Working With Providers

Promoting CDI-Provider Relationships to Improve Documentation

Pediatric Networking Group (APDIS) Meeting

March 2, 2023

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Disclosures

- We have no financial disclosures or conflicts of interest
- Our CDI program currently reviews inpatient charts at our free-standing children's hospital (almost exclusively pediatric patients).
- We are not formally trained in anything CDI; our awesome CDI team has taught us everything we know
- We gave a similar talk to the WI ACDIS chapter in the fall, but we have made some changes for this pediatric audience
- Our CDI program started in 2017
- Our query response rate is 98.9%

Objectives

- Understand the physician mindset
  - Physician psychology
  - What is important to physicians?
  - Why are they always so busy?
  - Why don’t they know what Brain Compression is?
- Understand the Physician/Provider Advisor (PA) role in CDI
  - How can the PA help a Pediatric CDI program?
  - What is different about Pediatrics in CDI?
- Tips and Tricks for your program

Physicians Can Be Challenging

- How many of you have had a query ignored?
- Have you gotten an unprofessional voicemail from a physician?
- How many of you have received an irritated email from a provider?
- Have you ever seen an unprofessional answer to a query?

Comments

I cannot follow what you want me to do and honestly could care less.

A Note On Unprofessional Behavior

- We will not make excuses for bad behavior in this talk
- We have a zero-tolerance policy for unprofessional behavior or abuse
- Paradoxically, setting firm limits assertively and calmly (as you might with a toddler) can often serve to calm the upset person as well as garner respect from them
- We escalated this comment to the hospital Chief Medical Officer

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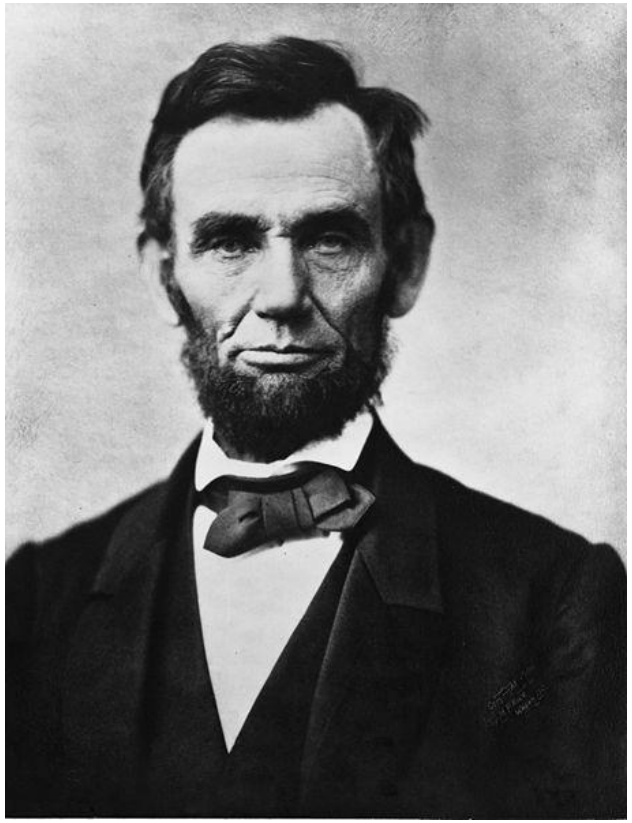
Why Are They Like That?



"I don't like that man. I must get to know him better."

— **Abraham Lincoln**

You Already Know Them

Guest post: A letter to physicians from their CDI team

October 6, 2020CDI Blog - Volume 13, Issue 51 (acdis.org)

by Christine Donnamiller, RN, ACDIS-Approved CDI Apprentice

I know it's not easy.

I see you documenting early in the morning, afternoon, and late in the evening. Somewhere in the middle you are holding that patient's heart by speaking your words to him, speaking with the dying woman's daughter, setting up home oxygen, putting in a central line while ordering a diltiazem drip for the patient in the next room—the good deeds and duties never end.

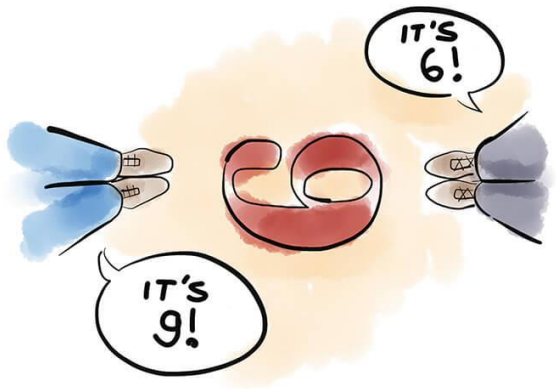
Then you have to document or answer that query. I imagine you're feeling "alert fatigue," and I want you to know that what you are doing is noticed and admired. I know I ask you for more, more documentation. Our goal as CDI professionals is to ensure the integrity of the chart…..As your CDI team, we interpret your clinical documentation into ICD-10 codes, based on the *Official Guidelines for Coding and Reporting*.

In my nearly three years as a CDI specialist, I have found some astonishing differences that one undocumented word may make in the code set. We are your second pair of eyes and here to help you. Our patients deserve a true account of the care they receive..

Understand Them Better

How would you feel in their shoes?

“Golden Rule”



How do they feel in their shoes?

“Platinum Rule”

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Deep Dive Into the Physician Psyche

- Family of Origin
  - May have played the fixer or healer role in the family
    - Can develop into a savior or hero complex
  - May have had to meet extremely high expectations
    - Self-critical when failure is perceived and/or critical of others who don't meet their expectations
  - May have been the "Golden Child"
    - Can become entitled and contemptuous
  - May have had a difficult childhood and became a physician to heal the past
    - Trauma can have significant effects on personality
- Upbringing
  - Child of a physician
  - Immigrant family or first in family to obtain an advanced degree
    - May feel pressure and responsibility to family or community

Physician Psyche

- Personality Traits
  - Perfectionism
  - Competitiveness
  - Skepticism, independent thinking
  - Difficulty allocating time for self-care
  - Exaggerated sense of responsibility to patients, more so than to institution or regulators
  - Works well for providing patient care, not as well for following rules
- Appeal of Medicine
  - Smart, like science, like working with and helping people, well-respected and well-paid career

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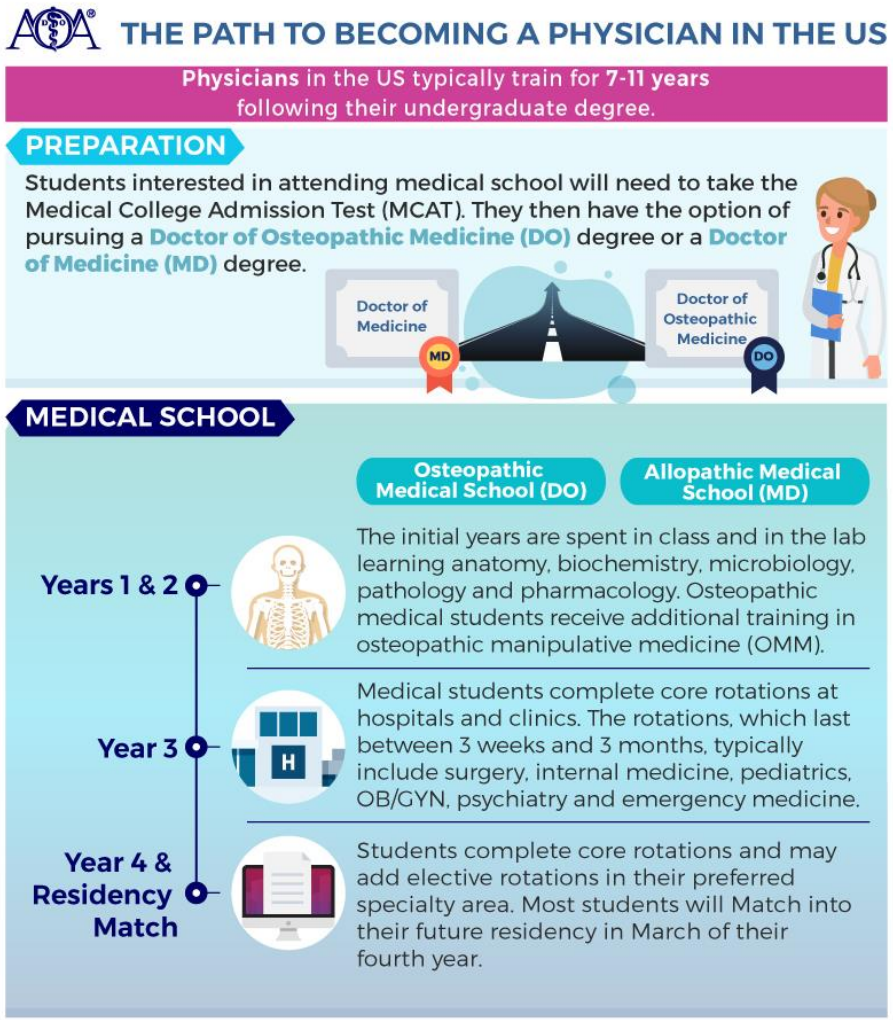
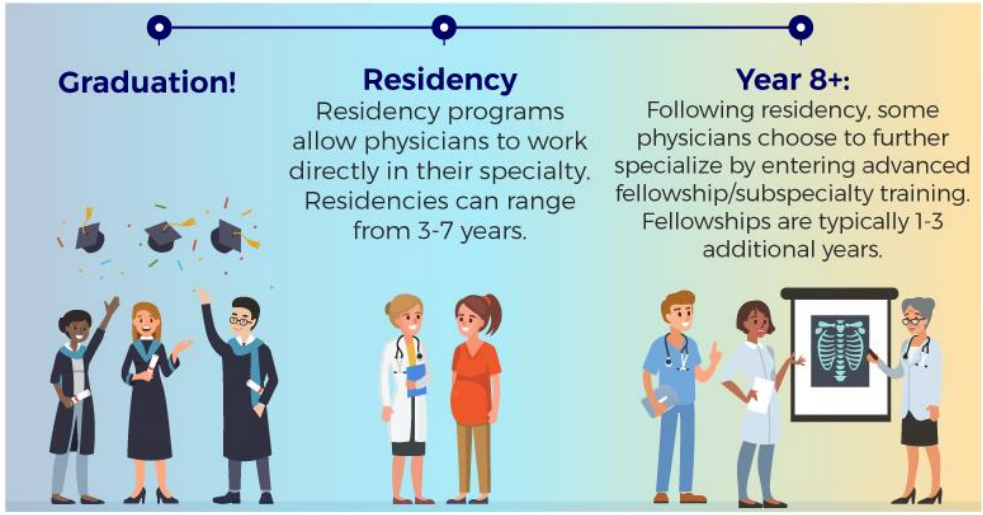
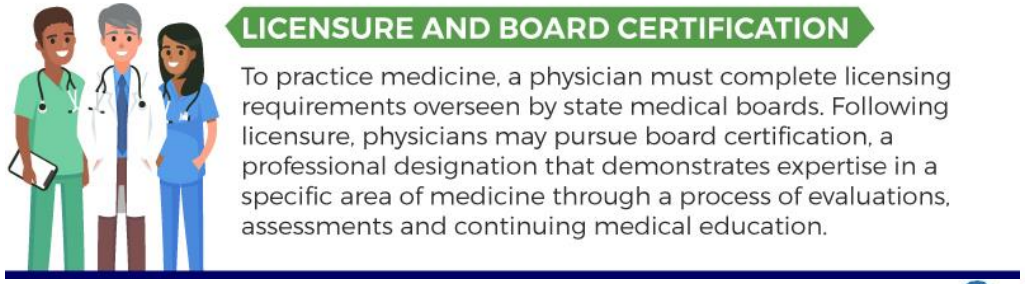
Path to Becoming a Physician

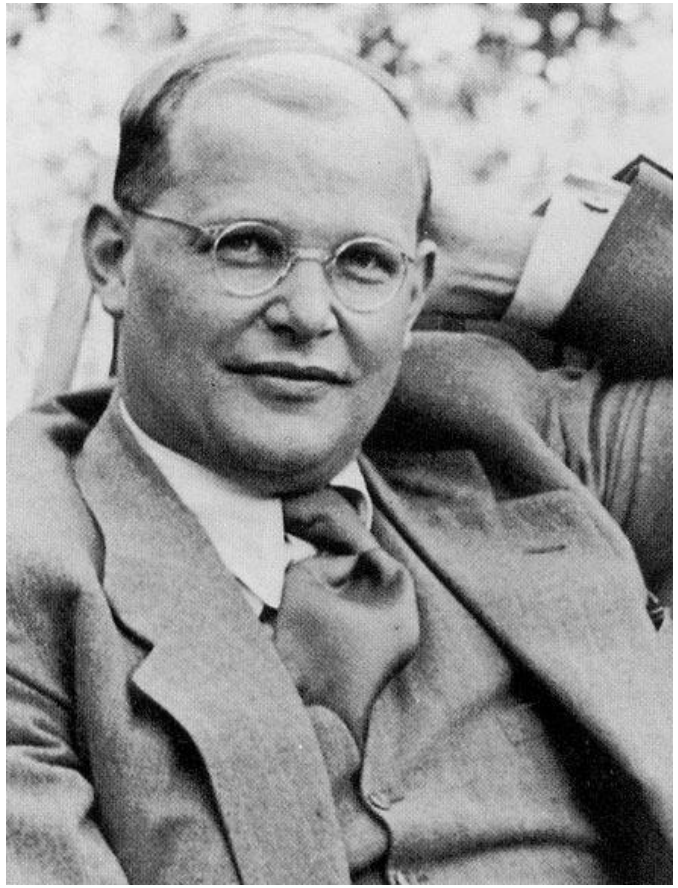






After college, they spend 7 to 15 years working up to 80 hours a week, missing nights, weekends and holidays with family and friends. They may be 29 to 37 years old Before they complete training and are in debt over $200,000

Why Can't They Just Document Right?



"We must learn to regard people less in the light of what they do or omit to do, and more in the light of what they suffer."

— Dietrich Bonhoeffer

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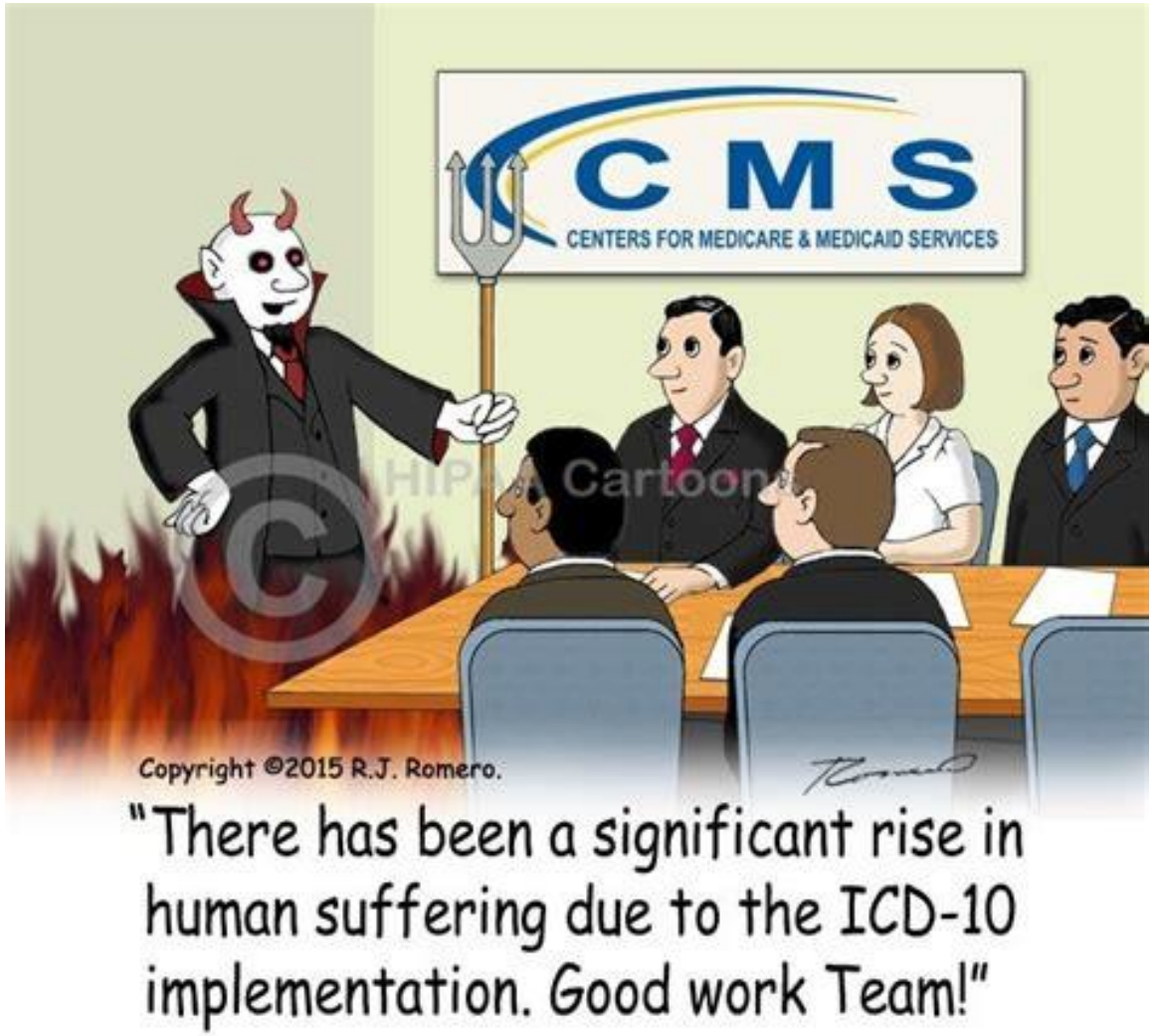
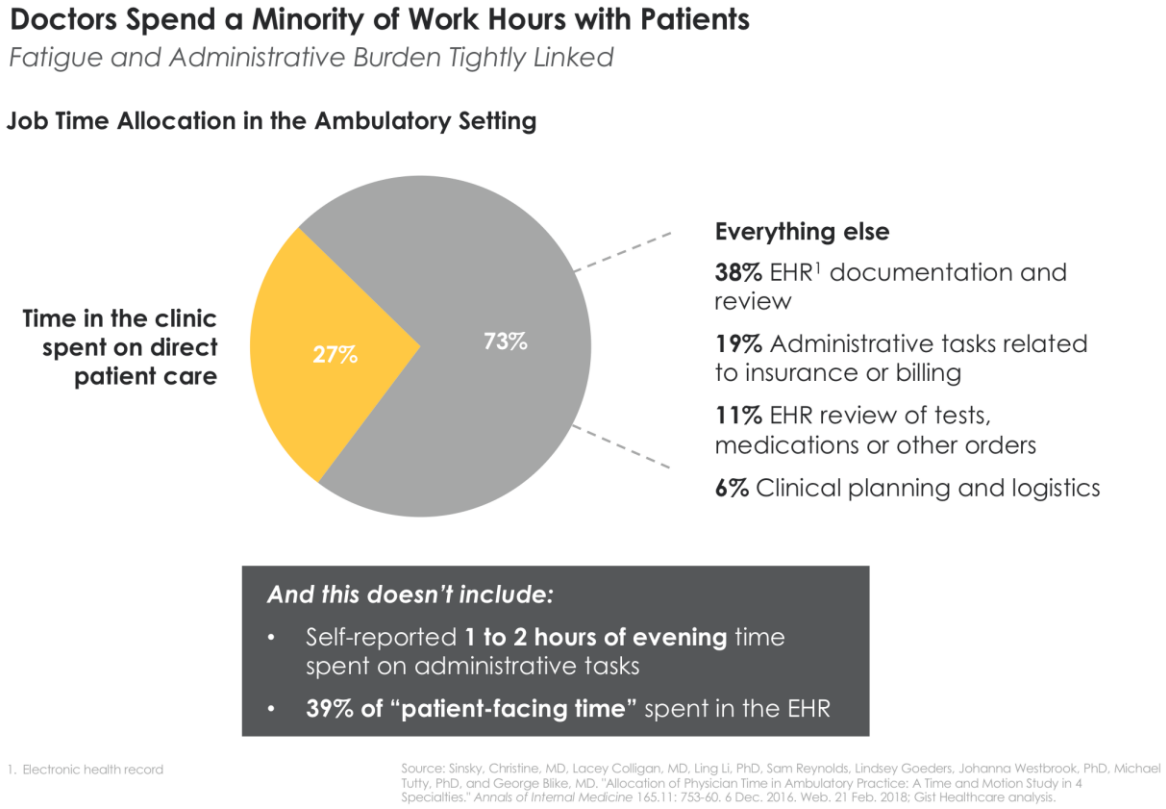


Culture of Medicine

- Hierarchical
  - Means that they are uncomfortable with a CDI professional telling them what to do
- Blame and Shame
  - Means that they are extra sensitive to errors and criticism, and may interpret simple requests as condemnation
- Specter of Malpractice
  - Physician will be the one sued if something goes wrong, so they want to make the decisions and be in charge
- Data-driven
  - Do not believe anything or make any changes without it
- Patient-centered
  - How does what is being asked directly help the patient?

Competing Responsibilities

Even Patient Care is Mostly Not Patient Care



Since this study, more patients use EHR access and send more messages to their providers, requiring review and response

The Federal Information Blocking Rule has increased time outside of work hours spent messaging patients because results are released immediately, and patients may receive a concerning result in the evening or weekend

Competing Responsibilities

- Teaching—residents, medical students and other professions
  - Preparing/giving lectures, creating curricula, reviewing/teaching documentation (!), mentoring, writing letters of recommendation, filling out evaluations, providing formal and informal feedback
- Research
  - Grant writing
  - Conducting studies, writing and publishing results
  - Disseminating at local, regional and national meetings

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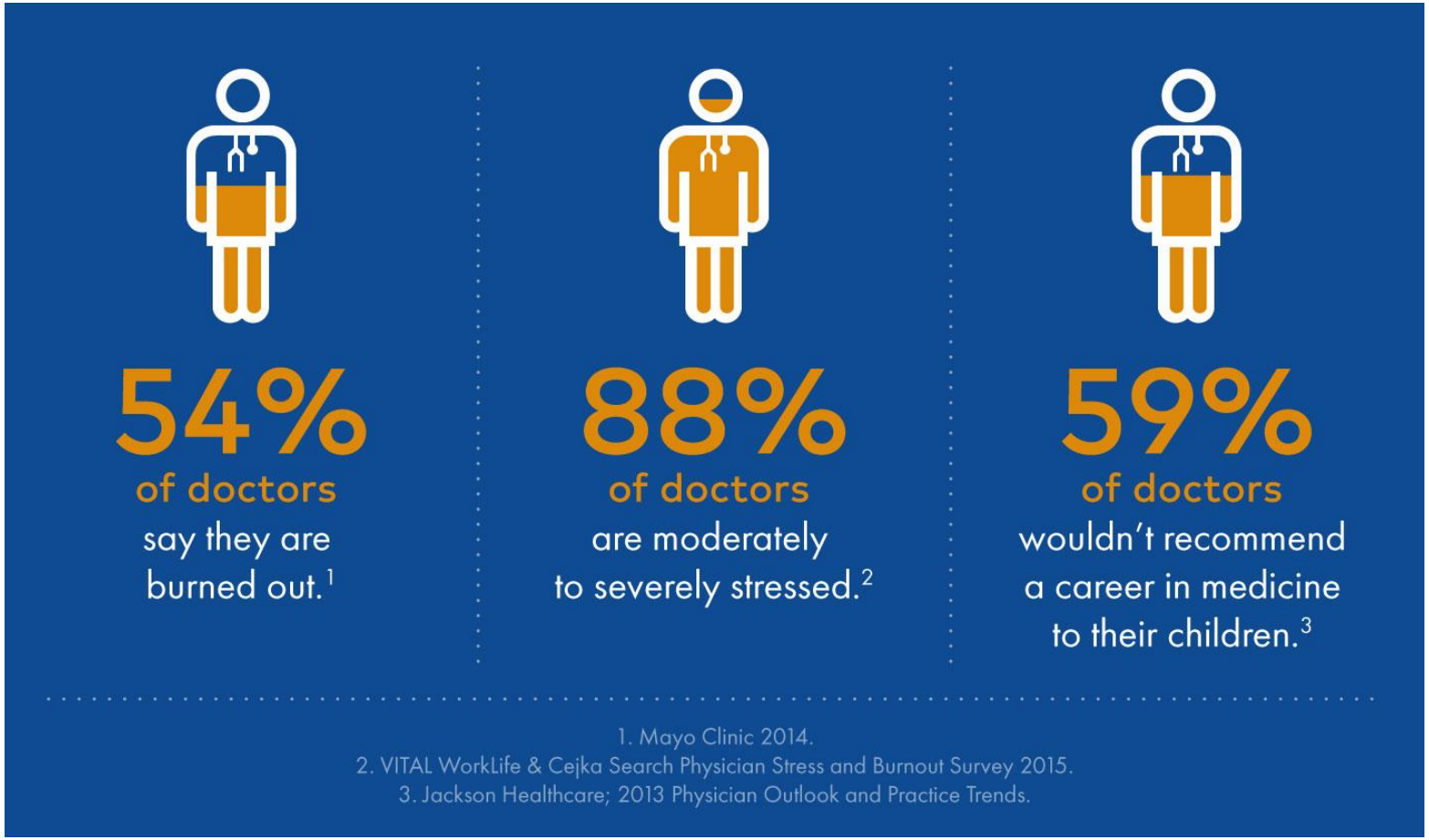
Competing Responsibilities

- Leadership
  - Hospital or practice
  - Local and national specialty societies
  - Medical School
- Administrative
  - Ongoing professional development and board certification
  - Practice management
  - Other institutional/hospital/CMS required trainings such as safety, CITI, DEI, ACLS, ATLS, PALS, BLS, Title IX, blood born pathogen, etc.
  - Institutional Engagement surveys, ACGME surveys
  - CMS CME time studies

Reality of Medical Practice



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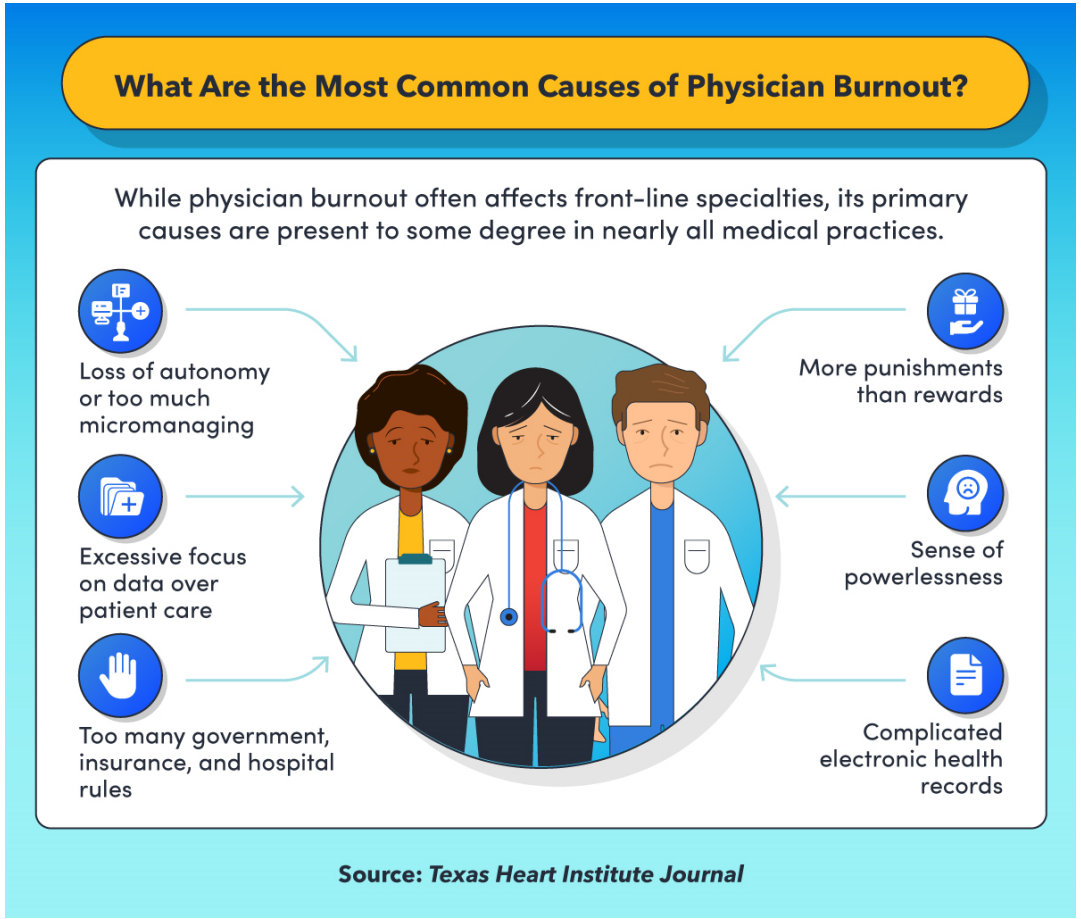
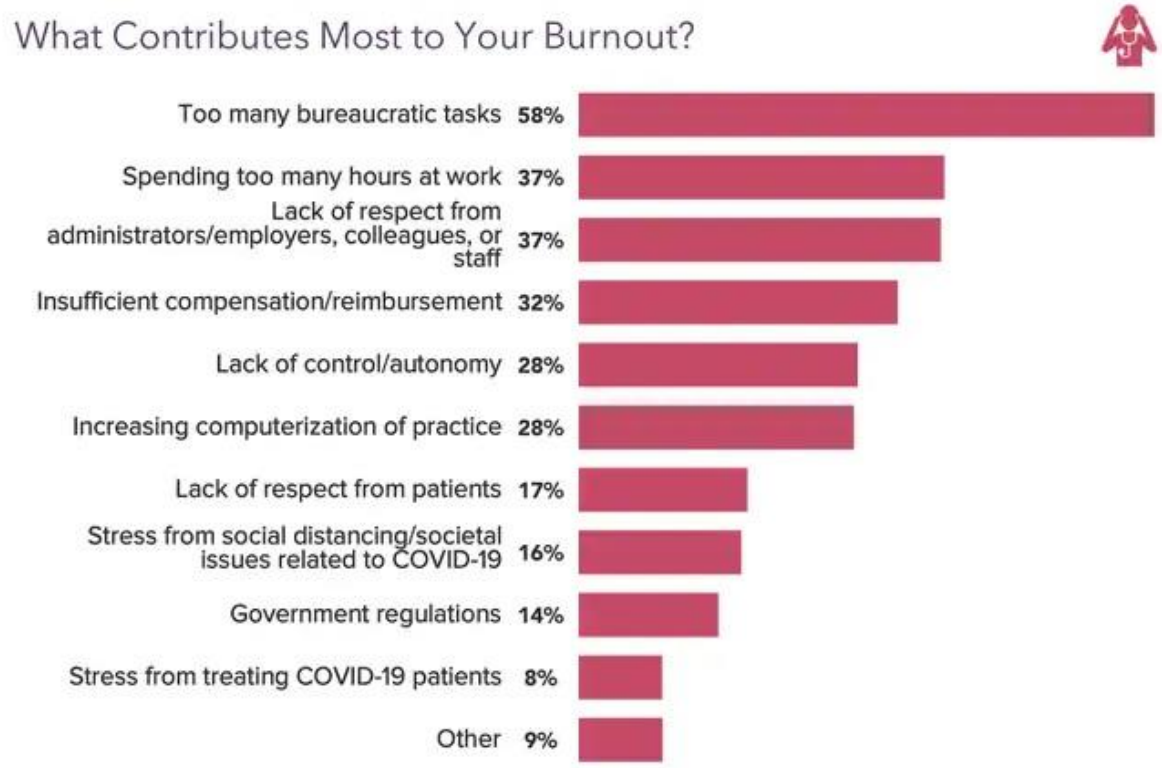
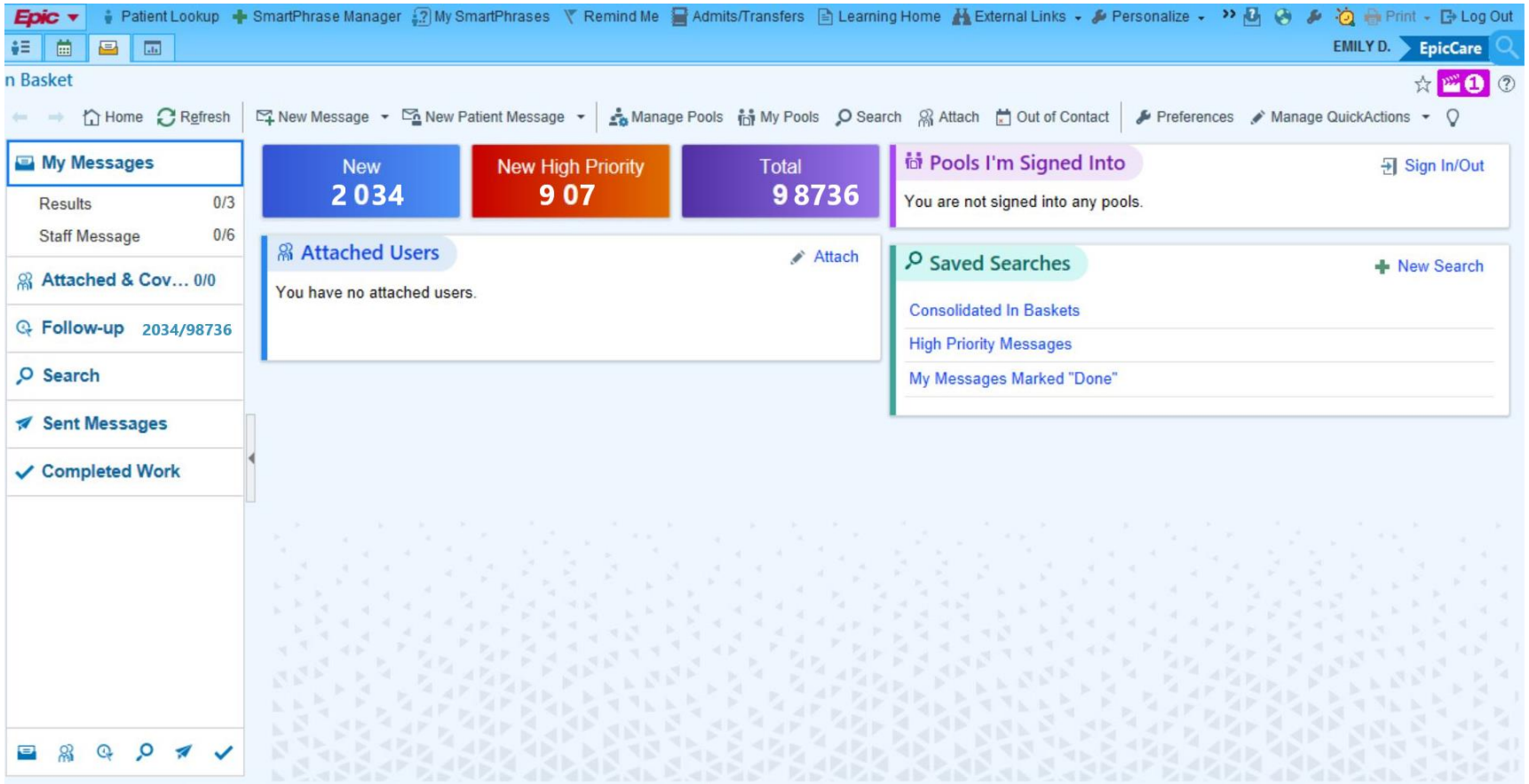
Reality of Medical Practice





Death by 1000 cuts: Medscape National Physician Burnout & Suicide Report 2021

Reality of Medical Practice



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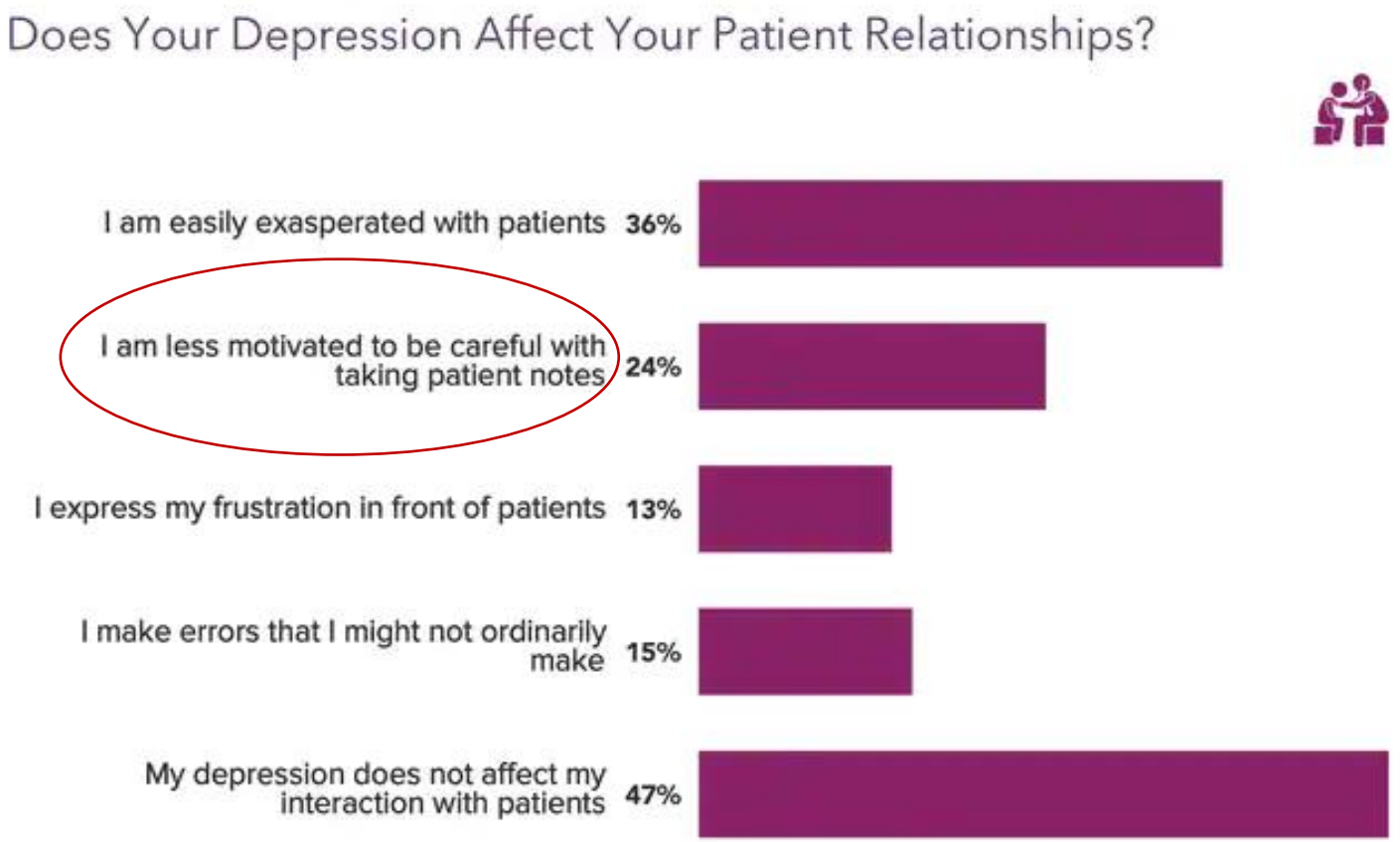
Reality of Medical Practice



Death by 1000 cuts: Medscape National Physician Burnout & Suicide Report 2021

Life and Death

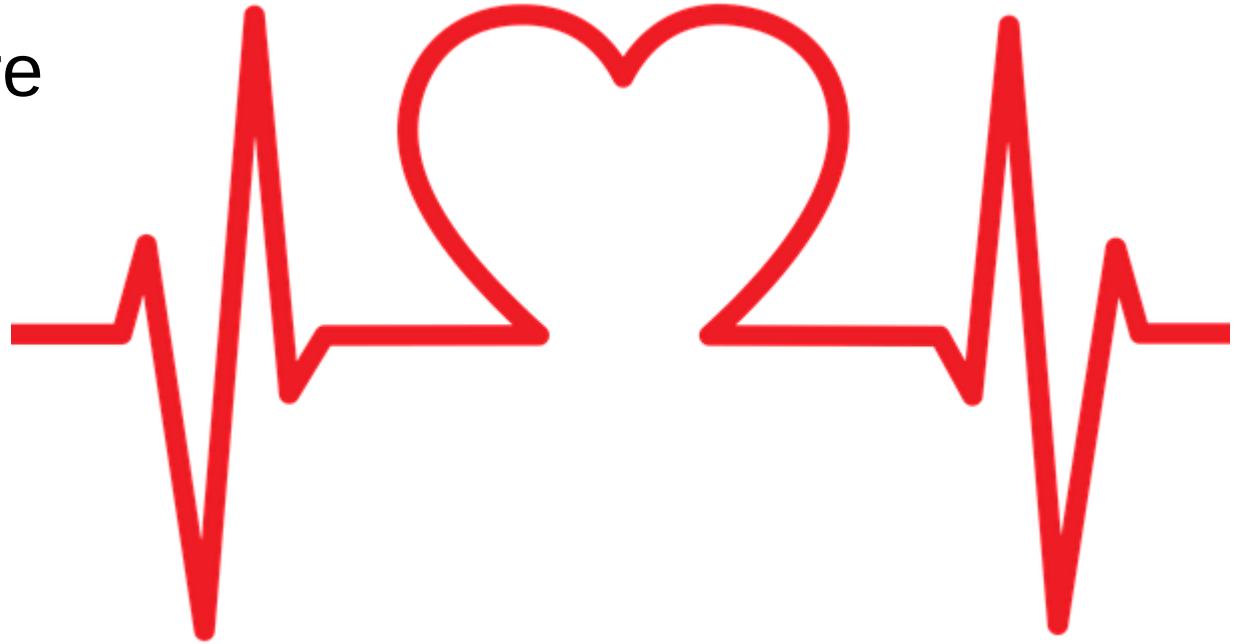
Outside of a Southern California hospital, an ER doctor is crouched down against a concrete wall grieving the loss of his 19-year-old patient.

This takes an emotional toll, especially given physicians' sense of responsibility for patient outcomes and the culture of blame and shame that they live in.

Being mindful of the timing of CDI requests will go a long way to continuing good relationships with physicians.

What Matters to Physicians?

- Patient Relationships
- Providing Quality Patient Care
- Intellectual Stimulation
- Professional Autonomy
- Time
- Respect
- Recognition
- Compensation



How Do They Differ from You?

CPT Codes/Provider Fee

- Are based on a discrete service or set of services provided to a patient, and incorporate the provider level of training, risk to patient, and time required to provide that service
  - Coding services provided may make more sense to providers than coding/billing for conditions
- Are a measurement of work and generate RVU's for providers
- RVUs directly or indirectly influence salary
- Especially for procedure CPT codes, documentation requirements may overlap with those for ICD-10 codes, but they also may be different
  - This can be confusing for providers, especially those who are not aware of the two different coding processes

Value-Based Reimbursement

Providers are skeptical about value-based reimbursement and the ability of administrative data to accurately reflect quality

- Many studies demonstrate poor ability of administrative data sets to measure quality outcomes
- A recent study using the American College of Surgery's National Surgical Quality Improvement Program (ACS NSQIP) to assess the accuracy of patient safety indicator (PSI) codes to identify safety events. The presence of any PSI code had a PPV of 0.55 (95% CI 0.53 to 0.57) and NPV of 0.93 (95% CI 0.92 to 0.93).
  - So only 55% of patients with a PSI actually had a surgical complication, and 93% of patients with no PSI did not have a complication.
  - Ref: McIsaac DI, Hamilton GM, Abdulla K, et al. BMJ Qual Saf 2020;29:209–216

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DRG-Based Coding/Reimbursement

- Providers are not trained in these payment strategies which are complex and often associated with an incomprehensible or proprietary calculation methodology
- They may not know what you mean by RW, LOS, CC, MCC, SOI, ROM or even CMI

Dx	CDI Query	RW	Expected LOS
Before CDI Query		5.31	6.0
Acute Blood Loss Anemia	X	7.84	9.0
Improvement		+2.53	+ 3.0 days

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Risk Adjustment

- They do know what risk adjustment means
- When Children's Hospital A surgery group's outcomes are compared to Children's Hospital B surgery group's outcomes, the group from Hospital A is better (less mortality, fewer complications, shorter length of stay, and less cost.)
- When you tell this to surgery group B, they will say, "but our patients are sicker than Hospital A's patients!"
- This is risk adjustment, and they understand this

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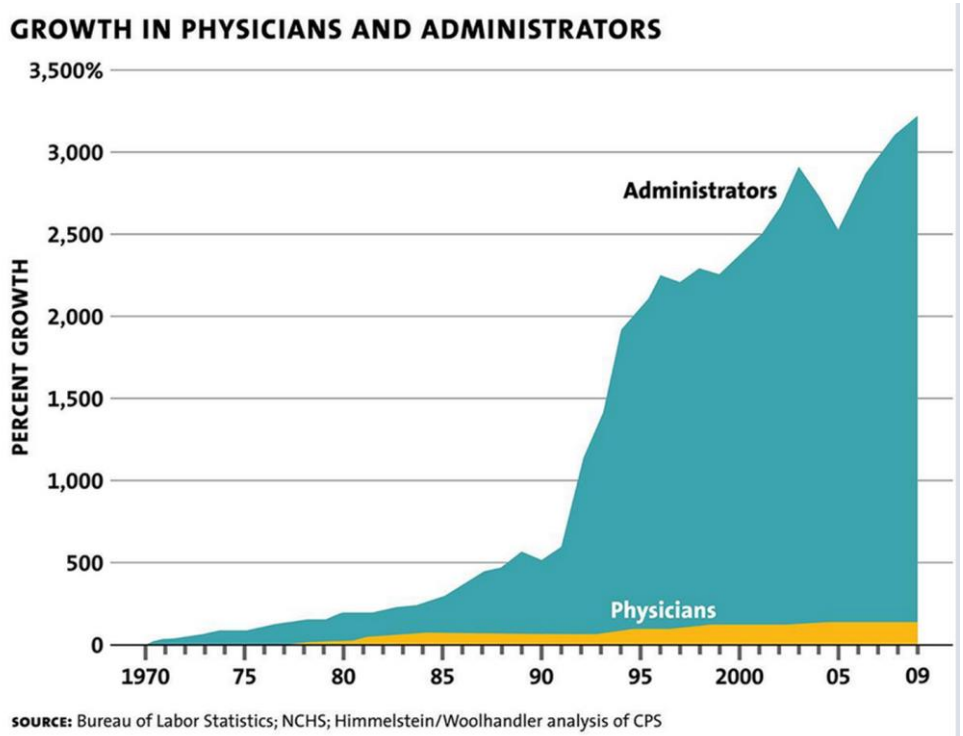
They May Wonder if Increased Revenue Actually Helps Their Patients (Or Them)

HIGHLY COMPENSATED *Non-Profit Hospital* EXECUTIVE SALARIES *banded by income* FY 2017

LEARN MORE AT OPENTHEBOOKS.COM

SALARY	EMPLOYEE COUNT	TOTAL COST
$10,000,000+	6	$84,677,448
$9,999,999–5,000,000	7	$48,275,883
$4,999,999–1,000,000	61	$157,729,963
$999,999–500,000	8	$6,892,853



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How Do They See CDI?

- This is just for hospital billing, not my professional billing
- Someone telling them what to do
- Someone questioning their professional judgement
- ABLA makes me look bad
- What's in it for me? Extra work with no direct benefit to me
- Does not directly affect patient care
- Confusing—coding-clinical disconnect
- Afraid of over-billing or fraud
- Concern about language that may imply an error making them vulnerable to malpractice
- Don't want patient to have a higher bill
- Don't want to be punished for complications
- Another administrative burden
- Necessary evil

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How does CDI See Them?

- A Google search for “educate physician CDI” shows biases
  - “Getting your physicians to document effectively”
    - Physicians are sensitive to being controlled or told what to do
    - They feel that their documentation is already effective and serves their purposes
  - “Physicians are not educated about proper documentation techniques.”
    - They are educated about documentation techniques, just not specifically about the intricacies of coding requirements
    - There are frequent modifications and additions to documentation requirements through Coding Clinics and new code sets
      - It is not part of their job to stay current on these

Providers Speak a Different Language

"…a broad gap exists between the terminology used by clinicians and the terminology of coding and billing systems. The CDI liaison role must then expand to reflect the complexity of an industry increasingly focused on regulatory compliance, managed care profiles, revenue and reimbursement, and mitigation of risk."

https://www.huronconsultinggroup.com/insights/optimizing-clinical-documentation-improvement

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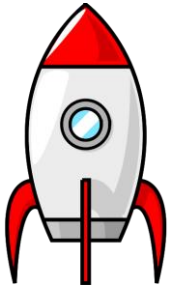
What Should Be Coded?

Both speak English

“The patient presented with Rocket”



“The patient developed a Torch”

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What Should Be Coded?

Both speak Medicine

AHIMA

"The patient has a history of leukemia"	The patient once had leukemia	The patient has active leukemia
"The patient has a post-op ileus"	The patient has an operative complication	The patient has an expected ileus after the operation

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Language Is Important

- Communicating with physicians
  - Instead of: “I need you to” or “you must”
  - Try: “Could you please”
  - Instead of using ALL CAPITAL LETTERS
  - Try: lowercase
  - Instead of using their first name
  - Try: Dr. X (if consistent with the culture at your institution)
- Communicating with your colleagues
  - Instead of: “looking for” or “get them to say” a diagnosis
  - Try: “wondering about” a diagnosis

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CDI Engagement with Providers Example

We know that this request is an additional administrative burden and we do appreciate your time and the care you provided the patient. We have attached a tip sheet on how to addend the body of the note after it has been attested as it is not an obvious workflow. Thank you for your understanding. Please reach out to me with questions.

Be kind and considerate/thankful of their time!

You are the kindest human ever. Thank you for this lovely email (and I am not being sarcastic).

I will try to fix first thing tomorrow!

They document that way for a reason Find out why

- Documenting neutropenia, anemia and thrombocytopenia separately makes sense to them because each has a different treatment and treatment threshold.
- “At risk for anemia and thrombocytopenia secondary to chemotherapy. Plan to transfuse PRBC if Hgb <7 or symptomatic anemia, and transfuse platelets for platelets <10,000 or bleeding. The patient had symptomatic anemia on 2/21 and received PRBC transfusion. Hgb improved to 9.9 post-transfusion.
- At risk for neutropenia secondary to chemotherapy. Will receive G-CSF 24-72 hours after completion of chemotherapy.”
- It does not really matter to them that the patient has pancytopenia. They care more about where the specific individual cell lines are and whether each needs treatment.
- It is obvious to them what is causing it; it is not a diagnostic dilemma

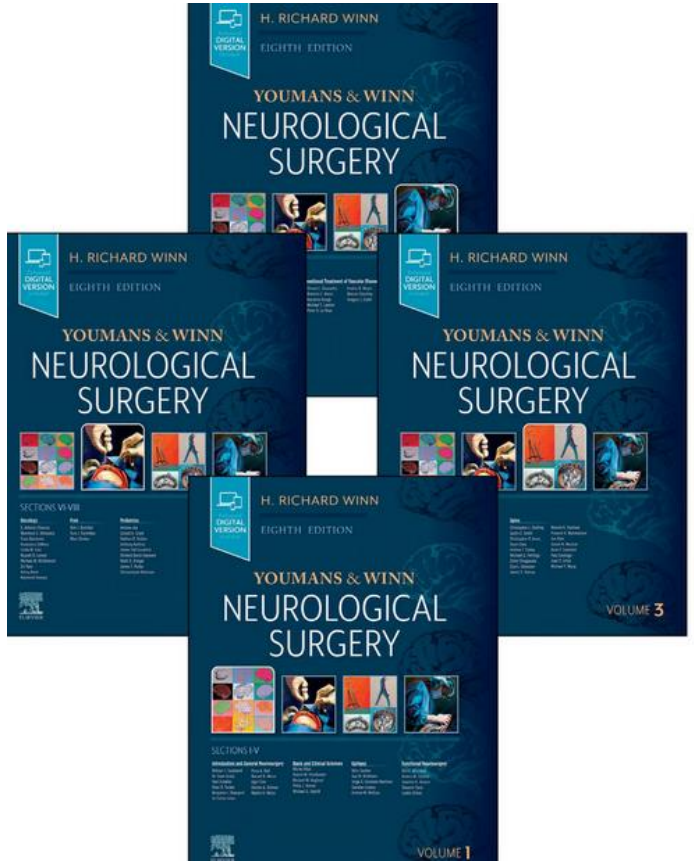
They document that way for a reason Find out why

- Documenting that “the patient had a large subdural hematoma exerting mass effect on the temporal lobe, causing midline shift, and requiring evacuation and decompression” may paint a more vivid picture in providers’ minds than
- “The patient had brain compression due to a large subdural hematoma that required evacuation and decompression.”
- Work to assist providers to combine documentation to suit multiple needs
  - For example, ask that they consider documenting “compression of temporal lobe”

Why Don't They Know What Brain Compression Is?

Number of Times Terms Used in Neurosurgery Textbook

Increased intracranial pressure	406
Mass effect	280
Cerebral edema	276
Herniation	206
Midline shift	92
Effacement	29
Brain compression	**6**



ISBN:	9780323674997, 0323674992	Page count:	4,568
Published:	January 21, 2022	Format:	Ebook
Publisher:	Elsevier Health Sciences	Language:	English
Author:	H. Richard Winn	Editor:	H. Richard Winn

Some Conditions Are Not Easily Defined

"There are inherent challenges in defining sepsis and septic shock. First and foremost, *sepsis* is a broad term applied to an incompletely understood process. There are, as yet, no simple and unambiguous clinical criteria or biological, imaging, or laboratory features that uniquely identify a septic patient."

Singer M, Deutschman CS, Seymour CW, et al. The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3). *JAMA.* 2016;315(8):801–810. doi:10.1001/jama.2016.0287

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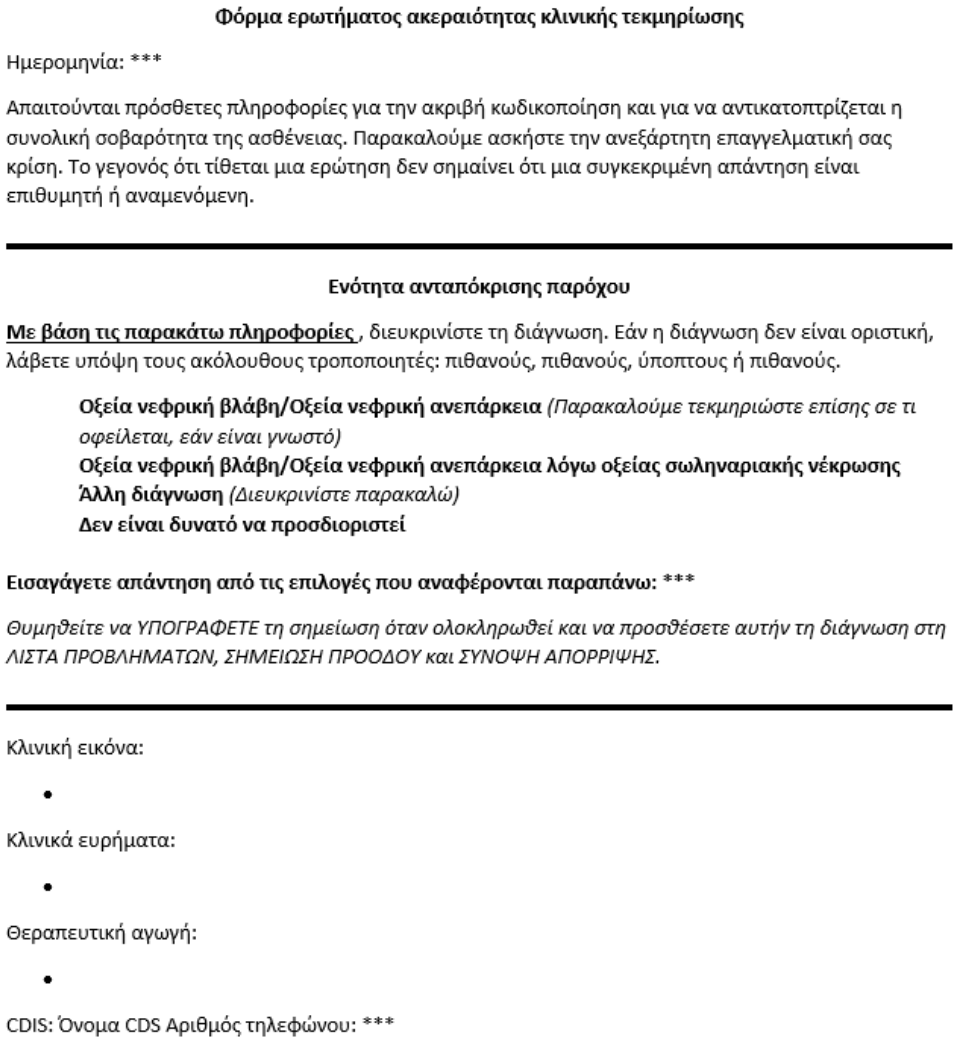
Queries Can Be Confusing



Φόρμα ερωτήματος ακεραιότητας κλινικής τεκμηρίωσης

Ημερομηνία: ***

Απαιτούνται πρόσθετες πληροφορίες για την ακριβή κωδικοποίηση και για να αντικατοπτρίζεται η συνολική σοβαρότητα της ασθένειας. Παρακαλούμε ασκήστε την ανεξάρτητη επαγγελματική σας κρίση. Το γεγονός ότι τίθεται μια ερώτηση δεν σημαίνει ότι μια συγκεκριμένη απάντηση είναι επιθυμητή ή αναμενόμενη.

Ενότητα ανταπόκρισης παρόχου

Με βάση τις παρακάτω πληροφορίες , διευκρινίστε τη διάγνωση. Εάν η διάγνωση δεν είναι οριστική, λάβετε υπόψη τους ακόλουθους τροποποιητές: πιθανούς, πιθανούς, ύποπτους ή πιθανούς.

Οξεία νεφρική βλάβη/Οξεία νεφρική ανεπάρκεια *(Παρακαλούμε τεκμηριώστε επίσης σε τι οφείλεται, εάν είναι γνωστό)*
Οξεία νεφρική βλάβη/Οξεία νεφρική ανεπάρκεια λόγω οξείας σωληναριακής νέκρωσης
Άλλη διάγνωση *(Διευκρινίστε παρακαλώ)*
Δεν είναι δυνατό να προσδιοριστεί

Εισαγάγετε απάντηση από τις επιλογές που αναφέρονται παραπάνω: *

Θυμηθείτε να ΥΠΟΓΡΑΦΕΤΕ τη σημείωση όταν ολοκληρωθεί και να προσθέσετε αυτήν τη διάγνωση στη ΛΙΣΤΑ ΠΡΟΒΛΗΜΑΤΩΝ, ΣΗΜΕΙΩΣΗ ΠΡΟΟΔΟΥ και ΣΥΝΟΨΗ ΑΠΟΡΡΙΨΗΣ.

Κλινική εικόνα:

•

Κλινικά ευρήματα:

•

Θεραπευτική αγωγή:

•

CDIS: Όνομα CDS Αριθμός τηλεφώνου: ***

- Especially if they are written using coding or CDI jargon (“Greek”)
- Because it can’t be leading, it can be very difficult to figure out why the query was sent and what is being asked.
- Terms like “clinical indicators” are foreign to providers, “risk factors” are used differently by physicians, and “risk of mortality” can be scary to providers and patients

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Better

Documentation in the medical record indicates that this patient has been diagnosed as having the symptom of **ALTERED MENTAL STATUS.** Additional findings also documented in the medical record: [include all that apply]

- Fever of ____
- Infection: [type]
- Dehydration
- Electrolyte Imbalance:
- Sepsis
- Hypoxemia
- Renal / Hepatic Failure
- Drug toxicity or adverse effect:
- Abnormal lab tests:
- Other findings:

Based on your medical judgment, can you further clarify in the progress notes if these findings associated with altered mental status are due to a definite or suspected **underlying neurologic cause** such as:

- Metabolic Encephalopathy
- Toxic Encephalopathy
- Altered mental status without encephalopathy
- Other condition (please specify)
- None of the above / Not applicable

In responding to this request, please exercise your independent professional judgment. The fact that a question is asked does not imply that any particular diagnosis is desired or expected.

Thank you!

https://www.pinsonandtang.com

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What Is A Physician/Provider Advisor?

What Is a Physician Advisor?

- An emerging and growing subspecialty of the medical field: one that integrates quality management, resource utilization review, patient safety, and regulatory compliance.
- In 2014, the American College of Physician Advisors (ACPA) was launched, establishing a peer-driven network for the growing physician advisor community.
- The new physician advisor subspecialty designation incorporates the American Board of Quality Assurance and Utilization Review Physicians' (ABQAURP) traditional certification in health care quality assurance and management (CHCQM) by adding the suffix -PHYADV (resulting in CHCQM-PHYADV).
- While there are basic tenants and expectations at the core, the role can be tailored to fit the specific needs of the individual facility as well as the interests and talents of the physician.
- Certification is not required and there is a wide range of level of training

Pooja Nagpal, MD, FACP, CHCQM-PHYADV, Ven Mothkur, MD, MBA, Physician Advisor Handbook, American College of Physician Advisors, Binghamton, NY, 2016.

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What Can A Physician/Provider Advisor (PA) Do?

- Utilization review
- Management of denials and appeals
- Length of stay and readmission reduction initiatives
- Champion for clinical documentation improvement and coding departments
- Champion for care management and social work functions
- Transitions of care and multidisciplinary care teams
- Expert in insurance regulations and partner with compliance team
- Provide practitioner education at every level from medical students to attending physicians, and across many disciplines, including nurses, therapists, coders, and billers.
- Partner in quality management processes
- Assistance with contract negotiation with insurance payers
- Assistance in promoting patient safety and addressing patient concerns

Pooja Nagpal, MD, FACP, CHCQM-PHYADV, Ven Mothkur, MD, MBA, Physician Advisor Handbook, American College of Physician Advisors, Binghamton, NY, 2016.

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Provider Engagement With CDI

- Most common concern of CDI programs
- Standard advice from CDI consulting groups
  - Support from Organizational Leadership
    - Uphill battle without it
  - Education
    - “Physicians never learned how to document correctly, so they need education”
  - Expectations
    - How long to answer a query
    - Professionalism
  - Physician Advisor
    - A colleague that can be a champion for CDI
    - Escalation process
  - Provide Data—response rate, agreement rate, case mix index

CDI engagement With Providers

- Find out what matters to them
  - What quality reporting programs are they involved in?
  - How do they get paid? Is it based on anything risk-adjusted?

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What May Help to Motivate Providers

- If employed by the hospital, CDI participation may be in employment contract
  - Find out if providers at your hospital are hospital-employed or are employed by a medical school or private practice
- The Joint Commission (TJC) requires hospitals to have Ongoing Professional Performance Evaluation (OPPE) systems for credentialed providers
  - These may use participation in CDI as one criterion
- Improving their own quality metrics
  - Don’t assume that they know how documentation affects this!

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What May Help to Motivate Providers

- Improving the accuracy of data sets, either national or local
  - Performing research or quality improvement projects with hospital data
- Many providers are conscientious want to do the right thing
  - Remember, they were the ones raising their hand in class all the time and doing the extra credit
- They are intrinsically motivated to fix problems
  - Enlist them to help improve the process
- Carrots work better than sticks so use sticks sparingly
- US News and World Report Best Hospitals Ranking
  - Only adult hospital rankings use administrative (coding) data
- CMS star rating system, Leapfrog, Viziant
  - Medicare data only

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CDI engagement With Providers

- Make it personal
  - Each provider has a personality style
    - Find out what will speak to them
  - Each specialty and practice group has their own processes
    - Who writes the notes? Do they use templates? Who makes the decisions?
  - Education should be specific to that provider or practice, with patient examples from their specialty
  - Who should queries be sent to on their team?

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CDI engagement With Providers

- Re-frame what CDI does
  - They do not believe that the only goal of CDI is to improve the accuracy documentation, otherwise the hospital would not support the program.

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Re-frame What CDI Does

"Since you should use your time caring for patients and not learning coding guidelines, we have trained in coding so that we can help you to document in a way that will demonstrate the quality of the care you provide."

"We want to make it as easy as possible for you to use the terms and documentation elements required by regulators and payors."

"We help to ensure that the hospital has the resources to purchase equipment, pay for RNs, OR techs, pharmacists, SW, PT, OT, etc."

"We want to make sure a complication is not coded for your procedure when it is not a complication."

How Can the PA Support CDI?

- Be a trusted colleague on the hospital medical staff, thus helping with provider acceptance of CDI
- Translate coding requirements into provider language
- Understand and translate the provider mindset to the CDI team
- Educate providers about CDI and CDI about clinical topics
- Assist with providers' unprofessional behavior
- Be a liaison between the CDI program and the chief medical officer, advocating for CDI
- Help with encouraging reluctant departments or providers to understand hospital expectations for their professionalism and participation
- Collaborate with specialists to establish disease definitions

How Can the PA Support CDI?

- Help with writing high-dollar appeals or having peer to peer conversations
- Discern when a provider needs more education versus when the CDI team needs more education (of both!)
- Present CDI work at hospital leadership and quality meetings to keep it in the forefront of leaders' minds
- Work with the chief medical information officer to use electronic health record functionality to help providers document in codable language
- Work with the chief quality officer on quality initiatives
- Work with contracting to advocate for fair pay for performance measures
- Explain queries to providers
- Query escalations

Some Examples from Children's WI

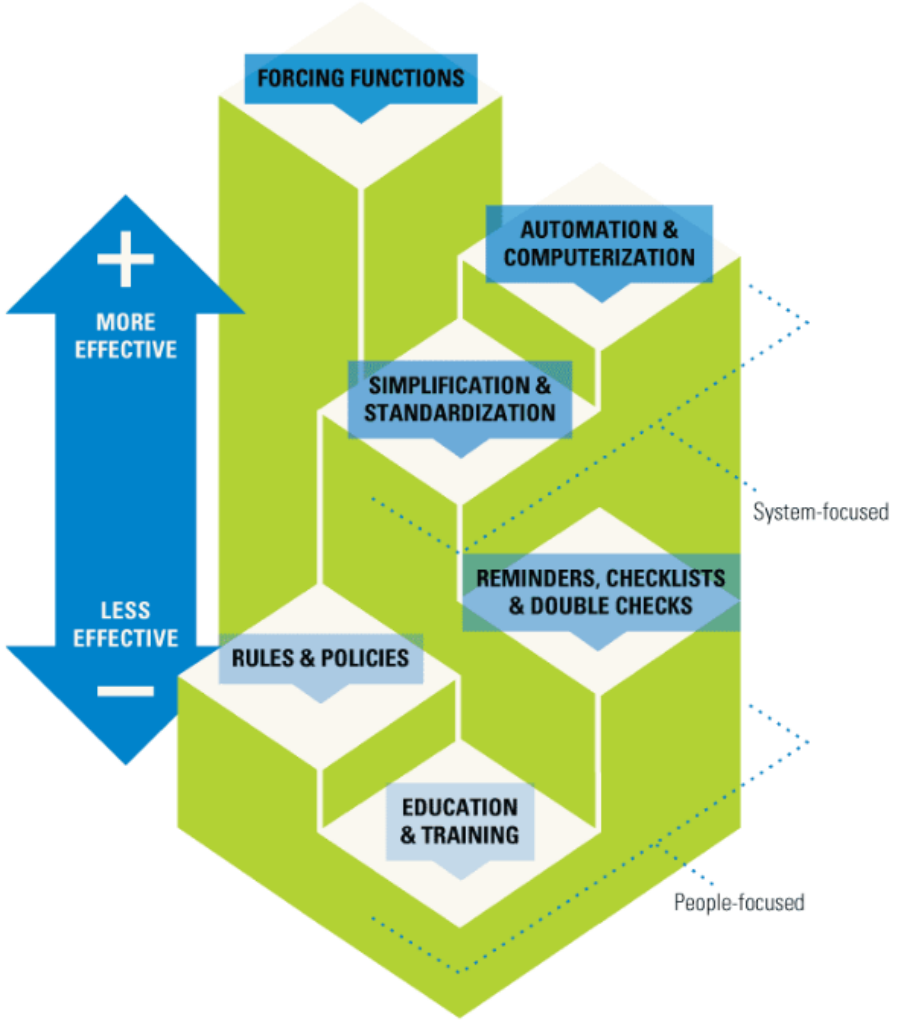
- Proposed a successful initiative to require CDI education for all new providers
  - Perform one-on-one education with all new providers
- Use the medical staff newsletter for CDI updates relevant to most providers
- Educate incoming residents and fellows
- Continue to expand CDI education to more divisions
- Recruited a general surgery Physician Assistant to be a Provider Advisor who understands the workflow and perspective and is a trusted face in the operating room

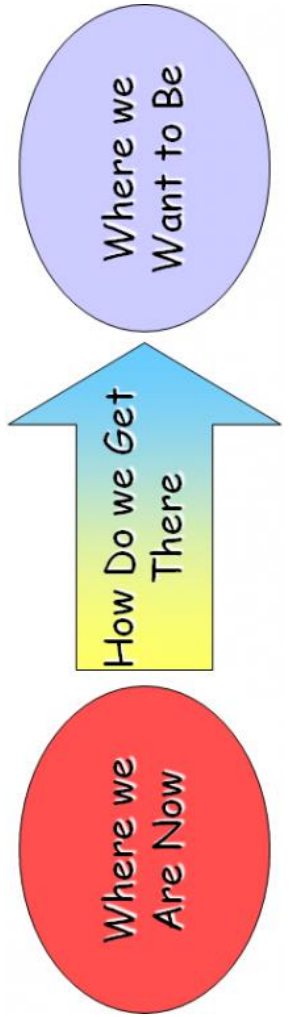
Some Examples from Children's WI

- Spend a lot of time having individual conversations with providers about their questions and concerns about queries and other documentation issues
- Meet frequently with subspecialist clinical experts to revise existing queries and definitions and create new ones
- Meet with and provide a quarterly CDI dashboard to an interested division chief about his division's documentation performance
  - Have offered this to the whole medical staff
- Collaborate with information services to leverage EMR tools
- Presented our work at our quality forum and for the VPs

Beyond Queries and Education

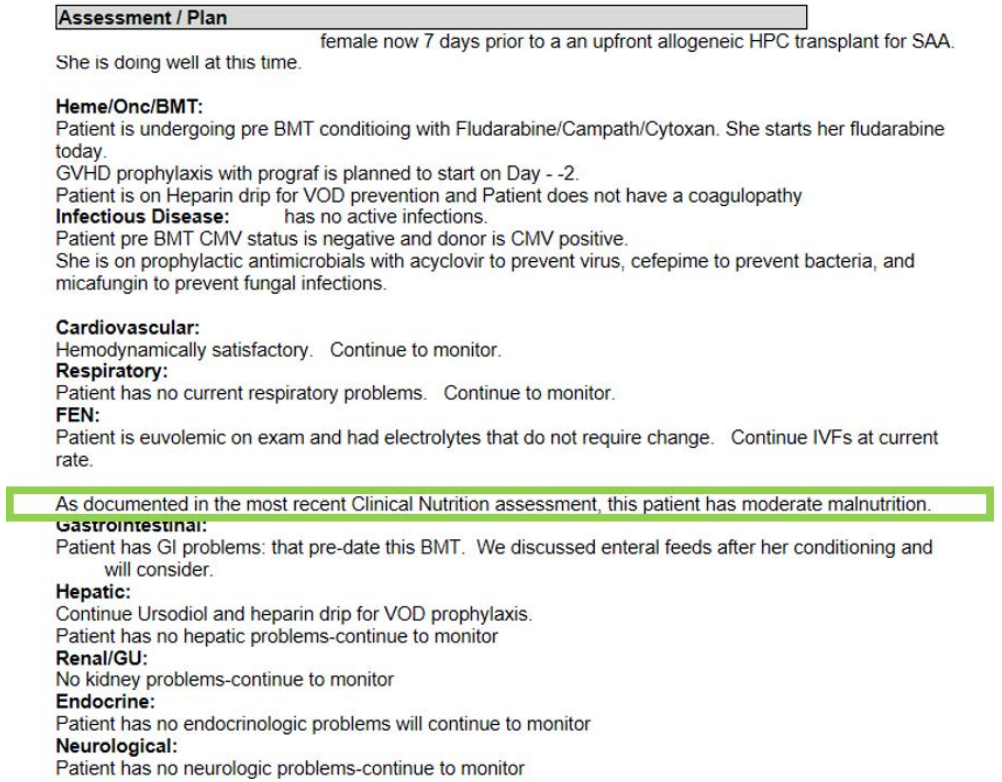
Hierarchy of Intervention Effectiveness





System-Focused Interventions at CW

- Worked with Information Services to develop decision support functionality in the EMR to improve documentation of malnutrition, respiratory failure, pressure injuries, debridement, and neonatal bronchopulmonary dysplasia, and are working on others including ABLA
- Worked with each applicable department to imbed these tools in their note templates
- Decreased queries for malnutrition by 75% while still improving the coding of malnutrition
- Disseminated our malnutrition work at the hospital quality forum



Assessment / Plan

female now 7 days prior to a an upfront allogeneic HPC transplant for SAA.
She is doing well at this time.

Heme/Onc/BMT:
Patient is undergoing pre BMT conditioing with Fludarabine/Campath/Cytoxan. She starts her fludarabine today.
GVHD prophylaxis with prograf is planned to start on Day - -2.
Patient is on Heparin drip for VOD prevention and Patient does not have a coagulopathy
Infectious Disease: has no active infections.
Patient pre BMT CMV status is negative and donor is CMV positive.
She is on prophylactic antimicrobials with acyclovir to prevent virus, cefepime to prevent bacteria, and micafungin to prevent fungal infections.

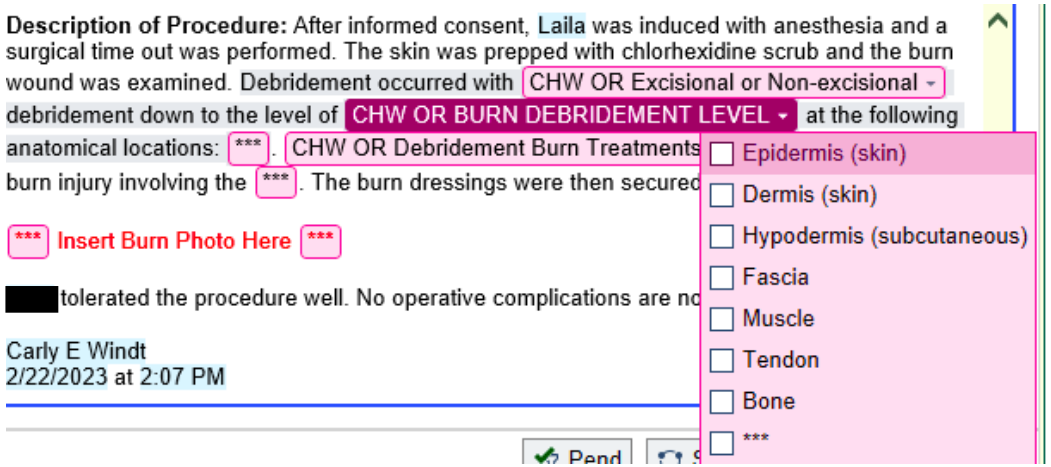
Cardiovascular:
Hemodynamically satisfactory. Continue to monitor.
Respiratory:
Patient has no current respiratory problems. Continue to monitor.
FEN:
Patient is euvolemic on exam and had electrolytes that do not require change. Continue IVFs at current rate.

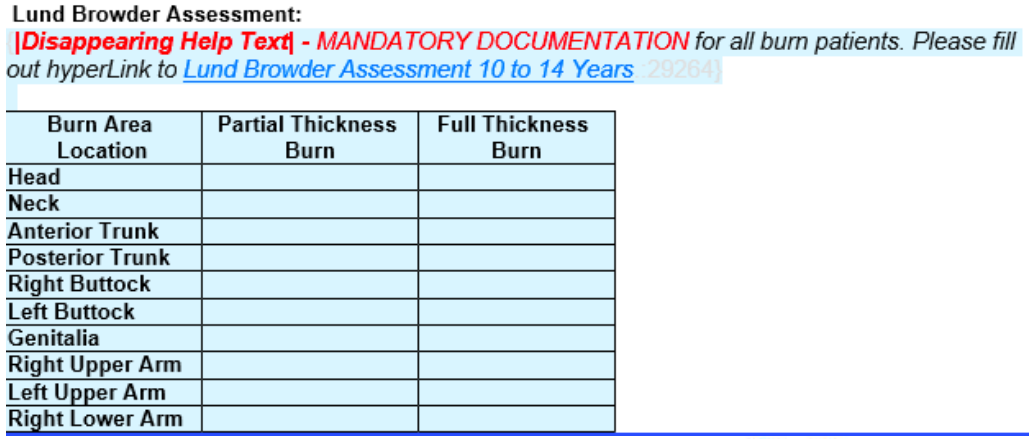
As documented in the most recent Clinical Nutrition assessment, this patient has moderate malnutrition.

Gastrointestinal:
Patient has GI problems: that pre-date this BMT. We discussed enteral feeds after her conditioning and will consider.
Hepatic:
Continue Ursodiol and heparin drip for VOD prophylaxis.
Patient has no hepatic problems-continue to monitor
Renal/GU:
No kidney problems-continue to monitor
Endocrine:
Patient has no endocrinologic problems will continue to monitor
Neurological:
Patient has no neurologic problems-continue to monitor

System-Focused Interventions at CW

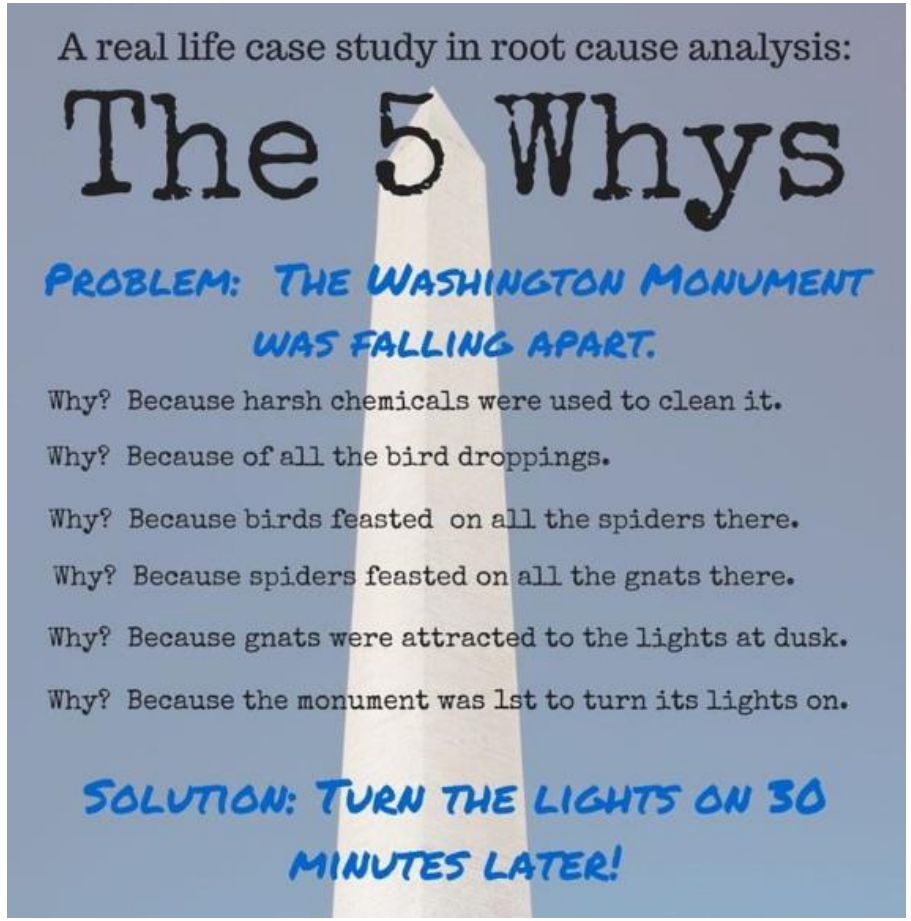
- Surgical providers were getting many debridement queries (we have a large burn population!)
  - Requirements include stating if the debridement was non-excisional vs excisional, depth of debridement (down and including), and specific locations
- General surgery debridement operative template updated to ensure all specific descriptors were included
- Also provided us an opportunity to collaborate with division professional fee coder/reimbursement manager, to ensure all required data was included in our notes (Lund Browder %TBSA)





Burn Area Location	Partial Thickness Burn	Full Thickness Burn
Head		
Neck		
Anterior Trunk		
Posterior Trunk		
Right Buttock		
Left Buttock		
Genitalia		
Right Upper Arm		
Left Upper Arm		
Right Lower Arm		

Get to the Root Cause



Problem: Providers always document "airway protection" as an indication for intubation instead of a more specific reason

Why? Because it has always been like that

Why? Because they are taught that way

Why? Because their mentor does it that way

Why? Because they all know what they mean

Why? Because it is in the note templates

Solution: change the template!

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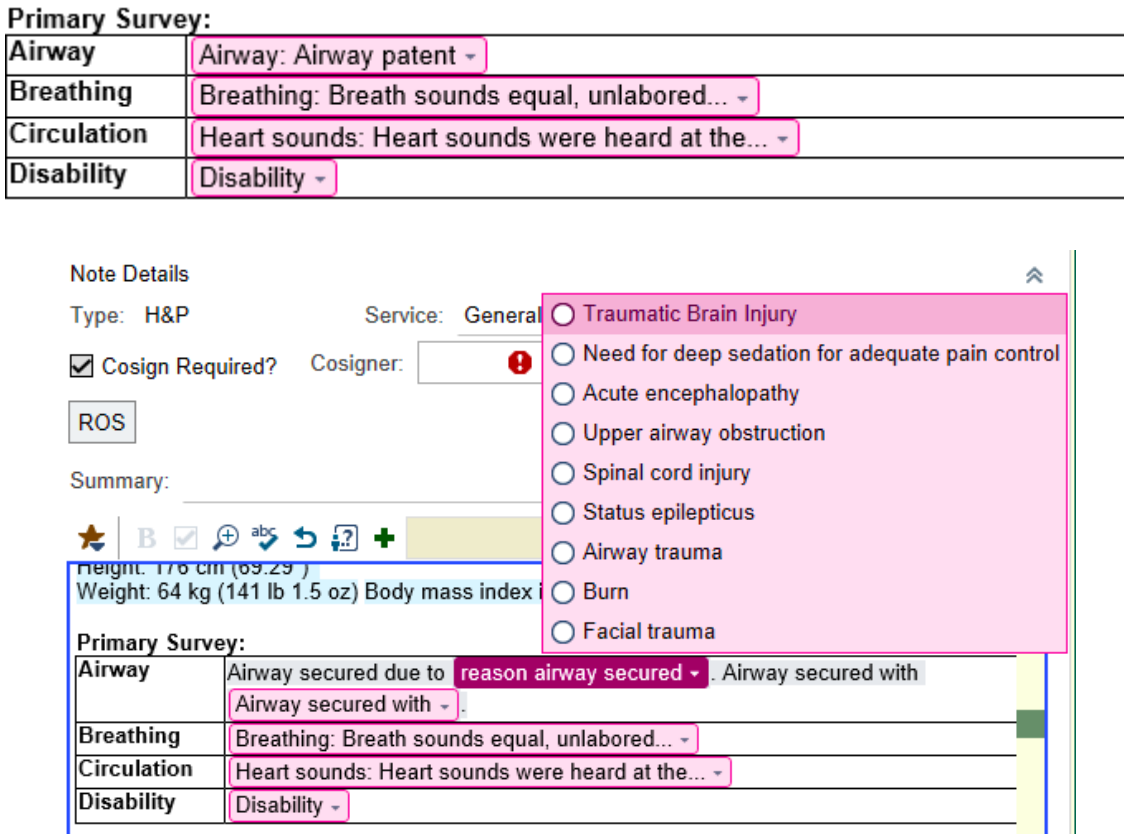
Trauma Focused Interventions at CW

- Airway protection was frequently documented as a reason for intubation
- We desired to help providers to document the more specific reason for intubation to decrease DRG denials of acute respiratory failure.
- Airway protection was previously included as a drop-down option in the General Surgery/Trauma templated H&P and consultation notes as a reason for intubation
- Drop down options were updated to provide more specific reasons for intubation
- BPA was then created and instituted amongst multiple services to alert providers to further clarify the reason for intubation



Advice From Our Experience

- Approach providers from a place of supporting them
- Listen to understand what they are saying
- Show appreciation for their time and when you see excellent documentation, point it out!
- Providers can be very affected by a bad patient outcome; be sensitive to this in your requests and conversations
- Work within providers' current documentation and patient care processes—they likely have good reasons for these
- Learn from unexpected query answers and revise query templates as needed
- Make queries as jargon-free and simple as possible
- Find champions in key departments and include updates in their newsletters
- Share some information about the financial impact of CDI with providers so that they can prioritize CDI among their other duties. They are usually not aware of the scale of CDI's impact.
- Provider education and interactions should be individualized and data-driven. Include real cases in their specialty and provide them with specific data showing where they have room for improvement.

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Advice From Our Experience

- CDI consulting firms' tips can be useful, but before making changes or implementing something new, evaluate your data to see if there really is a problem that needs to be addressed
- Develop and implement EHR-based support for provider documentation to decrease query volume and increase diagnosis capture
- Documentation education is better received when given by a provider
- Be honest about the financial benefits of CDI. Physicians are skeptical and will not believe that the hospital supports a CDI program purely to improve documentation.
- It's Ok if providers disagree with your query. It doesn't mean you were wrong to send it, or that their answer was wrong.
- Have a goal of making it as easy as possible for providers to do the right thing
- Enlist support from hospital leaders if there are providers or departments who are not engaged with CDI
- PAs with clinical experience and/or seniority will be able to gain the respect of providers
- Select PAs from different key specialties like Hospital Medicine, Critical Care and Surgery
- Advanced Practice Providers are a great addition to the PA lineup

Remember This
Letter to Physicians From Their CDI Team

- “As your CDI team, we interpret your clinical documentation into ICD-10 codes, based on the *Official Guidelines for Coding and Reporting*.
- We are your second pair of eyes and here to help you. Our patients deserve a true account of the care they receive.”
- Thank you for being our second pair of eyes!

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Appreciation for the CW CDI Team

Director of Coding and CDI:
Kenya Alexander, MS, RHIA, CCS, CDIP

CDI Supervisor:
Heather Pautz, BSN, RN, CCRN-K, CCDS, CDIP

CDI Provider Advisors:
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Emily Densmore, MD, MS, FAAP
Carly Windt, PA-C, MPAS

Questions?

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