2024 Mastermind Hot Topic Guide, Part 1

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A CDI leader's responsibilities are varied, and new and seasoned leaders alike can feel isolated in their struggles. Rather than braving the path alone, leaders can get a much needed helping hand by connecting with peers outside their organizations to collaborate, trade advice, and share challenges and successes. The ACDIS CDI Leadership Council connects leaders nationwide for conversations about hot topics and industry trends. But a smaller subset of the Council, the Mastermind group, gives participants an opportunity for focused brainstorming and problem solving.

This multitopic report, produced in partnership with Solventum, shares takeaways from the first half of the 2023/2024 CDI Leadership Council Mastermind term. These conversations cover a range of leadership topics, including CDI's impact on readmissions, handling scope creep with increased responsibilities, and mitigating staff and leadership burnout.

As the industry has matured, CDI departments have taken on more and more responsibilities, furthering their impact far beyond simple CC/MCC capture for DRG accuracy. Over the last several years, CDI's involvement with quality reviews has grown, generally focusing on measures such as Patient Safety Indicators, hospital-acquired conditions, and mortality observed to expected (O:E) ratios. In recent years, however, many organizations have expanded their CDI quality footprint to see how documentation integrity efforts can affect other measures such as readmission rates.

Like any new expansion area, the first step to involving CDI with readmission reviews is to determine a focus for your efforts. Trying to boil the ocean rarely ends well, so **Traci Lindner, RN, CCDS, CDI** manager at Marshfield Clinic Health System in Wisconsin, suggests limiting your focus to a few diagnoses. The CDI team at Marshfield decided to focus on congestive heart failure (CHF), pneumonia, chronic obstructive pulmonary disease, and acute myocardial infarction (AMI). Once you've selected a starting point, dig in and see if you can get even more specific in your focus.

"Our largest volume was CHF, and honestly, the only wiggle room we found would have put them into a different cohort," she says. "That was not a good use of our time. Where we found that documentation could make a difference was in the pneumonia and AMI."

For example, when looking at pneumonia, Lindner's team found that the index admissions were the pneumonia principal diagnosis and the sepsis principal diagnosis with pneumonia as a secondary diagnosis. Patients were excluded from the cohort, however, if severe sepsis was documented with a present on admission indicator of "yes," which physicians were missing in their documentation. Lindner's team was then able to go back to the providers and coders with education about linking the organ dysfunction to the sepsis to ensure accurate capture of the severe sepsis code, which then excluded the patients from the cohort and improved readmission rates. Similarly, specifying an AMI diagnosis as a type 2 MI, when appropriate, excluded patients from the AMI cohort.

In addition to identifying areas for potential impact on exclusion criteria, setting goals around your expected readmission rate is also a crucial step in making an impact, adds **Shawn Dickinson, BSHCM, RHIT,**

CDIP, inpatient product manager, CDI, at Solventum.

"Equally important to inclusion or exclusion from the cohort is setting expected rates of readmissions (and mortality)," he says. "Querying for diagnoses impacting risk adjustment (not just having a financial impact) is another step to improve readmissions and mortality performance."

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Once you have a focus in sight, it's important to set realistic expectations for what CDI can impact, says **Tiara Minor, RN, BSN, CCDS,** director of CDI at the University of Miami Health System in Florida. Though CDI can certainly help with readmission rates by ensuring that patients are appropriately included in or excluded from readmission cohorts, ultimately readmissions are a team effort and cannot be solely owned by CDI.

"It's an organization wide goal. It's something that CDI can't own," says Minor. "We have hired some nurse practitioners that are doing a lot of follow-ups with the patients and trying to make sure that at discharge they got everything they need. Then they're following up to make sure there aren't social issues or anything else that we can intervene in. [...] Again, CDI can't have a direct impact on that, but we can help with getting a few golden nuggets like severe sepsis and type 2 MI into the documentation to help exclude patients when appropriate."

At the end of the day, even though CDI can't be the sole group involved with an initiative to improve readmission rates, they can help identify potential issues in real-time and elevate those concerns to the teams that can make a difference in direct patient care.

"While I can't help impact patient care, I have more real-time data than the clinics that want to do right by their patients," says **Melanie Reineke, RHIA, CCS, CPC**, hospital coding and CDI manager at Nebraska Medicine in Omaha. "I can provide the data and understand the data better to help them start identifying issues in real-time while they're actively having these readmission problems."

Of course, as organizations see how successful CDI efforts have been, they'll likely want to leverage that CDI effect in other areas. While it's a good thing that CDI is seen as valuable to an organization, more responsibilities mean less time for "traditional" CDI reviews and could lead to the dreaded scope creep sneaking in. To address this potential problem, **Angelica Cage, MBA, BSN, RN, CCDS, CCS, CDIP**, CDI director at Tufts Medicine in Boston, Massachusetts, suggests keeping your mission front and center in all discussions about CDI expansion.

"It sounds cliché, but focusing on what the focus of your program is will dictate where you go next," she says. "[For example,] we report to revenue cycle, and I've had to have conversations with CMOs and presidents to say, 'It would be great if we could be Vizient top 5, top 20, but that's not the focus of our CDI program or our annual KPIs. And if you want it to be, then understand revenue may shift and revenue may change because Vizient variables do not necessarily equal dollars."

Keeping your goals—both departmental and organizational—in focus will help ensure your CDI resources are being utilized in the most appropriate places. Additionally, being fully transparent with leadership regarding realistic expectations

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ensures your team can manage the daily workload when current staffing ratios cannot be changed, according to **Debra Clark, RN, GERO-BC, CCDS, CDI** supervisor at Sanford USD Medical Center in Sioux Falls, South Dakota. While a CDI team can accomplish great things for an organization, it's important to collaborate with leaders upfront to identify what's manageable.

For example, in 2019, Clark's organization recognized there was an opportunity for CDI to impact the mortality O:E ratio through closer collaboration with the coding and quality departments. As their efforts got underway, however, the COVID-19 pandemic hit.

"Suddenly, we had more mortalities than expected. We had to take our teams and

say, OK, they're focusing on mortality. There may be other things we're not going to get to. We're happy to focus there, but we might not be able to prioritize something else," Clark says. "It takes considerable collaboration, to include communication of team bandwidth when adding workload expectations. We can help, but it might take us away from another area of focus, that was previously found to be very important."

Just like involvement with readmissions, it's also important to recognize that CDI can't be responsible for every problem an organization may encounter. CDI has a specific scope and specific resources, and therefore a specific potential impact. They simply can't be all things to all departments, Minor reiterates. CDI can make a big impact without getting away from their original goals and mission.

"You have to find a way of helping out but not owning it. I know that's a challenge when you prove success with something," Minor says. "If I recognize the problems, recognize the solutions, yes, I should put it out there, [but] you can help without owning it."

"Clear lines should be drawn on what is (and what is not) in the current role of a CDI," echoes Dickinson. "A great example is requiring CDI specialists to perform reviews using CDC hospital-acquired infection criteria. I consider this out of scope, but having the CDI team engage with infection prevention personnel to review and apply criteria would be in scope."

Ultimately, the best way to protect your CDI team from potential scope creep is to set clear boundaries around CDI's mission and goals, communicate openly with your organizational leadership about bandwidth and scope, and work collaboratively with other groups.

"The theme is interdisciplinary approach," says **Nicole Robinson, RN, CCDS**, regional director of CDI at AdventHealth in Orlando, Florida. "It's a collaborative approach. We need to approach process improvement opportunities from an interdisciplinary mindset. This will provide every interdisciplinary team an opportunity to own it and help show the impact because every team in the organization has an opportunity to evaluate the impact an opportunity can have. It's not just CDI."

The last few years have taken a toll on most in the healthcare industry, and increased pressure on CDI to "make up" for bottom-line shortfalls has led to greater levels of burnout. For some in CDI, however, recognizing and admitting possible burnout is a difficult battle because they think others "have it worse," says Lindner.

"Many of us are hesitant to consider that we can get burnt out or that someone else is burnt out doing [CDI work] because we're not providing direct patient care: 'No, I didn't have two patients code today; I don't have this angry family member demanding something,' " she says. "In some ways, there are times where we don't feel that it's legitimate to be feeling burnt out, but [burnout is] not unique to direct patient care. [We might say,] 'I've been at times where I've been worse,' but it still might not be good right now."

A leader's job is to build an environment where staff feel supported and able to admit if and when they're struggling with burnout. That job begins with a leader's ability to acknowledge when things aren't going well and verbalize those feelings openly, according to **Kerri Swart, RN, CCRN-K, CCDS, CDI** director at Upstate University Health System in Syracuse, New York.

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"One thing I've tried to do is lead by example. I am very humbled to go and say, 'I am not doing well this week. I'm very stressed and I'm sorry if my communication with you has been short,' " she says. "Something that I think remote workers don't understand is the importance of communication is amplified 100 times when you're working remotely. We're not just walking by each other's desks and seeing that somebody is unwell, seeing their physical indicators or their body language."

In addition to communicating feelings of burnout and encouraging staff to do the same, it's also important to prioritize an appropriate work/life balance and to set the expectation that time off is part of staff members' compensation and should be used, rather than just accumulated and ignored.

"I try to tell our staff and leadership that when you're on PTO, you're on PTO because I feel like they need that break," says **Patricia (Trish) Dasch, RN, CCDS, CDI** director at Johns Hopkins Health System in Baltimore, Maryland. "When people ask for PTO, the goal is to get them that time. We try and accommodate and cover as best we can. We also discourage anyone calling in or working on those days off. Burnout sneaks up on you. If you're taking your PTO, you earned it, you deserve it. You need to take it."

Though modeling transparency and encouraging staff to take the appropriate time off will mitigate burnout, another critical step is getting to know your staff as people. This makes them more comfortable reaching out when a problem arises, and it will help you identify when a staff member may be approaching burnout.

One way to foster this more personal environment is to accept that the remote work setting simply is more personal than the office setting. Excluding the use of virtual backgrounds, video calls in particular invite a more personal connection since staff are seeing into each other's home offices. This, according to **Joe Freet, RN, CCDS, CCS**, inpatient CDI manager at M Health Fairview in Minnesota, is worth embracing to foster a healthy culture that recognizes staff as people with lives outside of work.

"One of the things that we do in our institution is we try to make the remote environment a little bit more friendly. One of the problems or one of the fears people have is [the conception that] working remotely, you have to be all business all the time," he says. "Something we do at our office or even in division meetings and other meetings, we grab our office mates: our pets. [...] We acknowledge that working from home is different from being in an office environment and sometimes you're allowed to let it be a little more informal."