CLINICAL DOCUMENTATION INTEGRITY ANALYST – REMOTE

University Hospitals
Job Location: Cleveland, OH
Full Time, Days

JOB DESCRIPTION:

Applies clinical expertise and knowledge of health care workflows in order to educate and train CDI Specialists in the essential duties of their role to improve the overall accuracy and comprehensiveness of medical record documentation, with focus on ensuring accurate reporting of quality outcomes
Educates CDI Specialists on the rules/regulations associated with coding and clinical documentation integrity. Trains newly hired CDI Specialists and provides ongoing coaching and education specific to daily CDI Specialist job functions. Ensures the work output of the Clinical Documentation Integrity staff is accurate and compliant. Collaborates with CDI leadership and Coding team to identify training opportunities and assist with education of CDI and Coding staff with regard to clinical documentation integrity and/or clinical and coding scenarios as needed.

Essential Duties:
Training

- Subject matter expertise that exhibits excellent skills in essential components of CDI Specialist (CDIS) role.
- Trains new CDIS in all components of CDI workflow and the skills needed to properly analyze patient records for accuracy and specificity of diagnostic terminology; identification of opportunities for clarification in clinical documentation as well as query composition and mechanics that are clear, concise and compliant in providing accurate documentation support and collaboration with clinical care providers to resolve clarification requests (queries).
- Monitors and tracks new CDIS employee progression through the orientation period and communicates progress with both team member and CDI manager/supervisor.
- Validates accuracy of new CDIS's work for first 90 days with frequent 1:1 feedback, followed by formal quality review process as per policy.
- Serves as a role model, coach and resource for assigned CDIS team members individually during onboarding and orientation process and on an on-going basis in order to improve proficiency of work, efficiency and productivity and quality of work.
- Trains CDIS to identify and address complex documentation improvement opportunities such as clinical validation of high risk diagnoses, denial prevention and cases at risk for HAC/PSI and other quality related impacts.
- Collaborates with CDI and Coding leadership to develop and facilitate training regarding best practice clinical documentation and provider query processes that accurately captures patient severity of illness and risk of mortality.
- Prepares and presents educational information to CDI and/or Coding teams.
- Effectively works both independently and as a part of a team, often times in a virtual team environment, to prepare, develop and provide CDI educational material and feedback for things such as proper DRG assignment and compliant query writing
- Applies knowledge and expertise to daily job responsibilities. Maintains professional knowledge by reading and/or attending webinars that pertain to Clinical Documentation Improvement.
- Earns and maintains the Certification for Clinical Documentation Improvement
- Incorporates current literature, research and best practice (ACDIS and AHIMA) into daily practice and when training others

Quality

- Responsible for quality monitoring: Performs detailed analysis of cases reviewed by the CDIS for quality control and educational purposes and provides constructive feedback to CDIS.
- Conducts quality audits in an efficient and timely manner with required frequency as per department policy.

- Perform other audits as directed to provide education to CDIS regarding documentation improvement opportunities, to assess competency regarding writing compliant queries and other areas focused on supporting the CDIS to improve efficiency, productivity and competency in their role.
- Performs second level review prior to final coding of target case populations applying clinical and coding expertise, in order to identify both query and educational opportunities for CDIS (no CC/MCC cases, mortality reviews, HAC's/PSI's, etc…).
- Participates in quality improvement programs such as mortality, HAC and PSI by reviewing records for proper documentation and opportunity to improve the outcomes. Engages in weekly HAC/PSI meeting.
- Participates in CDI Professional Governance committee, High Reliability Medicine team and/or other hospital based committees, as approved by Manager
- CDI Workflow and Process Improvement
- Participate on CDI Department wide projects, developing and updating projects such as developing new query templates, updating audit tool, DRG reconciliation, developing quarterly competencies, developing CDI assessment tool
- Identifies workflow improvement opportunities (individual or technical) and works to provide potential solutions, resulting in improvements in efficiency, workflow and/or denial reduction.
- Facilitates change:
    - Develops and communicates action plan for change process/improvement
    - Supports CDI team through change management process
- Performs Second Level Reviews, Code Alert and DRG Mismatch Reconciliation case reviews
    - Provides 1:1 feedback and coaching to assigned CDIS regarding opportunity for improvement
    - Contributes to decrease in DRG mismatch rates.
- Partners with Denials Management Analysts to advance practices focused on clinical denial risk reduction
    - Reviews DRG denial cases and identifies clinical or coding support for appeal in collaboration with the denial/DRG downgrade team
    - Provides 1:1 feedback and coaching to assigned CDI Specialists regarding opportunity for improvement.
    - Demonstrates comprehension of CMI and can interpret, analyze, evaluate data, provide rationale for trends/impacting factors and develop strategy for correcting/optimizing CMI
- Support CDI leadership team by facilitating daily workflows as assigned, to include assessment of unanswered queries for potential escalation, working eCDI queues and messages to ensure follow through and timely completion, and evaluation of Impact reviews to ensure accuracy in department reporting metrics.
- Actively engages in advancing the CDI practice throughout the UH enterprise by developing/modifying/implementing/educating/evaluating new practice behaviors, guidelines, and technology enhancements (query format, quality measurement tools-criteria, guideline)
- Some travel required
- Performs other duties as assigned

QUALIFICATIONS:

Education:

- Bachelor Degree, Associates Degree or Diploma in Nursing
- OR Bachelor or Associates Degree in Health Information Management required

Required Credentials, License, and / or Certifications.

- Registered Nurse (RN) (or higher medical degree), Registered Health Information Administrator (RHIA) or Registered Health Information Technician (RHIT) required
- Attain and maintain CCDS certification within 1 year of hire

FOR MORE INFORMATION/TO APPLY:
https://careers.uhhospitals.org/job/16075737/clinical-documentation-integrity-analyst-remote-cleveland-oh/