2024 Mastermind Hot Topics, Part 2: Career ladders, provider engagement, UR collaboration, change management

Supported by solventum

TABLE OF CONTENTS

A CDI leader's role can be lonely, particularly if they are the sole CDI leader at their organization. Rather than facing their struggles alone, however, leaders can get much-needed advice, collaboration, and even commiseration by connecting with peers outside their organizations. The ACDIS CDI Leadership Council connects leaders nationwide for conversations about hot topics and industry trends, but the Mastermind group (a smaller subset of the Council) gives participants an opportunity for focused brainstorming and problem solving.

This multitopic report, produced in partnership with Solventum, formerly 3M Health Care, shares takeaways from the second half of the 2023/2024 CDI Leadership Council Mastermind term. These conversations cover various leadership topics, including career ladders, provider engagement, CDI and utilization review/utilization management (UR/UM) roles, and change management.

One of the first steps when developing a career ladder is to work with your human resources department to craft job descriptions that fit each level. According to **Traci Lindner, BSN, RN, CCDS**, CDI manager at the Marshfield Clinic Health System in Wisconsin, it's important that job descriptions for higher positions on the ladder include the expectation that they will be *leadership* roles, not just elevated staff-level positions.

"We made it so that within the job description for everyone from team lead and up, we have a statement saying that they are part of the CDI leadership team," she says. "So, we could start saying, 'You are part of the leadership team.' [...] Before, if the team lead was off, I had to take on all of her duties as well. Now it can be shared better amongst that group."

It's also important to consider what you'll use as the criteria for a staff member to advance up the ladder. For example, **Nicole Robinson, RN, CCDS**, regional CDI director at AdventHealth in Orlando, Florida, says that her organization uses performance on an annual assessment and the willingness to take on additional responsibilities as key indicators that someone is ready for the next step.

"We have CDI specialists 1, 2, and 3 on a ladder, and they have to earn a certain percentage every year on their annual competency assessment. [...] We have the people on the ladder helping with mentoring and precepting and things like that. We may have them do team lead work too. Depending on the size of their campus and the number of staff they have, each team lead may have about 10 to 15 people. They don't do any discipline, but they are a resource for the team," she says.

Having some sort of system beyond simple seniority for choosing which staff members to elevate to higher positions ensures that you place the *right* staff members in those positions, according to **Kerri Swart, BSN, RN, CCRN-K, CCDS**, CDI director at Upstate University Health System in Syracuse, New York.

"I want people to do well, I want this to be a great program, and I want people to not just get positions because they've been here a long time [because] then we're putting the wrong personalities in the wrong jobs," she says. "I'd rather invest and keep teaching people who want to

“Having some sort of system beyond simple seniority for choosing which staff members to elevate to higher positions ensures that you place the right staff members in those positions.”

— Kerri Swart, BSN, RN, CCRN-K, CCDS, CDI director at Upstate University Health System in Syracuse, New York.

grow and learn and keep getting better and not spend my energy trying to *make* people want to grow and learn and be better.”

Ultimately, offering staff members an opportunity to grow and take on higher-level roles in the department may help you retain your best-performing members. On the flip side, failing to offer such opportunities fast enough can result in those members seeking opportunities for growth outside your organization’s walls.

“Unfortunately, we’ve had a couple resignations in the process, and two of them were ones that I would have loved to have kept,” says **Patricia Dasch, BSN, RN, CCDS**, director of clinical documentation excellence at Johns Hopkins Health System in Maryland. “I have to really run to reorganize before it’s too late.”

One of the biggest challenges with CDI largely working remotely post-COVID is that CDI professionals are no longer a physical presence in the organization to interact with providers in person. In some ways, this change has been a positive one, according to **Tiara Minor, BSN, RN, CCDS**, director of CDI at University of Miami Health System in Florida, but still CDI leaders must find ways to engage providers beyond the query process.

"CDI specialists can participate in multidisciplinary rounds, but our contribution is often minimal," Minor says. "When CDI attends rounds to conduct verbal queries, there's a fine line to ensure the conversation remains compliant. In an effort to avoid leading the provider, the discussion can become indirect, essentially 'dancing' around the topic, which is frustrating for all. I've found that we can be more effective behind the scenes, but maintaining some onsite presence in a strategic capacity is essential. You don't want CDI to be perceived as merely 'invisible query senders.' "

One of the most common ways to introduce an on-site presence is through the use of physician advisors. Often, CDI teams share their advisor with another department such as case management or UR/UM. However, in some instances, the advisor may need to devote more time to another department, leaving CDI without support. The key to overcoming this obstacle is to build your relationship with the other departments sharing your advisor so that you're all on the same team, according to **Debra Clark, RN, GERO-BC, CCDS**, supervisor of CDI at Sanford USD Medical Center in Sioux Falls, South Dakota.

"Our case management, UM, and CDI are all under the care management umbrella and we find that it works very well,"

— Debra Clark, RN, GERO-BC, CCDS, supervisor of CDI at Sanford USD Medical Center in Sioux Falls, South Dakota.

"Our case management, UM, and CDI are all under the care management umbrella and we find that it works very well," she says. "We share a physician advisor, but I find that because we are so involved with one another, we are able to speak

each other's language. Our collaboration with our physician advisor has been successful."

Even if you have an effective advisor, though, don't ignore your other champions who already have relationships with the providers, says **Melanie Reineke, RHIA, CCS, CPC**, hospital coding and CDI manager at Nebraska Medicine in Omaha.

"We're really getting in with the admins now for the different departments because they're the ones that have those established relationship with the providers," she says. "So instead of us trying to keep squeezing in and trying to establish a relationship, we're just trying to leverage those relationships that are already in existence between the admin and the providers."

Similarly, Lindner suggests leveraging the resident groups at your organization (if applicable) to help further the cause of CDI. Even though this group of providers is new and still undergoing education, they're still something close to peers for your more senior providers simply because they're all physicians.

"One thing that we don't utilize as much as we can are the residents. We can say something isn't working well, but when a resident can step forward and say, 'This is how this is making it difficult for my flow and my training,' the other physicians are going to listen a bit more because the resident's still a physician and the initials behind your name make a difference," Lindner says.

As all industry leaders already know, the work of CDI has far-reaching implications that often touch the traditional responsibilities of other departments. The potential overlap between CDI and the work of UR/UM, particularly around denials and patient status, has been increasingly discussed within the world of CDI.

The challenge with any new expansion opportunity, of course, is the potential for scope creep. One of the issues is that CDI is often brought in as the "fixer" for issues related to patient status and denials, says **Cokethia Rachel, CCS, CPC, CPMA, SSBBP**, HIM director at the Shepherd Center in Atlanta, Georgia.

"It often feels like CDI is asked to do the back-end cleanup," she says. "Now I have to go back and find out everybody's part in this process, and who has the time for that?"

For Minor, when it comes to scope creep, understanding the actual issue is crucial to ensure CDI can offer effective assistance and avoid wasting valuable time on issues that are not CDI's responsibility to own.

"As with all organizations, we've seen an influx of focus on proper patient classification (i.e., observations flipped to inpatient and vice versa)."

—Cokethia Rachel, CCS, CPC, CPMA, SSBBP, HIM director at the Shepherd Center in Atlanta, Georgia.

"As with all organizations, we've seen an influx of focus on proper patient classification (i.e., observations flipped to inpatient and vice versa). It's a challenging situation because you don't want to overcorrect in either direction. There's a balance to be found in getting everyone in the correct status from the beginning," she says.

Even though the onus of patient status may ultimately fall on the shoulders of UR/UM and not be owned by CDI, it's still a good practice to teach the CDI staff what to look for that might indicate a patient is in the wrong status. Not only will this free up time that could have been spent reviewing a case that was erroneously placed in the inpatient bucket, but it can

also help clear up some of the status issues on the front end, according to **Angelica Cage, MBA, BSN, RN, CCDS, CCS, CDIP**, CDI director at Tufts Medicine in Boston.

"I feel like CDI should look at the status and admission orders before they start reviewing a case because CDI work-up and queries will be wasted if the case changes to observation or outpatient in a bed," she says. "I don't put patient status on them as a responsibility, but I tell them to think about it because we can save so much on the front end. Once the patient's discharged, good luck trying to change the status or level."

Regardless of CDI's level of involvement with UR/UM concerns, all the departments need to be on the same team, and that starts with education, according to Robinson.

"We have a consulting firm that they brought in to help our teams. They've helped our teams with UM, coding, CDI, and our physicians," she says. "What they're doing is bringing awareness to everyone that it's not just CDI, that it's everybody's responsibility. [...] Everyone needs to get the same information."

Change is a constant in CDI, and much of a CDI leader's role is navigating that changing landscape for their staff, themselves, and their own leaders. The first step to handling change effectively is to build trust with your team, which will take time and effort.

"My staff have grown to trust me. When I bring new information or a new process, they trust that I'm leading them in the right direction," Minor says.

Part of building trust among your team is showing them that you, as a leader, have their best interests at heart, according to Dasch, whether or not that means they stay through the various departmental and organizational changes. Trust has to be earned, and being your team members' advocate goes a long way to building the type of relationship that'll carry you through even the largest changes.

"I tell my staff all the time, if you grow here or you grow there, I'm still mentoring you. My goal is to keep you growing. If I can't keep my team growing, I can't have a great team," Dasch says. "I want to give people the opportunity to shine, whether it's here or somewhere else."

Managing up, so to speak, and getting your own leaders on board with necessary changes may be more of a challenge, however, because they may not have the depth of CDI knowledge to fully grasp the need for the change or understand the problem at hand. Those stakeholders, nonetheless, are crucial for reaching your goals. Again, this process simply takes time.

"Leadership presents greater challenges," Minor agrees. "As you ascend in leadership, you increasingly encounter other leaders who may lack expertise in certain areas or may not be familiar with CDI. Building trust in your knowledge and developing confidence in your abilities takes time."

Leading through change and managing up and down could be a full-time job of its own, and it can be easy to put your own needs aside as a result. If you have the trust from your team and leadership, they will (ideally) remind you to take care of yourself too through the changes by reminding you that you're doing a good job. The trust and recognition has to be a two-way street.

"I do have the best team I've had in a while from a staffing perspective. I didn't even know it was Boss's Day recently. And I didn't know that I needed that recognition. I was working so hard because I wanted my staff to be good," says Rachel.

"We need to take time away," adds Clark. "The work will be here when we get back. My team recognizes it for me, and I recognize that for them."