDI's role for many organizations. With reimbursement increasingly tied to quality-of-care measures and the public getting greater insight into hospital quality scores, many CDI teams are finding themselves collaborating much more closely and frequently with their quality department colleagues.

One of the benefits of expanding CDI into the quality space is that CDI can catch potential documentation errors concurrently before coding, escaping quality penalties entirely. Traditional quality department work, on the other hand, is done retrospectively and therefore doesn't necessarily catch the issues in time to avoid penalties. When organizational and quality department leadership realize the potential benefits in having CDI review for quality, it's likely that the door will be opened wide for CDI expansion, says **Jeanne Johnson, RN, MHA,** CDI director at Premier Health in Dayton, Ohio.

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— Jeanne Johnson, RN, MHA, CDI director at Premier Health in Dayton, Ohio

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In some instances, though the benefits of CDI quality reviews may be clear to an outside observer, the quality department may feel that CDI is stepping on its toes and indicting the caliber of its work. According to **Kelli Hill, BSN, RN, ACM, CCDS,** then CDI manager at North Mississippi Health Services in Tupelo, there's a fine line to be walked in

the relationship between the departments. Sometimes, CDI should step in when asked but ultimately defer to quality's authority to stay in their good graces.

"It often comes back to us anyway," says Hill. "Sometimes, they come back way too late, so we're trying to move that to real time, but sometimes we get pushback that it's quality's job and we should focus on the CDI aspect."

If the CDI department does need to cede some concurrent quality reviews back to the quality department, Johnson says it's important for everyone to be on the same page about compliant query practices. No matter who's asking the question, they should follow the latest ACDIS/AHIMA *Guidelines for Achieving a Compliant Query Practice* brief to the letter.

"I have shared the practice brief with me colleagues on other teams across the organization," says Johnson. "At the end of the day, we need to be asking the question compliantly. We don't want the OIG knocking on our door."

If tensions continue to mount, CDI leaders should work to explain how the departments don't simply duplicate efforts, but rather complement each other with CDI working on the concurrent side of the equation and quality on the retrospective side. Again, one of the biggest benefits of CDI reviewing for quality is that they can catch issues concurrently instead of just retrospectively. This outcome, according to **Ann Zierden, BSN, RN, CCDS, CDI** director at CentraCare Health in St. Cloud, Minnesota, should be something everyone can get behind.

"I trained our quality folks to get the PSIs [Patient Safety Indicators] and HACs [hospital-acquired conditions] out of our software, but they're looking at them from a different angle than we are in CDI," she says. "I feel like we have more control over how our PSIs and HACs are ultimately reported than a quality team can because we work concurrently."

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CDI leaders' plates have never been fuller. Now that CDI has proved its efficacy over the last couple of decades, organizations increasingly lean on their CDI teams to help with numerous initiatives.

"CDI has finally arrived, and people are now listening," says **Sheila Duhon, MBA, RN, CCDS, CCS, A-CCRN,** national CDI director at Steward Health Care in Dallas, Texas. "I'm being put in front of the top person in the company and I'm getting to explain that every query and every impact ultimately has a financial impact. If our CC/MCCs aren't there when they need to be, it may not always change the DRG, but it changes the severity and risk; it shows our patients are sicker. They're going to come to our hospital if our mortality ratios are good, they're going to come here if we get the good scores, and all that's money."

Balancing all those priorities, however, can be a full-time job. Leaders must be adept at prioritizing their to-do list daily. When the list appears unending, sometimes the only approach is to prioritize based on the most urgent project at any given time, says Zierden.

"Prioritization for me is always about deadlines—what's due when. And then, if I can put any attention to projects, or research, or looking at what the data are showing me to see if I'm missing anything," she says.

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The solution to lighten a leader's load or broaden CDI's reach might seem obvious: bring on additional full-time employee (FTE) positions. Yet a leader must take on a specific project or task to *prove* the need for additional FTEs, says Johnson—despite the fact that this project itself will represent added work. When you want to undertake a new type of review or a new service line, your organizational leadership likely won't approve any new staff positions until they know the project is worthwhile. In these circumstances, Johnson says part of a leader's role is often to run a one-person pilot program.

"I'm getting ready to take on the mortalities. My revenue boss initially said she didn't want me to do it, but I asked for permission to complete an audit and see where we land," she says. "If it proves beneficial, I will then submit a request for an FTE. We are so lean that I'm starting small."

In addition to the positive outcomes from the pilot, **Chana Feinberg, RHIA,** CDI product specialist at 3M Health Information Systems in Silver Springs, Maryland, says leaders should consider how much of their own time a project requires when requesting more staff. How much of your time as the leader is going to the project? How much more impact could a dedicated staffer have on the project?

"Your time as a leader should be taken into account," she says. "That information can be used to make the case for more staff."

According to the 2022 CDI Week Industry Survey, nearly 68% of respondents are involved in the denials management process in some way—up nearly 10 percentage points since 2019, the last time the topic was included in the survey. While it's an increasing area of CDI involvement, many CDI leaders find themselves thrust into the deep end with little preparation, overwhelmed by the volume of denials under their purview.

"I've been handed the denials, so I do all the clinical validation denials," says Hill. "I would love to focus more on CDI and less on writing appeal letters."

Because dealing with denials and writing appeal letters can become a full-time job, leaders need to determine where their limited resources are best spent. One method is to focus on diagnoses and DRGs that are at a high risk of denial. If you're pressed for time, Duhon suggests starting with DRGs on that list and working to shore up the documentation through a clinical validation review process both concurrently and post-coding, pre-billing. To gain insight into your particular risk areas, start with the data.

"[Our analytics team] built a report for us that lists all our high-risk DRGs: those that end up in a sign and symptom DRG, every sepsis case that ends up in DRG 872 [septicemia or severe sepsis without mechanical ventilation >96 hours without MCC], etc. As a result, our 872s have decreased massively. Those were all cases that were going to be denied because they weren't meeting Sepsis-3 criteria," says Duhon. "You can't change anything without good data."

If you do plan to institute a post-coding, pre-billing clinical validation process for high-risk diagnoses, developing a concurrent coding process may be a huge

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help, Feinberg says. This process often involves a partnership between a coder and a CDI professional and a real-time reconciliation of the coder-selected codes and the CDI-selected codes before the patient is discharged. Then, when the patient is discharged, most of the work has already been completed and the bill can be dropped faster with less concern about errors that could lead to a denial, Feinberg says. And in an ideal world, the process won't involve additional resources to accomplish, just a mindset and workflow shift.

"It should be so much faster to do things this way, and you'll be able to drop the bill faster and avoid a denial because all that work has already happened," she says. "Hopefully, it's more just a shift of staff rather than creating more work."

In addition to identifying potential at-risk documentation concurrently, you can also determine a threshold for when a denial is worth appealing, Johnson suggests. Instead of spending your time chasing small claims, save your resources for the cases that are worth fighting both from a documentation standpoint (i.e., cases with clear supporting documentation) and from a financial standpoint.

"You need a revenue department person who can run the denial reports for you," Johnson says. "Then, decide a dollar threshold for what you're going to fight. It's the only way it's going to be sustainable if you don't have additional staffing or outsourcing."

Ultimately, despite CDI's best efforts, denials will always be a reality. Choosing your battles—and, especially, catching as many red flags concurrently as possible—will go a long way toward building a sustainable process that includes CDI's involvement, says Hill.

"Anything you can do prior to discharge is great," she says. "Instead of reacting, if you can do it proactively, you're better off."

Thoughtful leadership is a journey that never ends. Having a high-performing staff doesn't necessarily mean you have a happy staff who want to grow and become leaders themselves. And that can lead to a high turnover rate. To retain staff, particularly over the course of the pandemic and continued remote work, CDI leaders must be considerate of their staff's needs.

Perhaps one of the most important investments thoughtful leaders can make is in listening. When you look back over your career, who stands out as your best leader? Likely it's the one who was available, flexible, and supportive to staff.

The world is stressful, says **Schimanya Sullivan, RHIA, CCDS, CCS,** CDI director at Prisma Health in Columbia, South Carolina, and that stress can take a toll. A team member may not be performing at their best, but listening can help you find out why. "See what's going on in their lives so we can help support them," she says.

Working remotely doesn't have to be a hindrance to knowing and listening to your staff, Duhon adds. "It's such a different world now that I feel like I know them, even in this virtual world," she says. "And a lot of it has to do with turning on our cameras."

"When a leader makes a decision [about promoting new leaders], we as leaders have to be ready to invest in them and to train them to be good strong leaders as well. You have to be able to support them and help them grow in that position."

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Duhon says she encourages people to use cameras "so that you're not just talking to a voice. You're not just looking at a screen and you hear a voice, but you see the nonverbal language, the sincerity when somebody's talking about something."

Leaders could also consider instituting drop-in office hours virtually—the equivalent of an open door in an in-office environment. It's simply a set time each week when managers are available online for team members to pop in virtually for a chat. The conversation can be about anything; it's about hearing your staff members and ensuring they know you're available for anything they might need.

Remote work is "a different way of communicating with people that we were forced into—the whole world was forced into—but there are advantages to that," Duhon says. And working remotely doesn't decrease the impact of what the team is doing.

Whether you're remote or on-site, investing time into your team and their professional development is an important part of being a thoughtful leader, says Feinberg.

"You hire people who are high performers, and over time you see their skill sets develop," she says. "When a leader makes a decision [about promoting new leaders], we as leaders have to be ready to invest in them and to train them to be good strong leaders as well. You have to be able to support them and help them grow in that position."

At the same time, you have to invest in yourself to keep growing as a leader, she says. You can't lead thoughtfully and effectively without investing in your own professional development too. ■

