2023 Mastermind Hot Topic Guide: Part 2

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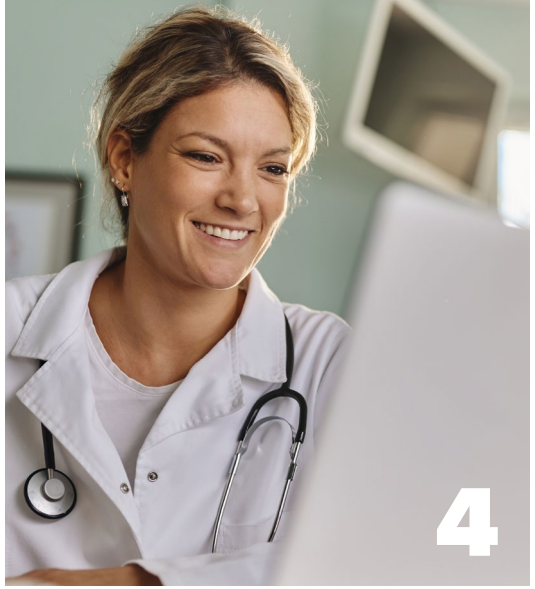
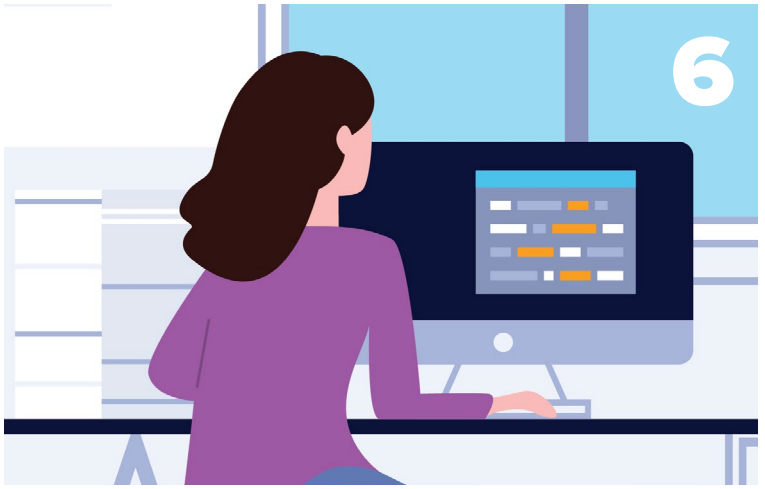




The ACDIS CDI Leadership Council exists to connect leaders nationwide (and even internationally!) for conversations about the hot topics and trends in the CDI industry. A smaller subset of the Council, the Mastermind group, provides participants with an opportunity for focused brainstorming and problem solving. The Mastermind members meet six times during their one-year term, covering a wide range of topics during hourlong meetings. Readers can find takeaways on metrics and monitoring staff performance, denials management, and problem list management in Part 1 of this series.

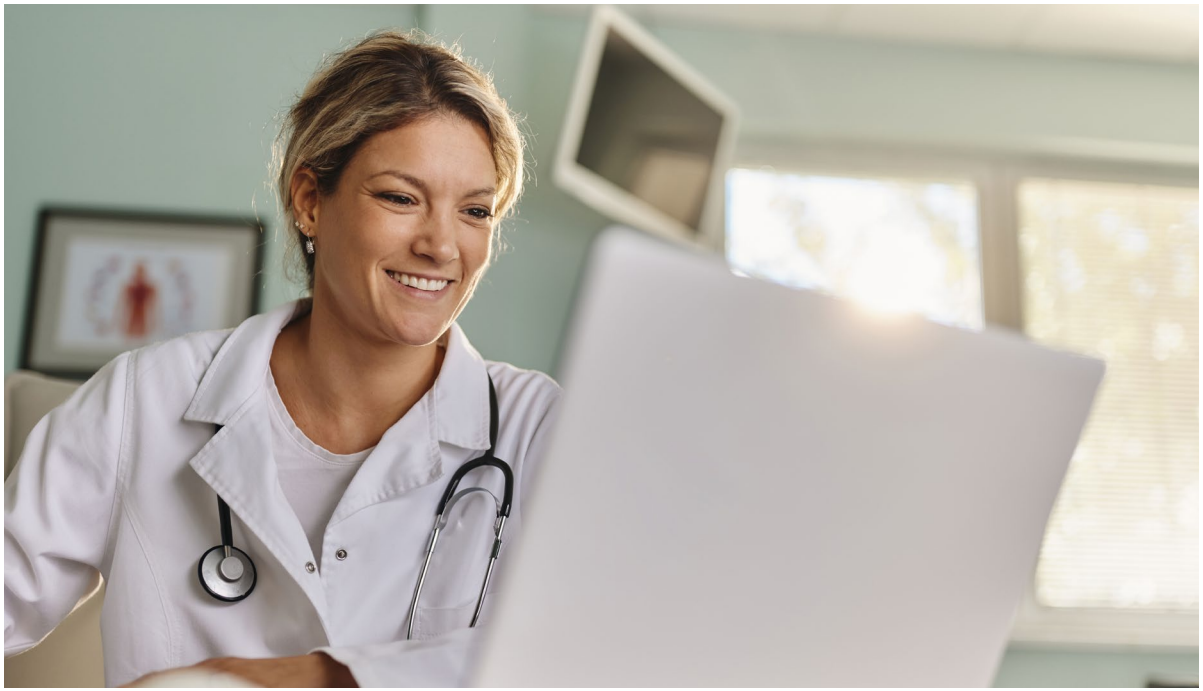
This second multitopic report, produced in partnership with 3M Health Information Systems, shares takeaways from the latter half of the 2022/2023 CDI Leadership Council Mastermind term, including a three-hour in-person meeting at the 2023 CDI Leadership Exchange. These conversations covered physician education for mortality reviews, prioritization and workflow, quality reviews, and change management.

PHYSICIAN EDUCATION FOR MORTALITY REVIEWS

According to the 2023 CDI Leadership Council Research Series survey, 67.33% of respondents reported performing mortality reviews retrospectively in order to accurately capture severity of illness (SOI) and risk of mortality (ROM). One of the challenges with these reviews, however, is that they are often time-consuming and require a high level of attention to detail. Boiling the ocean and reviewing every mortality is often not feasible for even a well-staffed CDI program. Instead, CDI leaders must choose where to apply their efforts to yield the greatest impact.

Of course, one of the best ways to choose a focus area is to review your data and see where there are "outliers" that could benefit from a CDI review. While leveraging your internal data can be helpful, Madelyn Rawls, RN, CCDS, CDI system director at FMOLHS in Baton Rouge, Louisiana, found that using an external quality database—Vizient in her case, though other organizations may use others—helped highlight focus areas.

"We recently obtained Vizient, which provides significant insight for various data points, including many items impacting 'expected' mortality scores. In addition to things outside of documentation and coding to collaborate on, the Vizient data is useful for identifying physician education opportunities and can be used in conjunction with our internal audits, query data, and overall CDI metrics," says Rawls. "The Vizient data is becoming the primary driver of CDI-related targets, as there is much focus on O:E [observed to expected] ratio."



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When picking a focus, it's also crucial to understand what CDI can and cannot impact, says Lena Wilson, RHIA, CCDS, CCS, MHI, CDI manager at Indiana University Health in Indianapolis, Indiana. Though no one wants it to be the case, the reality is that CDI cannot change the actual observed number of deaths at an organization. All they can do is ensure that the patients' SOI and ROM are accurately portrayed to ensure it does not erroneously look like the hospital's

observed deaths include perfectly healthy patients. In the O:E mortality ratio, the CDI team can only influence the expected.

"We can't change the numerator [the observed deaths]; the numerator is the numerator when we're looking at the mortality index, so the only thing that we can really fix is that expected," says Wilson. "We really need to be looking at that expected because that's where the bulk of our impact will be as well as the expected value for the length of stay index."

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Once you've selected a focus area, you need to decide how you'll communicate the education to providers. In the largely virtual post-COVID world where most CDI teams work remotely, CDI leaders may need to be creative, says Lori Ganote, RN, MSN, CCDS, CDI director at Baptist Health in Louisville, Kentucky.

"As opposed to us doing education live, side by side, going to find them on the unit, we had to alter our overall education and figure out how is it that we deliver education and what can we do differently," she says.

The good news, however, is that many CDI leaders have found a willing audience in their providers when it comes to virtual education, according to Karen Elmore, RN, CCDS, CDI manager at BJC HealthCare in Kansas City, Missouri. To meet the providers where they are without at-the-elbow education, Elmore's team worked to develop tip sheets and short one-to-two-minute videos to support the education, which the providers can then access from their computer or smartphone at their convenience.

"Education has changed tremendously since COVID, but I do like it because I think with the video vignettes, they send it over to their phone and the providers can look at it on their phone. They don't have to actually come to a class or try to log on to a computer or something like that," Elmore says. "It's a little more accessible."

PRIORITIZATION AND WORKFLOW

As CDI responsibilities expand and change over time, the workflow must adapt with it. One of the biggest challenges for many programs—particularly those that are not staffed to review 100% of all patient records—is prioritizing their CDI work queue to ensure the charts reviewed have opportunities for improvement and align with organizational priorities. Often, those priorities shift over time, so CDI leaders must be wary of making any one measure the ultimate marker of success for their department, warns Amy Kratochvil, RHIT, CCDS, CDIP, CDI director at UChicago Medicine in Chicago.

For example, recently Kratochvil's organization has embarked on a project focused on length of stay, and though her team is happy to assist in reviewing for this concern, it's been important to remind leadership that CDI can't fix everything, and that they have additional (and equally important) priorities during their reviews.

"I had so many concerns and still to this day, I get so many questions," says Kratochvil. "Some of it is, 'Well, your provider hasn't done the operative report, so it's going to still be in a medical DRG.' There's a capacity and access committee that I always have to go speak to and explain why it's not perfect and that [length of stay's] not the be-all-end-all either."

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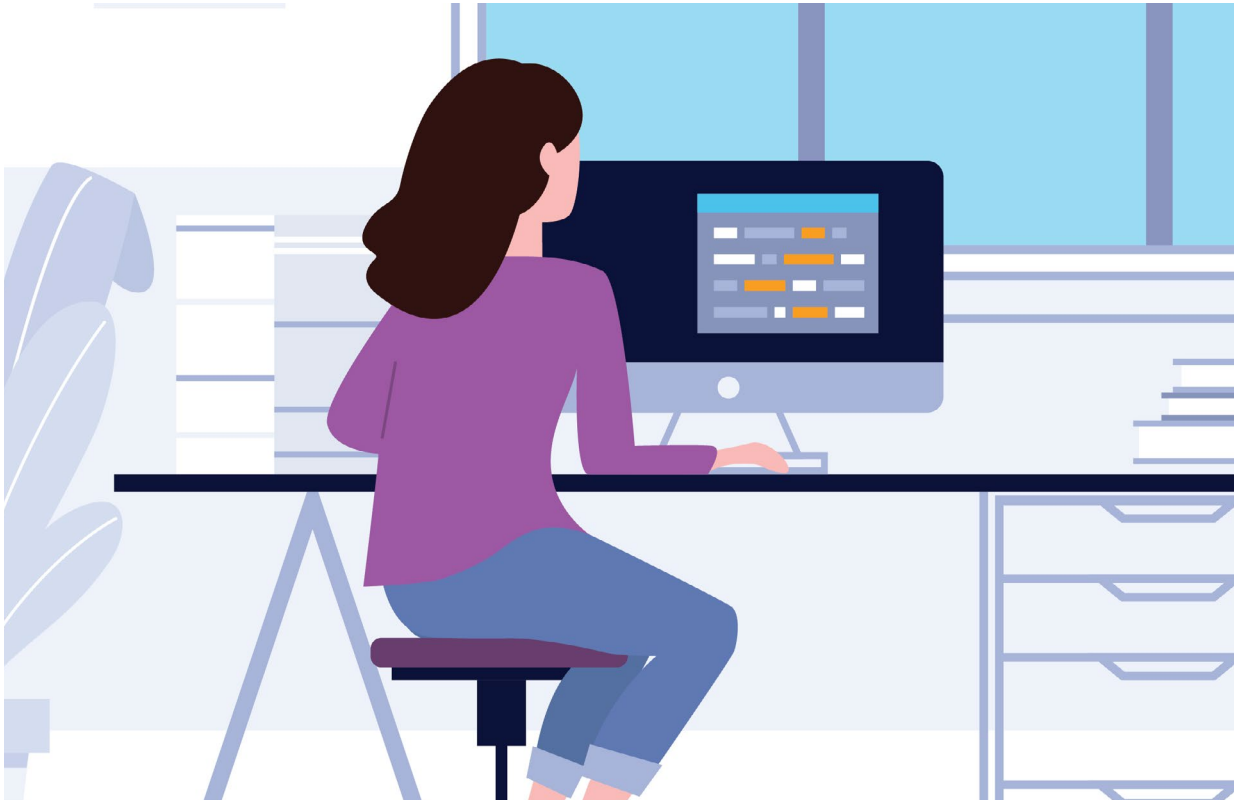
Regardless of current organizational focuses, many CDI leaders turn to technology to aid in this process. These technologies, however, are rarely (if ever) set-it-and-forget-it solutions. As a result, CDI leaders must develop a process for continual improvement and adjustment to ensure their tools work for them and not the other way around.



"We run reports on [our prioritization software] monthly and then make changes quarterly. I analyze it every single month," says Ganote. "When I make that change, I just let the team know, 'Hey, by the way, you may see some different DRGs in the prioritization list,' and then let it go after that."

In any review and improvement plan, Wilson says it's important to include your CDI staff in the conversations. Leaders have the luxury of a 30,000-foot view of the CDI department and organizational needs, budget constraints, etc., but they aren't the ones actively reviewing records day to day and working in the software. In order to make lasting and impactful change, you need both the high-level view and the minutiae of the everyday.

"I'm not in there concurrently reviewing those charts, so you have to tell me what you're experiencing because that's the only way we're going to know," says Wilson. "I've noticed that once I gave over that control to the team and said you're going to recommend what the changes need to be, they like it. [...] And no one feels bad if it doesn't work because if it doesn't work, it doesn't work. Try something else; we'll go back to the drawing board."

Developing an open feedback process is often easier said than done, but it starts with leaders making a concerted effort to ensure their staff know the door is open, says Madhu Subherwal, MBBS, MHA, CCDS, CDIP, CDI manager at Torrance Memorial Medical Center in Torrance, California.

"I've given them the open door to criticize and critique prioritization as much as they want," she says. "I let them explain to me what they're not happy with and they'll write out what they really think it should be and what should be priority because I'm not doing the reviews all the time; they are. They know what's trending; they know what they're sending."

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QUALITY REVIEWS

One of the areas that has required a reprioritization of CDI time has been the increased focus on quality measures. Finding the right balance for CDI involvement in these efforts can be a challenge for two main reasons. First, quality reviews often require more time than "traditional" CDI reviews, which can impact productivity and the percentage of charts your team is able to touch each day. Second, developing a CDI quality review process requires a collaborative effort with several other departments—from quality to coding to clinical services.

"The frustration is you either have maybe too much involvement where [others are] trying to tell you what you should be doing instead of staying in their realm, or you have the other end of the spectrum and they don't even think to invite you,"

— Kaily Schmeling, RN, CCDS, lead CDI auditor at Vanderbilt University Medicine in Nashville, Tennessee

"The frustration is you either have maybe too much involvement where [others are] trying to tell you what you should be doing instead of staying in their realm, or you have the other end of the spectrum and they don't even think to invite you," says Kaily Schmeling, RN, CCDS, lead CDI auditor at Vanderbilt University Medicine in Nashville, Tennessee. "Then halfway through, you find out this whole project is going forward and they didn't even want your input or your help."

One way to foster these collaborative relationships is to bring all the stakeholders to the same table during regular meetings. Not only does this ensure everyone is on the same page, but it can also illuminate areas of expertise and bring a more holistic view to your quality reviews, says Keisha Downes, RN, CCDS, CCS, senior director of middle revenue cycle at Tufts Medicine in Boston.

"We take it from a multidisciplinary approach, so we have everyone at the same table," she says, adding that each facility in the system has a committee that includes members from coding, CDI, quality, and physician advisors. "We have

the shared drive, and we all review it from our own perspective and then come to the table that way."

Of course, leaders still must find a balance of collaborating and avoiding meeting burnout, Kratochvil warns. Determining where CDI is needed will come down to a close appraisal of organizational goals.

"From a meeting perspective or ask, it's a lot to cover all these different meetings," she cautions. "It's tricky to cover everything."

Though it may be natural to have CDI and quality departments collaborate, regardless of focus area, don't forget your coding colleagues, cautions Michael Rant, RHIA, industry relations manager at 3M Health Information Systems in Murray, Utah. Because of the limitations of the UB-04 form, coders must grapple with only being allowed to submit 25 codes for billing purposes. If they aren't aware of the nuances of quality programs, exclusion criteria, risk adjustment, etc., the work that CDI and quality teams are doing may not be recognized in the billing.

Take, for example, social determinants of health (Z codes). Traditionally, Rant says, those codes were often sequenced below the 25-code line. Now, however, codes for homelessness hold a CC status, and other Z codes can be helpful in painting the picture of your patient population's true needs, resource use, and complexity.

Working with your coding colleagues means all those efforts to improve quality documentation will actually earn your organization credit.

"The Z codes are really a problem," Rant says. "It'd be great if CMS would just take all the codes. Everything is electronic, so why can't they take everything? But right now, you have to make sure they're being sequenced correctly."

In addition to meeting at the same table—whether in person or virtually—bringing all stakeholders onto one technology platform will make the ongoing collaboration smoother. Think of it as speaking the same language. Whether this means consolidating CDI, quality, and coding departments under one umbrella or simply developing a formal process for the work and communication flow, the effort is well worth the time, says James (Jamie) Doster, RN, CCDS, MS, CDI manager at Atrium Navicent Healthcare in Stone Mountain, Georgia.

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"Having quality and coding merging with CDI was a good thing for us," he says. "Quality is documenting in the software and sending the notifications through there, then we send it back to them in the same system, so they're logging our efforts and keeping the follow-up on track."

Whether it's taking on more quality and mortality reviews, expanding to a new setting such as outpatient, helping with denials and appeals, or expanding your team, one of the roles of an effective leader is shepherding staff through change smoothly. CDI leaders aren't new to navigating change, particularly when they've been in the industry for a while, but it doesn't mean it's an easy road to travel.

"We've gone through significant change. This is not the CDI of 10 years ago," says Downes. "We need to get up to par with the national standards when it comes to productivity, query opportunity focuses, etc."

When embarking on a change, whether large or small, Subherwal says it's important to communicate your departmental expectations up front and then reiterate frequently so staff stay on track even during transitions.

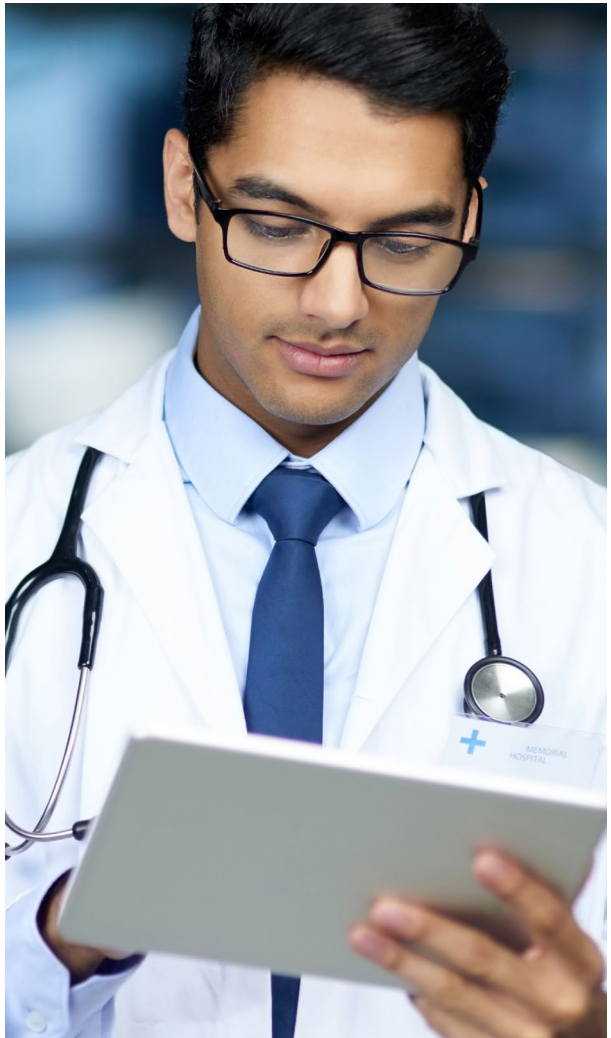
"One thing we make sure of is that when they start, we go through the policies with them and we tell them what the expectations are and they sign off on that policy, but that's not where it ends," she says. "I bring it back every three or four months. [...] We talk about it in the huddles."

Though it's important to set clear expectations, it's important to remember to listen to your staff members, just like you would when developing a new workflow or adopting a new technology solution, says Doster. As CDI efforts expand, it's not always one size fits all for the staff when it comes to ability, interest, and enthusiasm. If you have enough staff to manage it, exploring ways to allow CDI team members to specialize can help ease some of the woes that go along with change.

"The best thing I found is to find out their strengths. One staff member is very good with PSIs [Patient Safety Indicators]; she likes that. She's the PSI advocate. Another one loves queries; she likes to follow the doctors and catch up with them in the hallway," says Doster. "I brought their productivity standards down just a little bit temporarily for them so they can have those separate responsibilities."

Regardless of whether you decide to roll out specialized roles and projects for staff or have all staff undertake new priorities, Schmeling advises that leaders should pay special attention to what motivates individual staff members. Some staff members may need clearer consequences for failing to meet expectations, while others may crumble under that pressure. Your job as a leader is to understand what your staff need and lead them safely through the changes that will come.

"I do think for some people it is the stick. They need to know that they're not meeting expectations, [...] But for others, it's the carrot, maybe they need rewards, like schedule flexibility. And then I think there's the third person, which is where I put myself, who internally does both to herself," Schmeling says. "Finding what motivates each person is really important." ■



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