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cdiJournal

CDI and physician education efforts

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ASSOCIATE DIRECTOR'S NOTE

Physicians more engaged in CDI efforts, survey says

By Melissa Varnavas

Perhaps we're looking at the problem of physician engagement through a lens darkly. Engaging physicians is at the core of a CDI specialist's job. The whole query process aims to get physicians more engaged in the documentation and coding side of healthcare, to demystify the previously obfuscated world where the medical record went once the patient was discharged.

Perhaps physician engagement and education aren't as much of a challenge as an opportunity. Although the annual ACDIS membership survey shows these concerns overpowering most others (such as budget cuts, staff deficiencies, juggling priorities, and managing new initiatives), a 2019 survey (included on p. 8 of this edition of the *CDI Journal*) shows physician engagement with CDI efforts is actually on the rise: Of the more than 300 respondents, 80% said their providers are moderately to extremely engaged, and a third (32.61%) said their providers are either very or extremely engaged.

Our earliest physician query survey from 2010 doesn't specifically ask about physician engagement. However, a number of questions do illustrate a progression of physician support as CDI programs have matured. Namely, in 2010, 28% of respondents indicated their query rate has not changed since their program's inception, compared to 49% who suggested they haven't needed to leave as many queries as the years go by. At the time, the most common physician query agreement rate was 86%–90%. *In 2017*, 39% reported a 91%–100% agree rate, and that percentage has held for 2019.

Perhaps increased physician engagement makes sense now that the profession has more than a dozen years under its belt.

According to a 2016 Black Book survey of 907 health leaders, 85% of hospitals confirm documented quality improvements and increases in case-mix index within six months of CDI implementation. At the time, the survey found that financial and physician leaders saw coding and CDI initiatives as "imperative."

In the early years, CDI was seen merely as a response to MS-DRG implementation. Then, such efforts became crucial in easing the transition to ICD-10-CM/PCS and educating providers on the rollout. And

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EDITORIAL

Director
Brian Murphy
bmurphy@acdis.org

Associate Editorial Director
Melissa Varnavas
mvarnavas@acdis.org

Membership Services Specialist
Penny Richards, CCDS Coordinator
prichards@acdis.org

Editor
Linnea Archibald
larchibald@acdis.org

Associate Director for Education
Laurie L. Prescott, MSN, RN, CCDS, CDIP
lprescott@hcpro.com

Director of Sales and Sponsorships
Carrie Dry
cdry@hcpro.com

Copyeditor
Adam Carroll
acarroll@hcpro.com

DESIGN

Sr. Creative Designer
Vicki McMahan
vmcmahan@simplifycompliance.com

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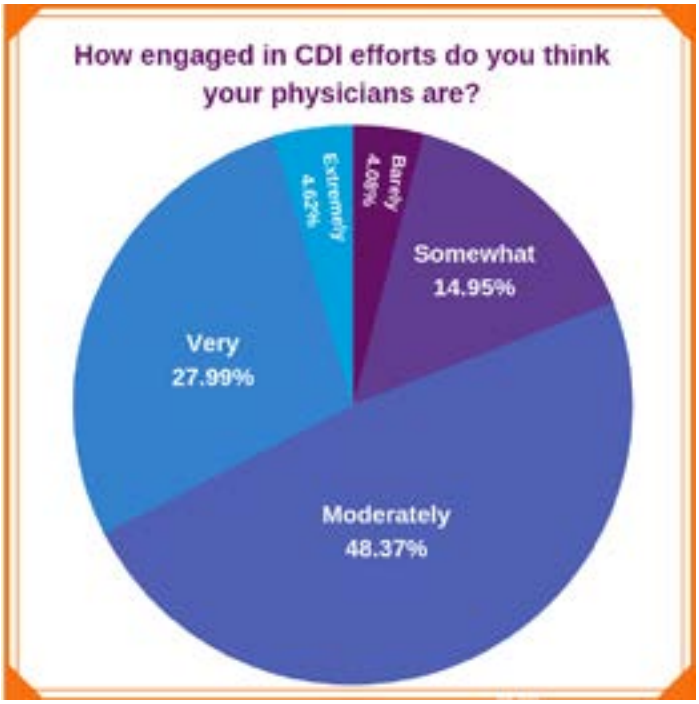


ever since, CDI programs have shown themselves to be an asset for any number of process improvement pilot programs, a panacea for virtually all of healthcare's administrative ills. As hospital administrators come to see this value—not only in dollar figures related to the return on CDI program efforts, but also in outcomes related to public reporting, population health, denials management, and audit defense—so does physician leadership. Increasingly, physicians have come to know and love their CDI teams. They have begun to look to the CDI staff to help them understand their own evaluation and management coding, their physician quality profile reports, and their risk adjustment scores.

As CDI programs continue to expand in a host of vital ways, they have proven themselves to be essential partners. These facts must, at least in the opinion of this ACDIS administrator, account for the ongoing improvement in physician engagement over time. But look through the survey (and indeed throughout the entire edition of this *CDI Journal*) and you'll find a number of other factors contributing to CDI programs' ability to work collaboratively with their providers.

Escalation policies go a long way toward increasing query response rates, according to our recent survey. And, contradictory to anecdotal fears, the survey shows a higher query response rate in CDI programs that are 100% remote. Survey data also holds that programs with physician advisors have improved willingness to participate in CDI efforts, better query response rates, and higher query agreement rates.

The article on p. 29, "Physician engagement: Six steps for solving CDI's biggest problem," echoes some of the survey's findings. It points to administrative support, physician advisor/champion activities, early training of residents and onboarding new physicians, and ongoing query and educational efforts from the CDI team as key elements of ongoing collaboration between the clinical and CDI sides of the documentation equation. The article also continues to support homegrown or purchased tools such as tip cards, online training, posters, and PowerPoint presentations.

Ongoing stratification of CDI roles and responsibilities may also help with physician engagement. As CDI staff mature, they're able to take on more specialized roles such as second-level reviewer, team lead, or dedicated physician educator. These positions free up newer specialists to focus on the day-to-day query efforts while more experienced staff dig into query response tracking and other data to identify documentation deficiencies and communicate opportunities for improvement to the physicians. The article on p. 22 explores some of the nuance of the physician educator's role, highlighting the opportunity of such individuals to tailor lessons, round with the clinical team, and research responses to physicians' questions.

On the whole, this edition of the *CDI Journal* illustrates a global story of the CDI industry's success in becoming even more indispensable to the healthcare system, both broadly and for the individual providers they serve. And while I've listed many of the reasons I think are behind this shift, I have to include one additional root cause: you. You all bring an honest integrity to the work you perform every day, and you always strive to move the bar higher in capturing the complete picture of patients' care. Take a bow.

Physician engagement: Tips from a physician

By Erica E. Remer, MD, FACEP, CCDS

I can teach CDI to anyone. Just get the providers in a room with me; they don't even have to be willing participants. While I have heard many times that physicians only listen to other physicians, I believe my success has less to do with the initials at the end of my name and more with the fact that the CDI cause is just, and I'm passionate when I teach. If you are passionate about CDI and come to physician education armed with CDI insight, you can teach physicians too.

Some people say that to win over providers to CDI, you have to answer the question: "What's in it for me?" That may hook some providers, and I do share that information with them, but it's more important to drive home the point that excellent documentation is in the patient's best interest.

Common education missteps

In that vein, there are a few common missteps that CDI professionals often make when presenting to physicians.

First, don't talk to them about the hospital's money. Even though providers should be invested in their institution's success, they are very much attuned to the popular stereotype of healthcare as big business and care more about their own practice and well-being. If they ask about the financial effects of CDI efforts, however, don't lie. Tell them the money follows the quality metrics and the hospital wants appropriate compensation for the actual costs of its patient care.

Second, know your audience. Don't talk to surgeons about hospitalist concerns; don't use an obstetrics example for an orthopedist. Speak to each group of providers about the conditions and quality metrics that concern them specifically.

Third, don't spoon-feed providers information. Allow them to work out for themselves how better documentation may have improved a situation and led to better outcomes. Make them think. Let them question. Let them show you how smart they are and how they get it. Such interactions leave your provider audience feeling empowered.

Fourth, let your CDI knowledge shine, but don't try to impress providers with your clinical knowledge. Let them recognize for themselves that you know what you are talking about. That said, don't

be afraid to admit you don't know something. If they ask a question you're not sure about, provide as much information as you can and tell them you'll do some research and get back to them. Then do that research and follow up once you have the answer. Remember, they may be the expert at patient care, but you are the expert at CDI.

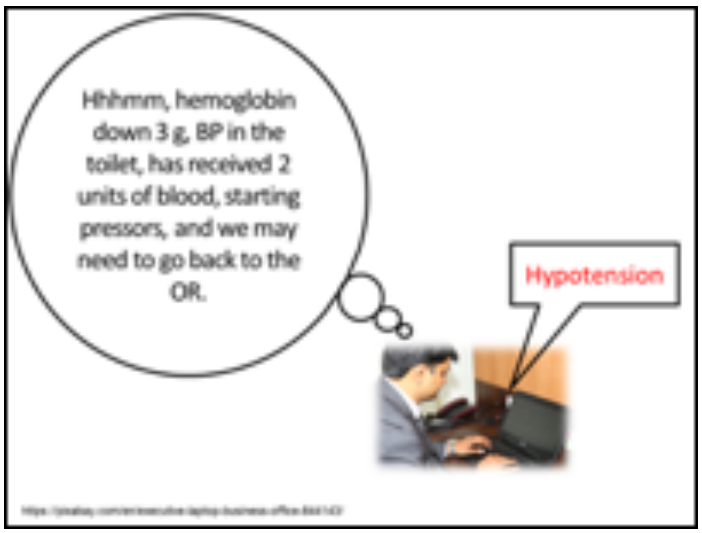
Fifth—and this goes for any kind of education you provide to any audience—make your presentation as dynamic as possible. Stay away from slide decks dense with text or full of bullet points. Instead, give your audience a single picture and tell a story. Better yet, make it experiential.

For example, I have physicians close their eyes and think of a patient with pneumonia. I ask one of them to tell me about that imaginary patient, then I paint the picture of an alternative patient. For example, I might say, "The patient you just described is a septic ICU patient from a pneumonia. My nephew had pneumonia last winter and he went back to college on a Z-Pak®. The code for pneumonia is the same. So, what makes the difference between these two patients? Right, the comorbid conditions! That is why we want you to list comorbidities comprehensively, so we can make the distinction by applying the correct codes."

Educational steps forward

As mentioned earlier, when educating physicians on CDI, we should concentrate on how improving documentation leads to improved patient care. To do so, sometimes you need to also demonstrate the converse: how bad documentation can negatively affect patient care. For example, take a look at these two slides I often show during physician education sessions:

Use case examples. Better yet, use pertinent case examples, and if you can, use pertinent case examples from audience members' own records. Make the

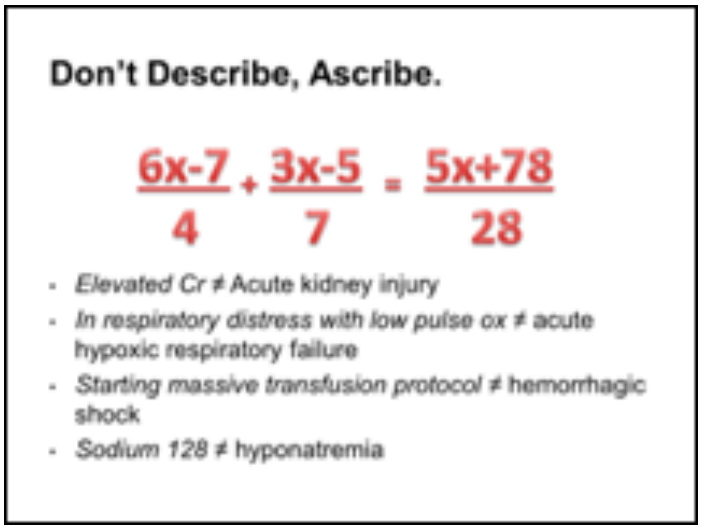


education relevant! Engage them. Have them fully present and participating.

For example, I display a math problem: (6x-7/4 + 3x-5/7 = 5x+78/28). Then I ask the physicians, "If I tell you the answer to this is 3, do I get full credit?" Eventually they will respond no. I ask why. Sometimes I prompt them, "Because you didn't show …" and they finish the sentence, "your work." Then I ask them, "If a student who has ADD shows all their work but never documents the final answer, do they get full credit?" They respond, again, no.

So, I point out that in patient charts, the providers often show all their work, providing ample documentation of signs and symptoms and lists of conditions, but they never tell me the answer—they never tell me the principal reason this patient is in the hospital. I add to

my metaphor by saying that an elevated creatinine level doesn't equal acute kidney injury; a patient with respiratory distress and low pulse oxygen levels doesn't necessarily equate to acute hypoxic respiratory failure; and a sodium level of 128 is not really hyponatremia in the face of significant hyperglycemia. Providers need to ascribe, not describe. (See the slide below.)



Show your audience how documentation affects their quality metrics. Optimizing all observed-to-expected metrics mandates thorough and precise documentation. Patient Safety Indicators are associated with the individual provider, case-mix index can be determined for a practitioner and compared to his or her peers, and robust diagnoses support complexity of medical decision-making for professional fee billing. Show them it's not only about hospital metrics, but about their performance too.

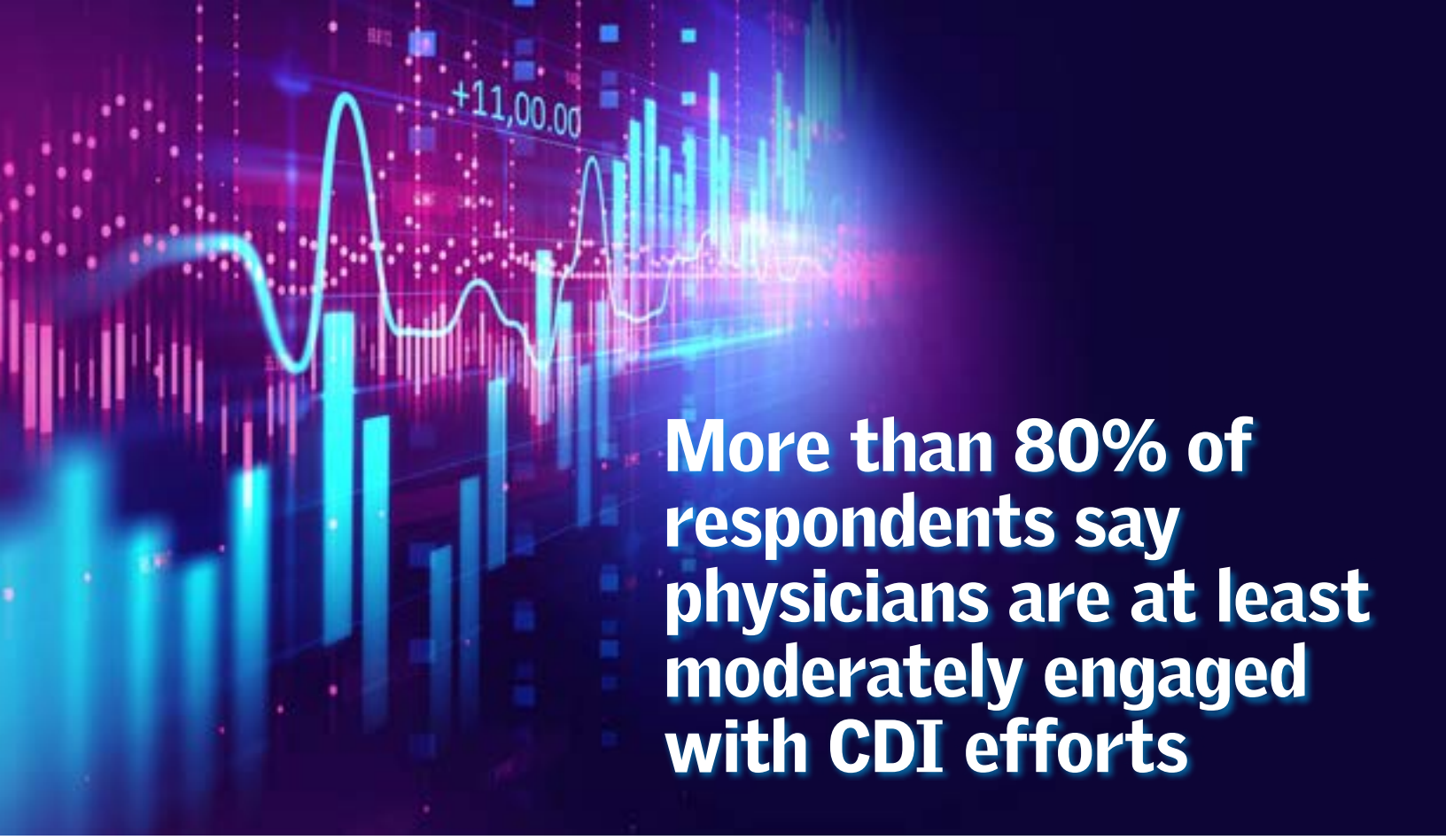
Providers really want to do the right thing for their patients, themselves, and their institutions. Make them understand that you are their ally and that you want to help them do best practice. Documentation is first and foremost for clinical communication, but there are lots of folks who read what the providers write. If they accept that you want to help them get credit for taking care of sick and complex patients, they will be receptive, interested, and engaged.

I show the following slide at the beginning of a general CDI presentation and ask if it is good documentation. I teach providers about quality metrics, observed to expected, and CDI lingo and conditions, and then I end with this slide again. Although the text below is good exposition of what the documenter is thinking, the implied diagnoses are not codable. I ask the providers to be CDI specialists for a moment and have them translate the text into good, specific, codable diagnoses. Here's what the slide includes:

Slide title: Good documentation?

Slide text: I spoke with the patient's family and explained that his infection is out of control and his vital signs are unstable with a very low blood pressure. I explained that his rapidly rising LFTs and INR, coupled with his hemorrhaging from all orifices, the fact that he is no longer making any urine, and his being unresponsive signify an extremely grave prognosis. I prepared them for the inevitable. We discussed comfort measures and the family expressed understanding.

Editor's note: Remer is the president of Erica Remer, MD, Inc. and a member of the ACDIS Advisory Board service through April 2021. Contact her at *eremer@icd10md.com.*



More than 80% of respondents say physicians are at least moderately engaged with CDI efforts

ACDIS routinely includes questions surrounding physician engagement on annual surveys, but there hasn't been a survey dedicated to the issue since the *2017 Physician Queries Benchmarking Survey*. Since physician engagement and education is routinely cited as the top issue facing CDI professionals—after all, if physicians aren't improving their documentation, CDI can't make a lasting difference—ACDIS undertook a focused 20-question survey on physician engagement that garnered 368 responses. Of those respondents, 80.98% said their physicians are moderately to extremely engaged with CDI efforts.

The majority of respondents (58.97%) are CDI specialists, followed by CDI managers/directors (20.38%). The rest of the titles—HIM/coding professional, HIM/coding manager or director, physician advisor, hospital executive, and more—each make up between 0.82% to 5.71%. (See Figure 1.)

The most common facility size is 201–300 beds, accounting for 19.29% of respondents, followed by 100–200 beds at 15.76%, 301–400 beds at 13.04%, under 100 beds at 12.5%, and more than 1,000 beds at 11.41%. (See Figure 2.)

When it comes to physician education, 70.28% said the responsibility is placed on CDI specialists, 35.28% give the job to physician advisors/champions, 34.44% assign it to the CDI manager, 17.78% have their CDI team lead handle education, and 12.5% place it on the CDI educators' plates. (See Figure 3.) (For information on dedicated physician educator roles, see p. 22.)

Encouragingly, roughly a third of respondents (32.61%) said that the physicians at their organization are very or extremely engaged with CDI efforts. That, however, does not tell the whole story. When it comes to escalation policy use, physician advisor involvement, and more, perceptions and results vary significantly.

Queries

In the 2017 survey, the plurality of respondents (38.58%) had a physician query response rate of 91%–100%. According to new survey results, this percentage

has jumped by roughly 20 points to 58.97%, showing a deepened awareness among physicians of the importance of CDI. (See Figure 4.)

According to the results, the query response rate may have a direct effect on the perception of physician engagement, or vice versa, as 77.5% of those who reported their physicians are very or extremely engaged in CDI efforts also said that their response rate is 91%–100%. Roughly 47% of those who said their physicians are barely or only somewhat engaged have a query response rate of less than 90%.

The query agree rate, however, has remained nearly flat, with the largest group in 2017 (38.58%) reporting a 91%–100% agree rate; in 2019, 39.67% fall into the same category.

When it comes to query formatting, by far the most popular type is multiple choice, with 76.63% reporting they use that format most frequently, followed by open ended (11.14%), verbal (5.43%), and yes/no (2.17%). (See Figure 5.)

According to the ACDIS/AHIMA "Guidelines for Achieving a Compliant Query Practice" brief, multiple-choice queries should include all the relevant response options in addition to "other" and "unable to determine."

"By doing so, you have not 'boxed' the physician into a particular response and you have not led the physician in any way," says **Sheila Duhon, MBA, RN, CCDS, A-CCRN, CCS,** national director of CDI education at Tenet Healthcare in Dallas. "A clear advantage to a verbal query, on the other hand, is that it opens the dialogue between the provider and the CDI specialist."

Though the multiple-choice format is the most frequently used, verbal queries seem to garner the best physician responses, with 65% of respondents who most frequently use verbal queries saying they have a response rate of 91%–100% as compared with 63.12% of those who favor multiple choice. In contrast, only 29.27% of those who most frequently use open-ended queries reached that 91%–100% response rate.

> **Irrespective of the format of the query, it's vital that even a verbal query be 'memorialized' in the medical record to reflect the conversation and details of the exchange between the physician and the CDI specialist.**
>
> *Sheila Duhon, MBA, RN, CCDS, A-CCRN, CCS*

"While verbal queries may garner a higher response rate from physicians, it's critical to maintain a keen awareness of compliant query practices. A verbal query should follow the exact same guidelines as a written one," Duhon says. "Open-ended queries risk the problem of the physician not understanding the focus nor intent of the query. […] Irrespective of the format of the query, it's vital that even a verbal query be 'memorialized' in the medical record to reflect the conversation and details of the exchange between the physician and the CDI specialist."

Escalation policies

According to the ACDIS/AHIMA "*Guidelines for Achieving a Compliant Query Practice—2019 update*" brief, "Facilities must develop an escalation policy for unanswered queries and address any medical staff concerns regarding queries." Yet traditionally, the percentage of organizations that actually have such a policy in place has hovered around 50%–60%. With this survey, however, that percentage has risen significantly to 76.09%. (See Figure 6.)

The steps in an escalation policy may vary from facility to facility, but the important thing is that the policy holds physicians accountable to cooperating with CDI efforts. This goal is largely a success, according to the survey, as 35.71% of those with a policy reported their physicians are very or extremely engaged and 61.79% said their query response rate is 91%–100%. Only 22.89% of those without an escalation policy, on the other hand, reported their physicians are very or extremely engaged, and only 51.81% said their response rate is 91%–100%, meaning that adding a policy can have a significant effect on engagement. (See Figures 7 and 8.)

"We wrote a query policy in 2018, and it was really to help improve the timeliness [of physician responses to queries] and to put some accountability around that," says **Alyssa Riley, MD, MEd,** pediatric nephrologist, CMI provider, and CDI physician advisor at Dell Children's

Medical Center at Ascension in Austin, Texas. "We weren't struggling with it too much, but every once in a while it's really helpful to have a policy in place to point to if you have someone who isn't playing ideally."

In instances when the escalation policy gets triggered, the checks and balances will rope in even the most difficult physicians, says **Bethany Towater, BSN, RN, CCDS,** CDI educator at West Tennessee Healthcare in Jackson, Tennessee.

Towater's policy requires physicians to respond to queries within seven days. If no response is received, a reminder is sent. "If it goes another seven days, it goes delinquent and then it's escalated and they're reminded every single day. If they do go delinquent, we haven't had anyone go more than a day without answering," she says.

Those looking to put an escalation policy in place should start by seeking out help from organizational leadership, Riley says. Since the policy will likely involve passing unanswered queries and problem physicians on to someone in a leadership role, leaders need to be on board with the game plan for it to succeed. (For a sample escalation policy, visit *the ACDIS Resource Library*.)

"Our [chief medical officer] read the drafts, helped revise it, and approved the whole thing," Riley says. "It's critical to get your administration buy-in to back up the policy."

Remote CDI work

Remote work, much like in the HIM/coding world several years ago, has become a buzz topic for the CDI industry, and the rate of remote work has continued to climb, according to the survey results. In fact, more than half of respondents (57.02%) now have some sort of remote work option—from 100% remote, to hybrid teams (where some staff work 100% remotely and some are 100% on-site), to teams that allow staff members to work from home a set number of days per week. (See Figure 9.)

Research everything, from compliance to schedules to what to do when there are remote capability issues. Look to your coding department for suggestions too if they're remote.

Johanne Brautigam, RN, BSN, CCDS

By far the most popular work-from-home setup is to allow staff to work a set number of days per week remotely (30.03%). Under this structure, staff focus on chart reviews and querying during days they're working from home because they can focus without interruption; then, when they're on-site, they can follow up with physicians on outstanding queries, attend meetings, and provide education. Plus, nowadays, remote work is often something staff members ask for since it gives them flexibility.

Towater's team is "really looking forward" to having a remote option, although the process remains in the planning stages. "Whether or not we go remote is almost entirely out of my hands," she notes; her organization is currently looking into various remote options.

For those in similar situations as Towater's team, "do lots of research," recommends **Johanne "Jo" Brautigam, RN, BSN, CCDS,** CDI manager at Roper St. Francis Healthcare in Charleston, South Carolina. "Research everything, from compliance to schedules to what to do when there are remote capability issues. Look to your coding department for suggestions too, if they're remote," she says.

Typically, teams that have remote or partially remote staff divide responsibilities between on-site and remote staff members, the survey shows. When it comes to physician education, 61.92% place the responsibility solely on on-site staff, while 34.06% split responsibilities between on-site and remote staff. For physician rounding, unsurprisingly 74.17% leave the responsibility to on-site staff only. For CDI/coding team meetings and education, 46.54% say it's only part of the on-site staff's role; 49.06% split the responsibility. (See Figure 10.)

Sydni Johnson, RN, BSN, CDI educator at Banner Health in Phoenix, says a hybrid system has been her team's ticket to success. "When

not in house, the CDI team members work remotely from home, which has been a source of satisfaction for our team. Our model has provided the team an opportunity for improved work/life balance and increased flexibility. We've been able to maintain provider engagement by having the CDI team members round daily with providers while in house and also provide monthly in-person provider education," she says.

One of the major fears of moving to a 100% remote model is that physician engagement and query response rates will falter. This concern, according to the data, seems largely unfounded. Of those respondents with a 100% remote CDI team, 62.96% said they have a response rate of 91%–100%, and 51.85% said their physicians are very or extremely engaged in CDI efforts. (See Figures 11 and 12.) The high rates of engagement for remote teams may be linked to the fact that many remote programs are built on years of on-site relationships and work. Fully remote programs are likely mature programs entering a new phase of evolution as opposed to brand-new programs striking out for the first time.

"The partnerships we've developed over the years and the touchpoints we have [such as on-site staff rounding, etc.] keep the physicians from forgetting about us," says Brautigam.

Physician advisors

According to survey results, 64.29% of respondents currently have a physician advisor and another 2.57% are in the process of hiring one. Most of those respondents (36.09%) have a single part-time advisor, 11.59% have a single full-time advisor, and 11.92% have multiple part-time advisors. Those with two or more full-time advisors make up 7.61% of the total respondents. (See Figure 13.) Twenty-two percent of respondents have had a physician advisor for three to four years, and another 22% have had an advisor for five to six years. (See Figure 14.)

Most of those physician advisors are salaried for their role with CDI (22.49%), 14.46% receive a stipend for the hours they spend dedicated to CDI, and 2.41% receive a flat bonus. However, 8.84% are not compensated any additional funds for their work with CDI. (See Figure 15.)

Whether they're compensated or not, physician advisors carry a range of roles (see Figure 16), including:

- Helping to "close" outstanding queries (54.44%)
- Assisting CDI staff with presenting CDI education to physicians (52.12%)
- Assisting with auditor appeals/drafting appeals letters (36.29%)
- Disciplining non-compliant physicians (30.50%)
- Offering coding/query suggestions to CDI/coding staff (28.19%)
- Reviewing charts for medical necessity of inpatient admissions (27.41%)

Anecdotally, CDI professionals can tell tales of physician advisors changing their program's course and the state of physician engagement at their organization. It's not just hearsay anymore, however, because the survey results show noticeable improvements to physician engagement with the addition of an advisor or champion.

Respondents who have physician advisors reported higher perceptions of physician engagement than those without an advisor by about eight percentage points, with 36% of those with an advisor saying their physicians are very or extremely engaged and only 28% of those without an advisor reporting the same levels of engagement. (See Figure 17.)

"I cannot express how important it is to have a physician on your side to have those peer-to-peer conversations," Towater says. "Once we added the physician advisor, we started to see the physicians jumping on board within about a year."

Specifically, 51.6% of respondents said that their physician advisor has improved their query agreement rate, 69.59% said the advisor has improved other physicians' willingness to participate in CDI initiatives and education, and 70.78% said the advisor has improved their query response rate. (See Figure 18.)

To further these findings, 61.78% of respondents with a physician

advisor have reached a 91%–100% response rate versus 56.8% for those without an advisor. (See Figure 19.)

Though their benefit is clear, physician advisors' time may be split across several departments and goals, as indicated by the following data (see Figure 20):

- 35.62% of respondents said their advisor splits their time between CDI and practicing medicine
- 34.70% said they split their time between CDI, practicing medicine, and advising another department
- 22.37% say they split their time between CDI and another department such as case management

Riley says it can be a challenge for an advisor to get up to speed on all things CDI when he or she is also attending to other departments and responsibilities. The best method for educating an advisor, in her opinion, comes from shadowing and working directly with the CDI team and attending outside educational events if possible.

"It was a lot of trial by fire with a couple really experienced CDI specialists to help me get up to speed. In the first year, I wouldn't go to meet with physicians without one of my CDI specialists for backup," she says. "I started in January and went to the ACDIS Conference my first year. That was a really good opportunity to understand where our program was in relation to other programs, too."

Once the physician advisor is well versed in CDI, it will be much easier to involve him or her in the needs of the department. Ultimately, one of the biggest changes a department may see from employing the help of an advisor is a dip in the percentage of charts a CDI specialist can query on, according to Towater.

"Our query rate is dropping because of it, but what we're seeing in the chart is that the physician is listening and learning and improving, so now it can be difficult to find something to query," she says. "CDI is becoming more excited about their role because it's no longer about the bottom dollar, it's about the quality of the documentation."

That extra time no longer spent on querying can be reallocated to other projects and tasks that could benefit from the CDI touch. "We started a pretty big cardiac program in the last year, and [the CDI specialists] have the ability to help with that," Riley adds.

Regardless of whether a program has the help of an advisor or an escalation policy in place, Riley says the best step toward improving physician engagement is simple.

"Be a resource to the physicians," says Riley. "Even if they grumble, listen and try to be a sounding board for them."

Figure 1: Respondent title/role

CDI specialist	**58.97%**
CDI manager/director	**20.38%**
HIM/coding manager/director	**3.53%**
HIM/coding professional	**1.90%**
Physician advisor	**2.45%**
Hospital executive	**0.82%**
Consultant	**1.36%**
CDI educator	**3.26%**
CDI auditor	**1.63%**
CDI lead	**5.71%**

Figure 2: Facility size

Under 100	**12.50%**
100-200	**15.76%**
201-300	**19.29%**
301-400	**13.04%**
401-500	**9.51%**
501-600	**5.98%**
601-700	**5.71%**
701-800	**2.72%**
801-900	**2.45%**
901-1,000	**1.63%**
More than 1,000	**11.41%**

Figure 3: Responsibility for physician education	
CDI specialists	**70.28%**
CDI team lead	**17.78%**
CDI educator	**12.50%**
CDI manager	**34.44%**
Physician advisor/champion	**35.28%**
Other (please specify)	**7.50%**

Figure 4: Physician query response rate, 2017 versus 2019	2017	2019
Under 40%	**0.93%**	**2.45%**
41%-50%	**0.00%**	**2.17%**
51%-60%	**0.93%**	**2.45%**
61%-70%	**3.70%**	**1.90%**
71%-80%	**8.64%**	**5.43%**
81%-90%	**30.86%**	**18.21%**
91%-100%	**38.58%**	**58.97%**
Don't know	**9.88%**	**3.80%**
We don't track this metric	**4.01%**	**1.36%**
Other (please specify)	**2.47%**	**3.26%**

Figure 5: Query formats	
Verbal	**5.43%**
Multiple choice	**76.63%**
Yes/No	**2.17%**
Open ended	**11.14%**
Other (please specify)	**4.62%**

Figure 6: Escalation policies	
Yes	**76.09%**
No	**22.55%**
Don't know	**1.36%**

Figure 7: Escalation policy use and perceived engagement	Have an escalation policy	Do not have an escalation policy
Barely engaged	**2.50%**	**9.64%**
Somewhat engaged	**10.71%**	**30.12%**
Moderately engaged	**51.07%**	**37.35%**
Very engaged	**30.71%**	**20.48%**
Extremely engaged	**5.00%**	**2.41%**

Figure 8: Escalation policy use and query response rate

	Have an escalation policy	Do not have an escalation policy
Under 40%	**2.50%**	**2.41%**
41%-50%	**1.43%**	**4.82%**
51%-60%	**1.79%**	**4.82%**
61%-70%	**2.14%**	**1.20%**
71%-80%	**4.64%**	**7.23%**
81%-90%	**18.93%**	**14.46%**
91%-100%	**61.79%**	**51.81%**
Don't know	**3.21%**	**4.82%**
We don't track this metric	**0.71%**	**3.61%**
Other (please specify)	**2.86%**	**4.82%**

Figure 9: Remote CDI work

We are 100% remote	**7.44%**
Only a portion of the staff is remote	**9.37%**
Staff splits onsite and offsite duties	**10.19%**
Staff are allowed to work a set number of days per week remotely	**30.03%**
We don't have remote work options	**42.98%**

Figure 10: Remote versus onsite staff responsibilities

	Only onsite staff	Only remote staff	Both onsite and remote staff
Physician education	**61.92%**	**4.02%**	**34.06%**
Physician rounding	**74.17%**	**3.32%**	**22.51%**
CDI/coding team meetings/education	**46.54%**	**4.40%**	**49.06%**

Figure 11: Physician query response rate for 100% remote teams	
Under 40%	**3.70%**
41%-50%	**0.00%**
51%-60%	**3.70%**
61%-70%	**3.70%**
71%-80%	**3.70%**
81%-90%	**18.52%**
91%-100%	**62.96%**
Don't know	**0.00%**
We don't track this metric	**0.00%**
Other (please specify)	**3.70%**

Figure 12: Perception of physician engagement for 100% remote teams	
Barely engaged	**7.41%**
Somewhat engaged	**11.11%**
Moderately engaged	**29.63%**
Very engaged	**44.44%**
Extremely engaged	**7.41%**

Figure 13: Number of physician advisors	
1 part-time	**36.09%**
1 full-time	**11.59%**
Multiple part-time	**11.92%**
2-5 full-time	**3.97%**
6-10 full-time	**2.65%**
More than 10 full-time	**0.99%**
Other (please specify)	**32.78%**

Figure 14: Number of years of physician advisor involvement	
Less than 1 year	**14.00%**
1-2 years	**19.60%**
3-4 years	**22.00%**
5-6 years	**22.00%**
7-8 years	**8.40%**
8-9 years	**5.60%**
10 years or more	**8.40%**

Figure 15: Physician advisor compensation	
Salaried	**22.49%**
Stipend by hours dedicated to CDI	**14.46%**
Stipend by flat bonus	**2.41%**
They're not compensated for this role	**8.84%**
Don't know	**51.81%**

Figure 16: Physician advisor responsibilities	
Helping to "close" outstanding physician queries	**54.44%**
Helping to draft compliant/effective queries	**13.51%**
Querying physicians on a concurrent or retrospective basis	**15.06%**
Offering coding/query suggestions to CDI/coding staff	**28.19%**
Providing pre-/post-bill clinical documentation support	**24.32%**
Assisting with auditor appeals/drafting appeals letters	**36.29%**
Reviewing charts for medical necessity of inpatient admissions	**27.41%**
Providing documentation/clinical education to CDI and coding staff	**25.10%**
Assisting CDI staff with presenting CDI education to physicians	**52.12%**
Disciplining non-compliant physicians	**30.50%**
Other (please specify)	**22.39%**

Figure 17: Physician advisor involvement and perceived engagement

	Have a physician advisor	Don't have a physician advisor
Barely engaged	**1.78%**	**7.20%**
Somewhat engaged	**11.11%**	**22.40%**
Moderately engaged	**51.11%**	**42.40%**
Very engaged	**29.78%**	**26.40%**
Extremely engaged	**6.22%**	**1.60%**

Figure 18: Physician advisor effect

	Improved	Did not affect	Worsened
Query response rate	**70.78%**	**29.22%**	**0.00%**
Query agreement rate	**51.60%**	**48.40%**	**0.00%**
Physicians' willingness to participate in CDI initiatives/education	**69.59%**	**29.49%**	**0.92%**

Figure 19: Physician advisor involvement and query response rates

	Have a physician advisor	Don't have a physician advisor
Under 40%	**2.67%**	**2.40%**
41%-50%	**2.67%**	**0.00%**
51%-60%	**3.11%**	**1.60%**
61%-70%	**2.22%**	**1.60%**
71%-80%	**4.00%**	**7.20%**
81%-90%	**17.78%**	**19.20%**
91%-100%	**61.78%**	**56.80%**
Don't know	**2.67%**	**5.60%**
We don't track this metric	**0.89%**	**0.80%**
Other (please specify)	**2.22%**	**4.80%**

Figure 20: Physician advisors splitting time

They work with CDI full-time	**7.36%**
They split their time between CDI and practicing medicine	**34.20%**
They split their time between CDI and another department (e.g., case management, utilization review, etc.)	**22.94%**
They split their time between CDI, another department, and practicing medicine	**35.50%**

GUEST COLUMN

Eliminating (or at least reducing) query fatigue

By Cathy Farraher, RN, BSN, MBA, CCM, CCDS

Physician burnout is at *an all-time high* and provider query fatigue is a real concern for every facility, whether your response rate is 100% or below 70%. To understand why, put yourself in the provider's place for a moment.

You come to work and get your patient assignments, receiving a multitude of reports from the emergency department or the previous shift's providers. You assess each patient and document the results. You order labs and tests. You later follow up on results, making care plan changes and ordering medications. Throughout your shift (of however many hours you've taken on due to staffing shortages and scheduling snafus) you receive patient updates and respond to questions from nurses and ancillary staff, consulting with specialists as needed. For some patients, you work with case managers to address patient status, discharge needs, and obstacles to continuing care.

In addition, you attend administrative meetings and grand rounds, meet with family members and deliver sometimes unpleasant news, take care of patients in critical moments, and respond to codes as they occur. You research concerns and respond to inquiries related to abnormal length of stay. And on top of everything else, you answer CDI queries.

It's no wonder that, *according to a 2018 recent study*, 83% of physicians say burnout is a major issue at their institutions. And of all their important responsibilities, is it any wonder that queries—especially from a CDI program focused on maximizing reimbursement—are often the least attractive and most frustrating part of physicians' days?

Keeping this in mind, we as CDI professionals can work to reduce the incidence of query fatigue. By following these recommendations, I believe we can improve the provider response rate while reducing everyone's frustration.

Method 1: Limit the number of queries per chart and/or provider per day

No provider should have to spend more than a few minutes a day responding to queries. Sometimes this might mean CDI should hold a query for a day before sending it. If a particular provider requires multiple queries, request a meeting with him or her to provide education around improved documentation, which can prevent the need for an unrealistic number of queries.

The exact number of queries that qualifies as "too many" is something your facility should determine. Once you've done so, all team members should adhere to that figure, except under extenuating circumstances.

Method 2: Remember that timing is everything

CDI managers need to collect data and assess whether staff are sending queries at the appropriate time. Although most programs review the record at the 24- and 48-hour marks (according to a recent survey), it's inappropriate to, for example, send a provider a query regarding congestive heart failure specificity with an echo pending. Instead, specialists need to flag the record for re-review once the results are filed and send a query at that time if warranted.

Method 3: Be mindful of providers' schedules

If you expect an answer to a query immediately, try to avoid sending it first thing in the morning on day one of a physician's rotation, or on a Friday evening at 5 p.m. In a teaching hospital, ask individual teams if they would prefer you to query the attendings, residents, or interns, and ask whether they would prefer to have a physician assistant be responsible for answering queries (providing facility and state documentation rules permit this).

You may find that some teams prefer to have CDI staff round with them, as was suggested by a surgical chair at one of my hospitals. Other physicians might prefer to have all queries sent to them at the end of the day, at lunch, as a group message, etc. Tailor your program to make the provider a part of the decision-making

process, and you will see more positive results and less query fatigue.

Method 4: Hold CDI specialists responsible for compliant, relevant, and reasonable queries

Some CDI staff members bend their energies toward generating a query without stopping to consider the relevance of the query itself—yet this is the most important consideration. All queries must be relevant. Some CDI specialists, especially newer ones, may not yet possess the critical thinking and clinical knowledge to draft reasonable queries.

They may be tempted to send noncompliant or superfluous queries that are not in anyone's best interest—queries that lack solid clinical indicators or ask for documentation specificity that will not impact the chart in any way. This can be a particular concern in programs with a "query quota" where staff need to submit or identify a minimum number of queries in a set time frame.

> **Any query without supporting clinical indicators not only raises a lot of issues from a compliance standpoint but also throws the credibility of the CDI specialist into question.**
>
> *Cathy Farraher, RN, BSN, MBA, CCM, CCDS*

Queries must be largely generated based on clinical indicators. Any query without supporting clinical indicators not only raises a lot of issues from a compliance standpoint but also throws the credibility of the CDI specialist, or even the entire program, into question.

I've seen queries for aspiration pneumonia when the chart doesn't mention aspiration at all, and queries about a surgical procedure that illustrate a lack of anatomy and physiology knowledge. Providers will certainly not appreciate their time being wasted with queries like these, and if bad queries happen with any regularity, they may begin to distrust the CDI program in general.

In addition to ensuring that queries are compliant, have a process by which a provider can notify management and/or staff if they find a query to be clinically unreasonable or unnecessary. Again, this allows for a team approach to documentation improvement. Holding CDI staff members accountable requires CDI leaders to audit queries on a regular basis. Emphasizing that quality beats quantity when it comes to metric tracking can also boost query relevance.

Method 5: Ensure a provider-friendly query process

A query should not take much time to read and reply to, but if your process is cumbersome, consider revising it using provider input and feedback. Make it as easy and fast as possible for the clinicians to respond, and you'll get more responses and happier providers.

For example, though there's no official requirement that queries be formatted with the question first followed by the clinical indicators, many providers find this arrangement easier to read and digest. For more information on this topic, read *this Q&A with the ACDIS Advisory Board*.

Method 6: Share data and trends with providers

CDI professionals should regularly share Program for Evaluating Payment Patterns Electronic Report (PEPPER) data and other trends with providers in a brief but simple format. Clinicians love data that is relevant to their practice, and it helps convince them of the need for CDI and for ongoing queries. You can share data quarterly by service line, or one-on-one with targeted data regarding specific physicians' documentation habits neutrally analyzed against their peers.

Call out documentation "stars" as well as those underperforming without using names (they'll know who they are as soon as you pull up examples). Physicians like to be acknowledged for their good work and strive to improve—give them an opportunity to do so.

Method 7: Let no be no

It sounds simple, and it should be: You won't make any headway with providers by resending a query that they've already answered negatively just because the CDI staff believes the query warrants a different answer. Although this practice is inappropriate, some CDI professionals and programs persist in maintaining it.

Not letting no be no only serves to drive a wedge between the provider and the CDI department. If the clinical indicators were present and the physician responded to the query negatively, the best thing to do is to provide education and ask the provider to explain the rationale behind the answer. If a query is not responded to, on the other hand, the CDI department can go through its escalation process to get it resolved.

I'm sure there are more ways than the seven I've outlined that can help reduce query fatigue. The best way to assess this is through a quick survey of your own providers. Try using the template on p. 19 as a jumping-off point. We can't improve the integrity of the chart if we don't have provider buy-in and assistance.

Editor's note: Farraher is a care manager at UC San Diego Health in the greater San Diego area. She was a member of the Massachusetts ACDIS chapter's leadership team and served as the chair of the 2018 CDI Practice Guidelines Committee. The opinions expressed do not represent a consensus agreement of ACDIS or its Advisory Board. Contact her at *catarrina@gmail.com*. This paper was reviewed by the members of *the 2018 CDI Practice Guidelines Committee*.

SAMPLE SURVEY

Dear Provider,

Our goal is to make our query practice as easy for you as possible, and we will be using the results of your responses to this questionnaire to make changes to our current CDI program practice. We appreciate your help with this effort. Please respond within the next 10 days.

Please rate the following from 1–10, with 1 meaning "strongly disagree" and 10 meaning "strongly agree."

Additional comments or suggestions would be greatly appreciated!

Thank you for taking the time to assist us. The final data will be shared with you in two weeks.

Sincerely,

CDI Director, contact information

The current query process is easy for me to reply to	1 2 3 4 5 6 7 8 9 10
I understand why querying is necessary	1 2 3 4 5 6 7 8 9 10
I believe that the CDI program is helpful to our hospital quality ratings	1 2 3 4 5 6 7 8 9 10
I prefer to receive verbal queries	1 2 3 4 5 6 7 8 9 10
I prefer to receive queries via email	1 2 3 4 5 6 7 8 9 10
I prefer to receive paper queries	1 2 3 4 5 6 7 8 9 10
I prefer to receive queries via the EHR	1 2 3 4 5 6 7 8 9 10
I prefer queries in a multiple choice format	1 2 3 4 5 6 7 8 9 10
I prefer queries in an open-ended format	1 2 3 4 5 6 7 8 9 10
I prefer queries in a yes/no format	1 2 3 4 5 6 7 8 9 10
The CDI queries I receive are clinically valid	1 2 3 4 5 6 7 8 9 10
Queries help me to improve my documentation	1 2 3 4 5 6 7 8 9 10
Queries do not take too much time	1 2 3 4 5 6 7 8 9 10
I can contact the CDI team with any questions I have	1 2 3 4 5 6 7 8 9 10

MAY 2019

S	M	T	W	T	F	S
			1	2 The AZ local chapter meets via webinar, 12 p.m.	3	4
5	6	7	8	9	10	11
12	13 The IL local chapter meets, 12-5 p.m.	14	15	16	17	18
19 ACDIS 2019 pre-cons Day 1 Kissimmee, FL	20 ACDIS 2019 pre-cons Day 2 Kissimmee, FL	21 ACDIS 2019 conference Day 1 Kissimmee, FL	22 ACDIS 2019 conference Day 2 Kissimmee, FL	23 ACDIS 2019 conference Day 3 Kissimmee, FL	24	25
26	27	28	29	30	31	

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Association of Clinical Documentation Improvement Specialists

JUNE 2019

S	M	T	W	T	F	S
						1
2	3	4	5	6 The pediatric networking group meets via webinar, 3 p.m.	7	8 The GA local chapter meets for an all-day event
9	10	11	12 The Kansas City, MO local chapter meets, 2-4 p.m.	13 Fighting denials & winning appeals—ACDIS webinar, 1 p.m.	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

VISIT THE ACDIS BLOG WEEKLY TO FIND OUT WHAT EVENTS ARE COMING UP IN YOUR AREA!

Focus on engagement: Physician educator roles

More and more facilities are employing full-time physician educators or liaisons. In fact, roughly 11% of respondents to *the 2018 CDI Week Industry Survey* indicated they currently have this role as part of their CDI team. But the industry seems to be seeing a differentiation between the physician educator/liaison and CDI educator roles.

While a CDI educator may be responsible for staff onboarding, developing educational materials, and providing ongoing education to CDI and coding colleagues, a physician educator's role is outward facing toward the medical staff. Their main job is to ensure that each provider at their facility receives necessary CDI education and unified messaging.

As remote CDI work increases, organizations are increasingly searching for an answer to their physician education and engagement woes. An on-site educator who can be the face of CDI may be the answer they've been looking for.

"When I went remote for about a year, my relationships with the physicians started to struggle," says **Cheryl Richardson, RN, CCDS,** CDI specialist and physician liaison at Hardin Memorial Hospital in Elizabethtown, Kentucky. "So, when I had the opportunity to come back on-site for our team to take the physician liaison role, I was really excited."

"One of the benefits of having a provider educator role is that your CDI team members can go remote because they have the on-site support," echoes **Shirlivia Parker, MHA, RHIA, CDIP,** regional physician educator, shared services, at Providence St. Joseph in Irvine, California.

Even with a fully on-site staff, though, having a dedicated person for physician education can help free up the CDI staff's time, especially if they're held to productivity metrics or are expanding their chart review focus.

Adding the position

Though the mainstay of CDI work is often—and rightly—seen as the

query process, those who are still querying for the same diagnoses and specificity five years into the program could have a problem. In that instance, there's no actual improvement in the documentation, says **Stacy Walker, RN, BSN, CCDS**, CDI manager and physician educator at St. Bernards Medical Center in Jonesboro, Arkansas.

"We always felt that educating physicians was a better method than just querying repeatedly because that's just nagging," she says. "If all your CDI department is doing is querying physicians and churning out HIPAA-compliant text messages, you're going to chase your tail. [Physicians] need to understand why you're asking these questions and know that it's not all about the money."

Knowing that there's a need for a dedicated physician educator is the easy part of the process, however. CDI programs must make the case for an additional position and provide the return on that investment to facility administrators, according to Walker. This will set the physician educator up for success and allow an entry point to the providers.

"You have to have the support from the VP of medical staff," says Walker. "If they don't support the role and don't support education for the physicians, it's going to be really hard to get in front of [the physicians]."

In order to start the new program off on the right foot, Walker suggests setting up meetings with key physician leaders and explaining the need for and purpose of the new role. That way, when the newly minted physician educator steps into his or her position, there'll be backup from above.

Once the position is approved, the team needs to choose the correct person for the job. Ideally, that person should have CDI experience, but not all CDI specialists would make good physician educators. Instead, CDI leaders should pay attention to personality traits.

"[A physician educator/liaison] needs to have major confidence, but not be overly aggressive," says Richardson. "They need to have confidence in themselves and own it. You have to know that you know what you're talking about."

Once the position's approved, the team needs to develop a formalized physician education process.

Everyday duties

Depending on the size of the organization and the budget afforded to CDI efforts, the physician educator or liaison role may be a part-time gig filled by someone who's performing other CDI duties as well, says Walker, who splits her time between the educator role and managing the CDI department.

"The first thing I do is make sure there's no staffing, worklist, or computer issues," she says. "The first part of my day is usually focused on the management side of my job. […] Sometimes, the squeaky wheel gets the oil."

When you're splitting time between the educator role and another role, it's important to consider the day of the week and the regular needs that occur on that given day, says Richardson. For example, Mondays likely won't be the best day for physician educator duties as both the physicians and the CDI staff will likely be tied up with post-weekend cleanup work.

"I worked for eight and a half hours and it was CDI work all day because it was a Monday," says Richardson. "I have a very big plate, and it's very full right now. My manager and I are working and trying to see what needs to be done to get me more into the educator role fully."

> **[A physician educator/liaison] needs to have major confidence, but not be overly aggressive. They need to have confidence in themselves and own it. You have to know that you know what you're talking about.**
>
> *Cheryl Richardson, RN, CCDS*

If your team does opt for a full-time, dedicated physician educator, the workday will still be filled with variety, Parker says, and the educator will need to prioritize his or her worklist just like a CDI reviewer would.

"On an average day, one of my top goals is query escalation. I'm the first level of contact, and if I can't solve it, I escalate it to the physician advisor," she says. "Then, one of my next goals is physician orientation. I review the process of answering a query in the EHR, go over some key documentation tips, show them the canned text in the EHR and what

they need to be careful of. After that, I usually do a bit of rounding depending on the targeted physicians I want to meet with that day."

No matter what form a physician educator's day takes, the main goal is to be a resource to the physicians for any questions they have. Educators can serve as the department's faces, even if the rest of the team, or a portion of it, goes remote.

"I enjoy that personal interaction—being able to interact with them and to develop those relationships," says Richardson. "I think it's more successful to have real people rather than just electronic communications."

Collaboration and reporting

As the CDI team takes on more in-depth reviews related to quality, clinical validation, and so on, the physician educator can provide focused attention to the needs of the physicians and work with the leaders and advisors to make meaningful improvements to CDI processes.

"The query process is a collaboration between the core CDI team and the physicians, but I'm the in-between," says Parker. "Through the escalation process, we've made a lot of changes to the query process—it's truly a science, and we've gotten a lot of feedback from our physicians."

The physician educator or liaison can also be responsible for analyzing the query rates and tailoring the education based on findings, says Walker.

> **It's hard for people who have other more pressing duties and responsibilities to focus on what we really need to improve on—physician engagement. It's our responsibility as physician educators to look at the data and figure out where it's worth focusing our educational efforts.**
>
> *Shirlivia Parker, MHA, RHIA, CDIP*

"We run monthly reports from our homegrown query log," she says. "We can see what the top queries are and what the responses are, and that helps us understand how to course-correct. […] It's not sustainable to keep querying for the same thing over and over again."

Walker also suggests that the physician educator/liaison should get involved with as many physician-led meetings and committees as possible. This gives CDI a voice at the table without taking up review time.

"I'm involved with a lot of our physician-led clinical efficiency meetings," she says. "Any education that's identified during those meetings allows me the opportunity to schedule time with individual physicians or groups to follow up with additional, individualized education."

Parker also attends physician-led meetings and tries to develop on-the-go educational materials for physicians to use, even if she's visiting a different facility in the system at the time.

"I created a tip card book for them that I usually email out. I tell them it's the answers to the test and that it will help decrease their queries," she says. "I also try to put together a one-page documentation tip for the physicians at every meeting I attend."

Ultimately, even without a full-time physician educator role, having someone dedicated at least part-time to improving physician engagement will further the CDI department's success.

"It's hard for people who have other more pressing duties and responsibilities to focus on what we really need to improve on—physician engagement," says Parker. "It's our responsibility as physician educators to look at the data and figure out where it's worth focusing our educational efforts."

After all, the goal of CDI is improving the documentation. Sending queries only gets you partway there.

"Physicians have long created habits for how they document," says Walker. "If we don't educate them, we're going to continue querying for the specificity of CHF forever."

PODCAST RECAP

Hiring and training CDI staff

"One of the things I really look for when I'm interviewing [CDI candidates] is that an individual has critical thinking and analysis skills," said **Sheila M. Duhon, MBA, RN, CCDS, A-CCRN, CCS**, national director of CDI education at Tenet Healthcare in Dallas, Texas, on *an episode of the ACDIS Podcast: Talking CDI (previously ACDIS Radio)*.

Hiring the right person for a CDI role can feel like a daunting process as many programs hire individuals with no prior CDI experience and then train them on the job. But not everyone is well suited for the role. Regardless of a candidate's professional background or education, finding the right hire comes down to personality and willingness to learn, Duhon said.

"I believe that a good CDI specialist is really self-motivated and driven to explore," she said.

So, successful candidates need to develop their sense of curiosity, push the boundaries of their comfort level, and go for it. This may mean enrolling in ACDIS' CDI apprenticeship program, joining an ACDIS local chapter, joining ACDIS, and/or subscribing to CDI-related publications even before applying for a position to gain a better understanding of what the role entails and whether it seems like a good fit for one's experience and skills.

In addition to being self-motivated, the right candidate will have good interpersonal skills for communicating with, and educating, physicians and other colleagues. Critical thinking skills are also needed to interrogate the medical record and become a CDI detective.

"It's sort of a Sherlock Holmes detective approach. CDI specialists need to look for clues in the record, look for the conditions, look for what physicians are not saying just as much, if not more so, than what physicians are saying in their documentation," Duhon said.

Once the department hires a candidate with the characteristics necessary to fit with the program, CDI managers and educators need to tune into how that individual learns and adapt their training requirements to play to the new hire's strengths.

"We're talking about adult learners. We each learn in different ways, and once you spend time with a learner, you can adapt your approach to their specific learning needs," she said. "I don't feel that there's a one-approach-fits-all. A combination is best."

At Tenet, all new CDI specialists start by attending formal education to provide them with a launching point and the basics needed before ever cracking into a medical record. This education includes a CDI boot camp,

> **We're talking about adult learners. We each learn in different ways, and once you spend time with a learner, you can adapt your approach to their specific learning needs. I don't feel that there's a one-approach-fits-all. A combination is best.**
>
> *Sheila M. Duhon, MBA, RN, CCDS, A-CCRN, CCS*

documentation requirements for ICD-10-CM/PCS code assignment, compliant CDI practices such as those described in the ACDIS/AHIMA "Guidelines for Achieving a Compliant Query Practice" brief, and other items.

Then, once they've completed the initial education, new hires are placed in the care of their CDI manager, who provides additional education tailored to each person's needs.

Job shadowing is key during this stage of education, according to Duhon. Many organizations require CDI professionals to toggle between several programs—the EHR and the CDI software, for example. This means that CDI specialists not only need to be comfortable

reviewing medical record documentation and sending queries, but they need to be confident in navigating the technology as well.

"It takes some one-on-one time, sitting with a seasoned, experienced, knowledgeable, high-performing CDI specialist," said Duhon. That seasoned staff member is responsible for "working with the new ones, bringing them on board, and teaching them how to navigate the software and between the different programs."

Even with a comprehensive training program for new staff, Duhon warns not to expect too much too soon, recommending that managers allow staff the proper time to digest and master the information. Even after the shadowing period, a CDI specialist may need additional time to practice his or her skills before being held to the same productivity standards as seasoned staff members. "It's going to be slow at first, and program managers need to expect that," she said.

During the course of onboarding and early education, Duhon suggests that CDI managers or on-site educators check in with their fledgling staff members to ensure they're mastering their new skills. If there are any sticking points, educators shouldn't be afraid to go back and spend some additional time on earlier concepts in order to create as solid a foundation as possible.

"When you have a new CDI specialist and are giving them all this new information, you need to set reasonable goals on a regular basis and work with them to ensure they get the support and materials they need and that they understand the information being conveyed to them," Duhon said. "If you need to go back a step and review something you've already covered, no problem, do it. You want (and need) your new staff member to get the fundamentals right."

Editor's note: To listen to the December 5, 2018, show, *click here*. The ACDIS Podcast: Talking CDI (previously ACDIS Radio) is a free biweekly show. To learn how to register, *click here*. To subscribe on Apple Podcasts, *click here*.

GUEST COLUMN

Buying in to ambulatory CDI

By Jennifer Boles, CPC, CRC

Before starting an ambulatory or outpatient CDI program, those tasked with the project must first create some universal definitions so everyone is on the same page and speaking the same language. Consider asking:

- What terminology will define inpatient and outpatient CDI?
- Will CDI be divided by hospital and ambulatory?
- Will outpatient fall in the same category as ambulatory?
- Will CDI stand for clinical documentation improvement or integrity (some programs now use assurance and the acronym CDA)?

Having definitions helps those involved understand the direction of the effort. It also allows stakeholders to communicate their goals in each conversation, whether they're communicating within the system or with external vendors, colleagues, and physicians.

Of course, to get things rolling, program administrators need to establish the reason behind the expansion—typically, this will be the pressure to remain competitive in an ever-growing healthcare industry.

To gain support for the program, a specialized team will need to be established that can divide and conquer. Members will have their own strengths and can each take on a portion of the workload. When putting the team together, make sure you have someone who has influence with executive leadership, plus someone who understands analytics and how to obtain/transfer data. The team will also need personnel who are great communicators with healthcare departments and providers. These team members will need to be able to sell your core message repeatedly in multiple ways, depending on the target audience.

Obtain the analytics to back your objective. Determine the focus of the program and create a strategy for education. Take time to build trust and belief in the cause.

The health system will also need to decide which department will manage and direct the program. Our health system decided to separate the hospital and ambulatory CDI departments and place them under different directors, but both under the HIM umbrella. While our hospital CDI specialists are predominantly registered nurses, our ambulatory CDI team members have professional billing/coding backgrounds. Both teams assist each other with provider education.

> **It's important to have the inpatient hospital and ambulatory CDI staff develop and agree to universal messaging regarding the program's scope, values, and mission prior to addressing the providers and department staff.**
>
> *Jennifer Boles, CPC, CRC*

It's important to have the inpatient hospital and ambulatory CDI staff develop and agree to universal messaging regarding the program's scope, values, and mission prior to addressing the providers and department staff. That way, each team supports the other and physicians will receive the same pitch for CDI regardless of setting type. As physicians move between private practice and the inpatient setting providing care, the mission and basic tenets of the CDI process can remain essentially the same.

It is important that the message is agreed upon by the organization across all departments. It will gain universal support if everyone feels that it's compliant and produces minimal risk. The message will affect many measurements, so plan to discuss it with each measurement's respective team. The health systems value-based team, Medicare spending, service line/

quality teams, compliance department, and coding will all have keywords, guidelines, or timelines that will influence the message.

For example, when Medicare spending needs the Hierarchical Condition Categories (HCC) captured within 90 days of a patient's admission, we ask providers to capture HCCs every time they are pertinent to the patient's visit by satisfying the MEAT (monitored, evaluated, assessed, treated) criteria with detailed specificity, instead of telling them that HCCs only need to be captured once a year

Quality measurements, as another example, may track "uncontrolled" diabetes, but ICD-10-CM doesn't have a specific diagnosis code for uncontrolled diabetes. We educate our providers to state why the diabetes is uncontrolled instead of trying to get them to eliminate that word from their vocabulary. This helps documentation support acute and chronic diabetes with complications.

Once the message begins to spread and followers begin to join the ranks, recruit new members to help advocate within their peer groups. These followers will span multiple sectors and corporate levels: physician leaders/advisors, providers of all types, administrative assistants, practice managers, directors, coders, compliance, finance, IT, accountable care organizations (ACO), educators, operations, legal, CDI, catering, and so on. Each member will play a vital role in the success of the ambulatory CDI program.

Recruiting internal members from your system's *ACO/value-based* team will help add personnel to meetings, and these members will often already have an established relationship with providers in their region. They will know which providers prefer one-on-one education over group sessions and which ones prefer to receive education from a fellow physician. Tailoring your message to each listener is half the battle. Certain audiences relate more to data and methodology, while others will want to know how the message relates on a more personal level. Understanding each listener's thought process and decision-making concerns will help get the message across as smoothly as possible.

In order to best spread the message across your health system, consider including a third-party vendor. Make sure that the vendor is committed to the same message as you. The vendor can help provide labor for pre-visit planning, chart reviews, education, reports, and tracking queries until the program gains momentum. All new departments take time to establish a return on investment and support additional full-time employees (FTE). There will be a high demand on education, reports, and provider meetings across the system, and you will need support internally and externally.

As soon as you've gained buy-in, be prepared to track participation, risk scores, clinical indicators, and measurements through reports. Funding for additional FTEs, follow-up education, and growth will need to be reinforced by statistical facts. Set goals for the program to achieve over time, and make sure to plan and budget for the future.

Gaining buy-in for an ambulatory CDI program takes time and patience. Be prepared and expect pushback along the way; plan how to respond when it happens, and remember to be flexible. Once the program gets started, hold on and enjoy the growth!

Editor's note: Boles is the system manager of ambulatory CDI at Baptist Health in Louisville, Kentucky. Contact her at *Jennifer.boles@bhsi.com*. Opinions expressed do not necessarily reflect those of HCPro, ACDIS, or any of its subsidiaries.

Physician engagement: Six steps for solving CDI's biggest problem

One of the few constants in the CDI industry is the problem of physician engagement. Year after year, ACDIS members report that their biggest challenge is physician engagement and education. In fact, 57.43% of the respondents to ACDIS' 2019 membership survey cited physician engagement as one of their top three challenges.

While many familiar ideas are often discussed—newsletters, tip sheets, organizational clinical definitions, and the like—not every physician responds the same way to the same educational techniques. For this edition of the CDI Journal, ACDIS put out a request for members' best physician education and engagement tactics. Here's what the CDI community had to say.

Bring backup

While the CDI team can make significant progress on its own related to physician engagement, having backup for particularly difficult cases, or even simply for instilling the importance of the CDI education provided, can make a big difference. At the onset of the CDI department's efforts, organizational leadership support (or lack thereof) can make or break a program's success, according to **Tammy Vidal**, network CDI manager at St. Luke's University Health Network in Bethlehem, Pennsylvania.

"Senior leadership support and proactively addressing the basis for excellent clinical documentation are the best tactics for ensuring physician engagement," Vidal says. "With that in place, a climate of professionalism, respect, and accountability is the way to go."

If upper management doesn't consider CDI a priority, neither will the physicians. If the C-suite doesn't understand the importance of CDI—the effect on hospital reimbursement, quality outcomes, public reporting, and so forth—they won't be able to defend CDI activities when physician questions arise. Conversely, an engaged administration can carry CDI efforts further by enlisting key medical staff leaders to serve on the CDI steering committee, creating cross-departmental focus groups for emerging process improvement concerns, and working with the CDI team to delve into data that illustrates obstacles, opportunities, and successes.

Employ a physician advisor or champion

According to ACDIS' physician engagement survey, 36% of respondents with a physician advisor said their physicians are extremely or very engaged. In contrast, only 28% of respondents without an advisor indicated positive physician engagement. (To read the full survey results, see p. 8.)

A physician advisor's job description may include clinical oversight of documentation needs; providing education to physicians and holding them accountable to answering CDI queries; identifying trends in documentation and developing strategies for improvement; reviewing clinical denials and writing appeal letters; developing organizational clinical criteria for common diagnoses; and more. (For a sample physician advisor job description, *visit the ACDIS Resource Library*.)

Adding a physician advisor to the CDI team not only brings a physician perspective to documentation initiatives, it also allows the advisor to be an advocate for CDI among the other physicians. Because of this visibility and positioning, the individual chosen to be the advisor should be liked and respected by his or her peers.

Those unable to employ a physician advisor should attempt to recruit a physician champion. Physician champions take a much less formal role in the CDI department and may only help on an as-needed basis. Advisors, on the other hand, are often compensated for their work with CDI and have set hours devoted to the department each week. (For more information about physician advisor compensation, see the survey results on p. 8.) By demonstrating support of the CDI team, illustrating exemplary documentation skills, and serving as an extended resource for their peers on documentation concerns, champions can serve as liaisons between the clinical and CDI worlds. They can also work as intermediaries when CDI staff encounter an uncooperative physician, offering tips to the team for how to handle the situation.

> **I think it helps a lot to empathize with [the physicians]. I tell them I understand how this effort can seem like an additional burden and that I also need to respond to queries. I try to explain to them that we're all in the same boat working to improve outcomes for our patients, our practices, and our facilities.**
>
> *Alyssa Riley, MD, MEd*

"We have a very involved physician champion, and without her push and support, we would not be where we are today," says **Tami Brees, RN, DQC, CCDS,** supervisor of CDI with MedPartners at an academic facility in St. Louis. "She has just really, really gone over and beyond for us. She just gets it and sees how important CDI is."

That physician advisor or champion can also listen to physician concerns and questions and relay that information to the CDI team for process improvement, according to **Alyssa Riley, MD, MEd,** pediatric nephrologist, CMI provider, and physician advisor at Dell Children's Medical Center at Ascension in Austin, Texas.

"Especially when they're frustrated, I listen and try to be a sounding board," Riley says. "I think it helps a lot to empathize with them. I tell them that I understand how this effort can seem like an additional burden and that I also need to respond to queries. I try to explain to them that we're all in the same boat working to improve outcomes for our patients, our practices, and our facilities."

Get them early

If your organization is a teaching facility, a great way to instill physician engagement is to get in front of the new residents when they arrive on campus for the first time. Often, these newly minted doctors are the primary ones documenting in patients' records, and they may even be responding to queries in some cases, so their understanding of CDI's purpose is paramount. (See p. 33 for a sample onboarding document for new residents.)

While CDI should work with the director of the resident program, department heads, and hospital leadership to build CDI into the

orientation program, once you're in front of first-year residents, it's easy to engage them in the CDI process, says **Jeanne O'Connor, RN, MS, CCDS**, CDI specialist at Partners HealthCare Coding, North Shore Medical Center, in Salem, Massachusetts.

"We orient the first-year residents within a month of their arrival," she says. "It really is a great opportunity because they are so willing to learn and do the right thing. They're so enthusiastic and ready to go full-throttle ahead into their first year as an MD."

This is another area where a physician advisor or champion can come in handy, according to Brees. "When new residents come in July, [our advisor] does an actual in-service with every group and teaches them about CDI and why documentation is important."

That first meeting, according to **Amanda Just, RN, BSN, CCDS**, system manager of CDI at Integris Health in Oklahoma City, also helps the CDI team know how to best contact the new physicians. "CDI is included in our new provider hospital orientation," she says. "It gives CDI a chance to provide specialty-specific CDI education and introduce our team to new providers."

With current technology, providers use multiple avenues to communicate, so catching them on the floor can be a challenge, Just says. She requests providers to complete a slip listing their communication preferences (e.g., email, phone number, name/contact info of "gatekeepers," etc.).

Of course, all communication options must be secure. The team maintains a shared drive that stores each provider's communication preferences for CDI reference.

O'Connor says the CDI specialists also meet with all new hospitalists during their orientation. "It's only 15 minutes long," she says, and although brief, one of the main purposes is a secondary gain. "We get to meet them in person. Later, if there is a question or concern we have on a patient or a question about a query response we may have received, we can meet them on the unit and they'll know who we are and our role."

Create resources

Developing resources and references for physicians to use in their daily work and refer to when the CDI team isn't available represents an additional touch point for engagement. Such resources may take several forms, but likely the most ubiquitous is the tip card or tip sheet. These cards help to reinforce CDI education when the physician is out on the floor by providing a quick reference. (For sample tip cards, visit *the ACDIS Resource Library*.)

CDI staff can carry the cards with them while rounding to hand out as needed. This approach, according to **Julie Fenton, RN, BSN,** CDI specialist at St. Mary's Healthcare in Amsterdam, New York, often yields the best results because the physician is in a position where the card will be immediately helpful. In contrast, handing them out during an educational session may just prompt physicians to leave them in the room after the presentation is done.

"We carry the tip cards with us and attend multidisciplinary rounds," says Fenton. "Whenever we have a physician interaction with an opportunity for education, we provide it to them."

> **[Orienting first-year residents] is a great opportunity because they are so willing to learn and do the right thing. They're so enthusiastic and ready to go full-throttle into their first year as an MD.**
>
> *Jeanne O'Connor, RN, MS, CCDS*

Abandoned tip cards led Brees in another direction altogether, taking the concept into the 21st century by creating a CDI phone app open to any provider at the organization.

"In order to track how many people use it, [the physicians] need to have a pin that comes from the [CDI team]," says Brees. "The more we push it, the more emails we get wanting the pin."

The team worked with an external app developer to create and roll out the program to their physicians. The content of the app mirrors previous hard-copy tip cards. It's organized by body system and includes frequent types of queries that fall under those systems.

There are also examples of incorrect phrasing followed by examples of specific, precise documentation

options. Brees and her team developed the content in roughly six months, with additional time spent editing and adjusting the information for ease of use.

Since the tip cards are essentially digitized, the CDI team can push updates to the clinical criteria and documentation tips to all the physicians at once without worrying about redistributing a bunch of paper tip cards, and without worrying that physicians might accidentally pull out an old card and erroneously use that outdated information.

When putting such programs in place, Brees says CDI staff need to pay attention to the formatting of the education to ensure it's user-friendly and accessible. "We knew if we made it too confusing, the physicians wouldn't use it," she says.

Make yourself visible

of the best ways to build engagement among the physicians and medical staff is simply to make the CDI team visible, put faces to names, and ensure CDI specialists are available for physician questions. There are a couple of ways to accomplish this goal.

First, CDI teams should participate in grand rounds if possible, says **Cheryl Richardson, RN, CCDS,** CDI specialist and physician liaison at Hardin Memorial Hospital in Elizabethtown, Kentucky.

During rounds, a multidisciplinary team, usually consisting of a CDI professional, a case manager, social worker, and nurses, share an office work space. Physicians come and discuss each patient's current clinical status, updating all departments simultaneously. The various team members in the room can ask questions, offer insight, and provide status clarifications.

"The rounding model has been extremely successful for us," Richardson says. "We've cut the length of stay by about a day, and the nurses are extremely happy with it."

Those unable to participate in rounds should seek alternative face-to-face interaction and educational opportunities, such as attending physician service line educational sessions. Typically, the CDI representative at these meetings would be the manager or team lead, but this can vary depending on the service line.

"Approximately three to four times per year, we meet with the hospitalist group through the help of our physician advisor and present a clinical documentation topic," says O'Connor. Last year, for example, members of the CDI team presented quick, 15-20-minute overviews of pneumonia and encephalopathy from CDI's perspective, O'Connor says.

If attending service line meetings and the like proves infeasible for a CDI team, simply being available and visible can make a world of difference. Whether this means the CDI team members sit somewhere on the units to do their work, attend rounds, or turn to designated physician educators/liaisons, the team will be positioned as resources for the physicians and help providers put faces to the names of query authors. (For more information on physician educators, see the article on p. 22.)

"I think one of the reasons we're successful is that we're not sitting behind a desk," says Brees. "The CDI specialists are out on the unit, out in front of the physicians. Our role is to be available and answer any questions the physicians have, especially when it comes to queries."

CDI PHYSICIAN ONBOARDING

This document was submitted by Deanne Wilk, BSN, RN, CCDS, manager of CDI at Penn State Health in Hershey. It's part of Penn State Health's physician onboarding manual. For academic facilities, new interns and residents will arrive at the facility in July. For those CDI teams wishing to catch the new physicians when they're young, consider including something similar to this document in the onboarding materials.

Contact Information: _____

Definitions	
Clinical documentation improvement (CDI)	The link between physician documentation and its translation into coding/administrative data. This data is used for quality improvement, reimbursement, public reporting, quality patient care, and population health initiatives.
Clinical documentation improvement specialist	A specialty trained registered nurse or physician (editor's note: or coding professional) in the clinical and coding concepts of provider documentation. ■ Clinical resource that reviews documentation to assist providers in obtaining accurate, specific, complete, compliant, and quality documentation. ■ CDI staff meet face-to-face with providers and also communicate via a "query" process to clarify documentation.
Principal diagnosis	That condition, which after study, is found to be chiefly responsible for occasioning the admission.
Secondary diagnosis	Those conditions that coexist at the time of admission, or develop subsequently, and that affect the patient care for this current episode of care.
Secondary diagnosis	Those conditions that coexist at the time of admission, or develop subsequently, and that affect the patient care for this current episode of care. Those conditions that are (MEAT): ■ **M**onitored ■ **E**valuated ■ **A**ssessed ■ **T**reated ■ Extend length of stay (LOS) ■ Require increased nursing care ■ Chronic diseases should be documented in the past medical history of the History and Physical (H&P) or at least one time within the medical record.
Present on admission (POA)	It is essential to document and clinically support those conditions that were present on admission. ■ **Hospital acquired conditions:** Adverse events attributed to hospital care. ■ **Hospital acquired infections:** CLABSIs, CAUTIs, VAPs, C. diff ■ **Patient safety indicators:** Adverse events primarily surgical in nature. ■ **Never-events:** Serious adverse events with potential of patient harm.

Query	A question posed to a provider to obtain documentation clarification. Queries are communicated via verbal discussion or Cerner Messaging Center. Queries are a part of the patient's permanent medical record and are considered physician documentation. Queries should be answered within 24 hours and the information carried into the patient's medical record.

Clinical diagnoses and data reporting through coding

Able to report from	Unable to report from
ED summary	Pathology report
H&P	Laboratory report
Progress notes	Radiology report
Consultations	Nursing notes
Physician orders	Ancillary staff reports
Operative reports	
Discharge summary	

Documentation tips

- Support diagnoses with clinical criteria or clinical assessment
- Document the etiology or underlying condition
- Capture acuity, type, stage, degree and laterality of conditions
- Make the link between conditions
- Possible, probable, likely and suspected are acceptable as a diagnosis and should be used in place of "rule out" and carried throughout the record to time of discharge/discharge summary
  - If ruled out or resolved, document as such

Avoid unapproved abbreviations

It is the policy of this organization (editor's note: name policy and where to find it) that abbreviations are generally not recommended. Only organizationally approved abbreviations may be used. The list is available at (editor's note: list location and provide link).

Avoid copy and paste

It is the organization's policy (editor's note: list the name of the policy and where to find it) that the EHR copy/paste functionality is to be used with caution. Overuse of this feature risks errors including, but not limited to:

- Copying problems that are no longer active
- Copying medications that are no longer current
- Indicating levels of intensity or severity that apply to earlier visits rather than the current encounter
- Failure to identify the original documentation author

PHYSICIAN ADVISOR'S CORNER

Oxygen levels related to respiratory distress

By Howard Rodenberg, MD, MPH, CCDS

If anyone under 60 has heard of Allan Sherman, it's probably in reference to his melodic letter from camp entitled "Hello Muddah, Hello Fadduh." One of my favorite Allan Sherman ditties is called "One Hippopotami." The song concerns itself with singulars and plurals: "A pair of mouse is mice. A pair of moose is meese."

I bring this up because I ran into two interesting issues in documenting acute respiratory failure recently, and I was looking for a more clever, literary way to say, "I have more than one thought" than just saying, "I have two thoughts." I was going with "conundrums," which is probably grammatically correct, but if I had two conundrums, would I have two conundrii instead? Regardless, I'll go ahead and share these conundrii with you.

The first concerns a case brought to me by our coding manager. The patient was a middle-aged female with no history of respiratory problems. She didn't use oxygen or any pulmonary medications at home. She came in for acute dyspnea, was placed on 3 liters per minute (LPM) of oxygen, and given other pulmonary care, including nebulized bronchodilators and intravenous steroids. She was established to have chronic obstructive pulmonary disease (COPD), did well, and was subsequently sent home on 3 LPM after failing ambulatory oximetry. Her discharge problem list included acute-on-chronic respiratory failure. The coding manager asked if I could clinically validate the diagnosis.

I don't think there's a question about the patient's chronic respiratory failure. In general, anyone who uses oxygen at home for a primary respiratory condition (COPD, pulmonary fibrosis, etc.) can be considered to have some degree of chronic respiratory failure. The problem is confirming that the patient had acute respiratory failure without any objective measures of a baseline status. On one hand, you could say that as she presented with an acute problem and needed oxygen that she had not required before, she would clearly be in acute failure. On the other hand, you could make the case that she probably chronically needed oxygen at home all along. She undoubtedly presented with an acute exacerbation of COPD.

Since the patient's home oxygen dose was the same as was prescribed during her hospital stay, however, she might not be considered to have acute respiratory failure. Of course, this would be an easy decision if she was on a venti-mask at 40% and went home on 3 LPM. In that case, she would have clearly had an acute oxygen requirement on top of her chronic oxygen needs. After hemming and hawing, I came down on the side of using chronic respiratory failure but not validating the acute diagnosis. I don't know if this was the right decision, but it seemed to have more logic behind it.

This case dovetailed with some questions I received from hospitalists regarding oxygen requirements for the diagnosis of acute respiratory failure. Our pulmonologists are very aggressive about diagnosing acute respiratory failure, often in patients using oxygen at lower concentrations than the CDI literature might suggest. It's been proposed that a clinical indicator for acute respiratory failure might even be oxygen requirements as low as greater than 2 LPM above the patient's baseline (so a patient who normally uses no oxygen at home might be considered to be in acute respiratory failure if placed on 3 LPM). While I have complete faith in our critical care group and their clinical skills, I haven't been able to find a lot of literature to support the lower oxygen requirement.

Recently, I saw a Facebook post from an ED physician group regarding oxygen needs (or rather, the lack of such needs) for many acute illnesses. I was somewhat aware that *the 2015 American Heart Association update for CPR and ECC (emergency cardiac care)* suggested that, unless the patient was in respiratory distress with unacceptable oxyhemoglobin saturation values, oxygen was no longer required in the care of

suspected acute coronary syndrome (ACS) or stroke. It seems that respiratory status is first assessed using oxyhemoglobin measurements, and then oxygen is delivered to achieve a target saturation regardless of how you get there—nasal cannula, face mask, BiPAP, or intubation. This is a huge paradigm shift for those of us who grew up knowing the best treatment for ACS was a visit from Miss MONA (morphine, oxygen, nitroglycerin, aspirin), and you can imagine what it might mean for the generation before who knew that the care of acute heart failure was MOST DAMP (morphine, oxygen, sitting up, rotating tourniquets, digoxin, aminophylline, mercurial diuretics, and phlebotomy).

It's not unusual for something we use physiologically to also have applications as a drug. Our adrenal glands are busy making steroids every day, and yet we use those same steroids exogenously as medication, with inherent risks and benefits.

Howard Rodenberg, MD, MPH, CCDS

Some further digging revealed a 2018 document entitled "*Guidelines for Oxygen Use in Adults in Healthcare and Emergency Settings.*" Developed by the British Thoracic Society and supported by just about every alphabet soup medical group in the United Kingdom, it's extensive, well researched, and surprisingly easy to read. There's lots of good stuff, but the distillation can be found in a single recommendation:

> Oxygen should be prescribed to achieve a target saturation of 94-98% for most acutely ill patients or 88-92% (or patient-specific target range) for those at risk of hypercapnic respiratory failure.

This article was just the tip of the iceberg. It turns out that not only are Australia and New Zealand nearly a day ahead of the United States on the clock, they're also several years ahead of both the States and the Brits in thinking about respiratory care. The Thoracic Society of Australia and New Zealand developed a clinical practice guideline in 2015 for acute oxygen use in adults, suggesting an even lower target range for oxyhemoglobin saturation of 92%–96%.

More recent work in the *British Medical Journal* provides even more specificity, with a weak recommendation to hold oxygen therapy in patients with stroke or acute myocardial infarction with oxyhemoglobin saturations from 90%–92%, a strong recommendation to not start oxygen therapy in patients with saturations ≥ 93%, and to stop oxygen use in acutely ill adult medical patients with saturations ≥ 96%.

So, what's the problem with oxygen? Medical oxygen is a drug, and like any drug, it has risks and benefits. It's not unusual for something we use physiologically to also have applications as a drug. Our adrenal glands are busy making steroids every day, and yet we use those same steroids exogenously as medication, with inherent risks and benefits.

Oxygen seems to cause physiologic mischief in two ways. First, it promotes vasoconstriction. That's a function of the chemoreceptors in our bodies; with higher arterial oxygen content, the receptors presume that there's plenty of oxygen getting to the tissues, so they slow down what they perceive as unneeded flow. This vasoconstriction may worsen local perfusion, which can extend areas of infarct in the heart or brain.

Also, hyperoxia may interfere with mitochondrial function, leading to decreased levels of adenosine triphosphate, the "fuel" maintaining cellular integrity. The risks of excess oxygen therapy appear to be more than theoretical. *A meta-analysis in The Lancet* suggests that adult patients with acute illness whose care included a liberal oxygen strategy had an elevated relative risk of mortality in the hospital and at 30 days post-admission. None of this will be surprising to our pediatric colleagues, who are well aware of the potential toxicity of neonatal intensive oxygen therapy to the lungs, eyes, circulatory tree, and gastrointestinal tract.

These works turn most of the dogma about oxygen use in acute illness on its head. First, it alters the target range for oxyhemoglobin saturation. If "normal" saturations are usually considered to be greater than or equal to 94%, then what should we make of an acutely ill patient with a saturation value of 91%? Does this number

represent hypoxia compared to a "normal" value, or does it lie within the target range and require no further care? (By my review, it still seems reasonable to hold a saturation value of 90% or less as representing hypoxia.)

The second, larger implication is that it doesn't matter how you get the saturations into the target range or how much oxygen it takes to do so. The recommendation effectively uncouples the diagnosis of acute respiratory failure from specific oxygen requirements.

This is not to say that other elements we've traditionally emphasized in the diagnosis of acute respiratory failure (especially noting the signs and symptoms of respiratory distress, difficulty with speech, or increased work of breathing) should be ignored. Now that we have more leeway with measurements of oxyhemoglobin saturations and oxygen requirements, it's more important than ever to document the overall appearance of the patient rather than relying on numbers alone.

There are still unanswered questions, of course—does hypoxia, in and of itself, equal acute respiratory failure, or is there some qualitative or quantitative difference on the spectrum between normal respiratory status, hypoxia, and acute respiratory failure?—but with these guidelines in hand, I can see how our pulmonologists might consider lesser oxygen requirements and higher oxyhemoglobin saturations to still be indicative of acute respiratory failure.

As a doc who still spends time in the "real world" of patient care, these are the kinds of issues that make CDI fun: finding problems, doing research, and thinking about clinical scenarios in new and different ways. Or scenarii. Maybe scenarium …

Editor's note: Rodenberg is the adult CDI physician advisor at Baptist Health in Jacksonville, Florida. Contact him at *howard.rodenberg@bmcjax.com* or follow him at *writingwithscissors.blogspot.com*. Advice given is general. Readers should consult professional counsel for specific legal, ethical, clinical, or coding questions. Opinions expressed are that of the author and do not represent HCPro or ACDIS.

GUEST COLUMN

Steps for successful ambulatory CDI implementation

By Ellen Jantzer, RN, MSN, CCDS, CCS, CRC

CDI specialists who have been around for a while might recall how in 2007 CMS implemented the Medicare Severity Diagnosis-Related Group (MS-DRG) system. This variation to the inpatient prospective payment system (IPPS) linked reimbursement to accurate documentation and coding. For many hospitals, an effective CDI program became the solution, and the profession grew as a result.

As found by *the Berkley Research Group in 2017*, changes to the Medicare physician payment model—such as the implementation of the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) and its two tracks, the Merit-based Incentive Payment System and Advanced Payment Models—are poised to have a similar effect on outpatient and physician payment systems. In fact, interest in outpatient CDI appears to be growing. As noted in the 2016 ACDIS white paper, "*Outpatient clinical documentation improvement: An introduction*," ," a 2016 survey found that only 10% of hospitals had an outpatient CDI program. In contrast, two years later, the *2018 CDI Week Industry Survey* found that 50% of respondents reviewed outpatient or ambulatory records.

In 2015, my organization decided to implement a CDI program in the primary care setting and quickly discovered just how complex and confusing this process can be. After two and a half years and many lessons learned, the program launched in January 2017. The Asante ambulatory CDI team currently consists of four RN CDI specialists who review documentation and coding related to Hierarchical Condition Categories (HCC) for approximately 80 primary care providers. As found by the Asante team, here are the elements necessary for successful implementation of a CDI program in the ambulatory clinic setting.

Executive leadership

Creating an ambulatory CDI program takes coordination between multiple departments, so a vision from the top is essential. At Asante, executive support was the starting point for implementing an ambulatory CDI team. Asante leaders recognized the value of population health and desired to create a healthcare delivery system that was more than just a collection of hospitals and physician offices. This drive for excellence across the continuum meant documentation and coded data needed to be consistent between the inpatient and outpatient settings.

Some health systems might need to look outside their own walls to understand the need for outpatient CDI. In organizations without a top-down initiative, inpatient CDI specialists can research the potential benefits to better understand how such efforts might benefit the organization. To float the idea from the bottom up, CDI leaders will likely need to speak to the organizational and administrative needs of the system. CEOs and chief financial officers worry about many things, some of them conflicting: return on investment (ROI), demand on staffing resources, quality of patient care, and physician and employee engagement, among others.

Consider networking with department leaders to learn about the organization's priorities. Colleagues in operations, finance, or quality may have initiatives that an outpatient CDI team could help advance. Ask yourself, "How could outpatient CDI help solve these problems?" Just like on the inpatient side, accurate coding and documentation can improve reimbursement as well as promote accurate reported quality scores on the outpatient side, but be prepared to prove it with data—administrators want to see numbers.

Identify a patient population and intended outcomes

On the hospital side, patients are readily identified by their admitted status; in the ambulatory clinic setting, it

can be harder to know who your patients are. Check with your payer contracts department to see if your health system has any shared risk plans, and conduct research to determine whether your state participates in innovative payment methodologies where CDI could have an effect.

For instance, Oregon is one of 18 regions participating in Medicare's *Comprehensive Primary Care Plus* (CPC+) program, which is a "national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation." To support the delivery of quality patient care, providers who participate in the CPC+ program are eligible to receive a Care Management Fee (CMF) in addition to the Medicare fee-for-service payment. Since CMF payments are risk-adjusted based on HCCs, CDI specialists can work with the providers to ensure appropriate reimbursement through accurate documentation and coding of chronic conditions.

Outpatient CDI can mean different things to different people. In addition to determining a patient population to focus on, there needs to be clarity around intended goals before an organization can move forward. Do you envision outcomes related to HCC capture or E/M levels—or both? Will your CDI team work to solve issues related to the problem list, or will the focus be on the documentation in the encounter note? Of course, any CDI program needs to adhere to guidance from ACDIS and follow the ACDIS/AHIMA "*Guidelines for Achieving a Compliant Query Practice*" brief, updated earlier this year.

Asante chose to focus its ambulatory CDI team on chronic conditions and HCC capture. The goal was, and still is, to ensure that documentation and coding accurately depict the patient's clinical condition(s) and the provider's medical decision-making. The key word here is accuracy: The documented conditions need to be clinically supported and adhere to the ICD-10 *Official Guidelines for Coding and Reporting* and applicable issues of *Coding Clinic*.

Input from compliance

Compliance should be consulted prior to introducing any new program or process, but you will need an idea of what's being proposed first. Be prepared to educate the compliance team on the role of CDI. You may be asked to supply documentation from ACDIS or AHIMA that demonstrates how the program you intend to build is compliant with industry standards.

Since outpatient CDI is still in its infancy, finding resources can be a challenge, so networking outside of your organization can come in handy. Attend your *local ACDIS chapter meetings* to learn how other organizations are structuring their programs. If you have the budget for it, consider attending larger national events such as the *ACDIS conference* or the *ACDIS Symposium: Outpatient CDI* to connect with others on the outpatient CDI path. At Asante, we were able to set up a phone meeting between our leaders and leaders at other health systems who were further along than we were, which helped our compliance and executive teams verify our direction was consistent with what other organizations were already doing.

Outpatient CDI can mean different things to different people. In addition to determining a patient population to focus on, there needs to be clarity around intended goals before an organization can move forward.

Ellen Jantzer, RN, MSN, CCDS, CCS, CRC

Build the team

Dedicating some inpatient CDI specialists to the outpatient setting is not enough; successful implementation of an ambulatory CDI program is a team sport. As a first step, involve an operations staff member to confirm that any CDI processes or workflows will not hinder patient care. Ask for introductions to the clinical staff. The incoming CDI team will need to know which staff member processes what type of information in each physician office. For example, some offices have an office manager who could help the CDI team identify which records need to be reviewed or fast-track physician queries if necessary.

Furthermore, physicians can have different ways of interacting with the electronic health record (EHR). Ask the IT department to show the "provider view" in the EHR to give the CDI team a better understanding of how and why the encounter notes look the way they do. This can help generate empathy for the providers who are responsible for the actual documentation. Over time, CDI professionals may be able to identify trends related to EHR drop-down menus, problem lists, and other matters. In some cases, working with IT may help streamline the documentation process for physicians. In other cases, CDI staff may be able to educate physicians on how to more effectively manage the EHR tools.

> **In organizations where providers do their own coding, input from CDI can facilitate a balance between the need for provider education and advocating for increased coder support.**
>
> *Ellen Jantzer, RN, MSN, CCDS, CCS, CRC*

And, of course, coding professionals are an integral part of any CDI initiative. On the inpatient side, a coder touches most, if not all, encounters; this may not be true in the ambulatory clinic setting, where providers may generate their own codes. Monthly meetings between CDI and coding can increase everyone's knowledge and promote collaboration. In organizations where providers do their own coding, input from CDI can facilitate a balance between the need for provider education and advocating for increased coder support.

Recruit a physician champion

A dedicated physician champion is a must for any successful CDI program, but finding the right person can be tricky. Often, the best choice in a physician champion is someone who is initially a bit doubtful about the value of CDI, but who will become your strongest ally once convinced. When recruiting a physician champion, look for someone who is respected by other physicians, willing to advocate for change, and committed to the organization.

Hire and train CDI specialists

Asante employs an all-RN inpatient CDI team and elected to hire RNs for the outpatient setting as well. Many outpatient programs choose to hire outpatient coders for their CDI team, and ACDIS supports the idea that CDI efforts can be undertaken by people with a variety of professional backgrounds. Since Asante's goal for CDI is accurate documentation and coding across the healthcare system, the inpatient and ambulatory teams report to the same leadership. Both teams attend weekly staff meetings to promote collaboration and idea sharing.

Over the last year, Asante has found it helpful for CDI specialists to be trained first on the inpatient side. This allows new CDI specialists to learn in an established program that is supported by software applications and to work with physicians who are familiar with CDI efforts. The CDI specialists participate in ongoing training to develop comprehensive clinical knowledge, understanding of coding rules, and knowledge of payment and quality reporting methodologies.

Establish a chart review process

visits in the clinic setting are measured in minutes rather than days, there is no time for a concurrent review; chart review is done prospectively before the day of the encounter. At Asante, CDI nurses run a report each morning showing the upcoming visits. Two or three days before the scheduled visit, the CDI nurse conducts a medical record review, including most recent clinic notes, consultations with a specialist, the problem list, and claims submission. The chart review process identifies areas where documentation could be improved to achieve accurate quality measure reporting, compliant coding, and appropriate reimbursement, as stated in the ACDIS white paper, "*How to conduct a medical record review*."

When there is an opportunity to clarify based on the ACDIS/AHIMA query practice brief, the CDI specialist will send a query to the provider, who responds by addressing the condition with the patient and documenting information in the encounter note. For instance,

CDI can query the physician to clarify if active cancer has been eradicated and is now "history of," or ask the provider to further specify the type and acuity of the patient's heart failure. CDI specialists are available when providers have coding questions or want help updating the problem list to the most accurate diagnosis.

After the scheduled visit, the CDI team conducts a follow-up review, retrospectively, to evaluate the effect of the CDI query. Asante follows the AHIMA practice brief, "*Documentation and coding practices for risk adjustment and hierarchical condition categories*" when determining if the documentation supports coding HCCs. The acronym MEAT (monitor, evaluate, assess, treat) can be a helpful tool for evaluating the integrity of clinical documentation in the ambulatory setting. At Asante, CDI is about building a working relationship with the provider; CDI specialists round in the clinics each week to answer questions, provide feedback, and offer ongoing education.

Reporting tools/ROI

The March/April edition of the *CDI Journal* included an article titled "*Measuring success: DIY outpatient tracking tools,*" which suggested most CDI teams rely on homegrown reporting tools, often based in Excel, to track CDI metrics. While these tools can be clunky, CDI teams should expect that administrators will want numbers to support ROI before investing in a vendor-provided, readymade software solution. Additionally, CDI managers should collect data to establish standards related to the productivity and quality of the CDI team.

Just as on the inpatient side, programs will need to track the number of records reviewed, the number of query opportunities identified, the number of queries generated, and physician response and agreement rates, as well as the effect on HCC capture if that's one of the program's stated goals.

Outcomes and future state

The Asante ambulatory CDI program is still in its infancy, and as every parent knows, raising a toddler can be an eye-opening experience. Asante has seen the most success in physician engagement. Some primary care providers appreciate queries because they highlight clinical information from the chart, which can decrease the provider's chart-prep time. Since the providers often select their own diagnosis codes, they see value in CDI when they are unsure of proper ICD-10 code selection or they want to better understand documentation requirements.

Currently, the team is working to decrease obstacles related to patient access. Having identified the patient population—CPC+ patients—the goal is to create a process for effectively managing this group of patients through accurate diagnosis coding so that every patient gets the right access to the right resources at the right time. Problem list bugbears seem to plague most facilities, and the Asante CDI team is a part of a physician-led initiative to address these challenges. (For some tips on dealing with problem list difficulties, read *this article, titled "EHR's troubled path: Three persistent problems," from the March/April edition of the CDI Journal*.)

> **Flexibility and fostering a culture of change is critical to the successful implementation of an ambulatory CDI program.**
>
> *Ellen Jantzer, RN, MSN, CCDS, CCS, CRC*

The CDI team has learned to develop priorities and processes over the years that help the organization reach its goals. Understanding organizational priorities and developing an ambulatory CDI program aligned with those goals has occasionally proved challenging; however, strong executive and physician leadership can mitigate the madness. Flexibility and fostering a culture of change is critical to the successful implementation of an ambulatory CDI program.

Editor's note: Jantzer is the CDI manager at Asante in Medford, Oregon, co-author of *The Outpatient CDI Specialist's Complete Training Guide*, and a member of the *2019 ACDIS Symposium: Outpatient CDI committee*. Contact her at *Ellen.Jantzer@asante.org*. Opinions expressed are that of the author and do not necessarily represent HCPro, ACDIS, or any of its subsidiaries.

CODING CORNER

10 things every coder wishes providers knew about sepsis documentation and coding

By Sarah Nehring, CCS, CCDS

From the coding and CDI perspective, sepsis can be one of the trickiest diagnoses. Here are 10 things coders wish physicians knew about sepsis documentation and coding.

10: Urosepsis

Urosepsis isn't sepsis—not from a coding standpoint, at least. Unless you want a query, don't document it. If it was a urinary tract infection (UTI), then document that. If it was sepsis due to a UTI, please say that in your documentation.

9: Catheter-associated UTI

While we're on the subject of UTIs, documentation of "sepsis due to UTI, patient with Foley" is going to prompt a query. Was the UTI due to the Foley? We can't assume; we need you to tell us. This is true of any infections that may be related to a procedure or other medical care. Please remember that from our standpoint, coding a complication isn't an assignment of blame or admission of fault. We have additional codes we can add to indicate if misadventure was involved, and we rarely need to. We do need you to document directly if you suspect that the infection was or may have been related to recent surgery or the presence of a device, and it's important to indicate if that infection was likely present on admission.

8: Bacteremia

Like urosepsis, bacteremia isn't sepsis. Sometimes we see sepsis and bacteremia used interchangeably. From a coding standpoint, bacteremia is an abnormal lab finding—an R code, which means it falls into the Signs and Symptoms chapter of the codebook. It's not ideal as a principal diagnosis on an inpatient admission.

As a secondary diagnosis, bacteremia is what we sometimes refer to as a "junk code": It adds little value. We realize that sometimes the patient really did just have bacteremia, and in those cases, we're stuck with it. However, if the patient met sepsis criteria, please avoid a query and let us code this as more than just an abnormal lab finding by documenting something like this: "Sepsis due to e-colic bacteremia."

7: Organ dysfunction

If you document sepsis, please document all organ dysfunction related to it. It doesn't have to be organ failure. It's also important that you make the link between any organ dysfunction and sepsis that exists (auditors are favoring Sepsis-3 criteria more and more).

> **Urosepsis isn't sepsis—not from a coding standpoint, at least. Unless you want a query, don't document it.**
>
> *Sarah Nehring, CCS, CCDS*

For example, "elevated creatinine in the setting of sepsis, hypotension" isn't great. It's a lab value mentioned with but not linked to sepsis. "Renal insufficiency due to sepsis" is a better—we've got an organ dysfunction stated and linked to sepsis. Better yet: "acute kidney injury, likely due to sepsis with hypotension." If you really want to make our day, call it acute tubular necrosis due to sepsis, but only if it's clinically supported.

6: Hypotension and elevated lactate

Sometimes, physicians document "sepsis with hypotension and elevated lactate" and note that hypotension didn't resolve with IV fluids, and maybe that vasopressors were required. This documentation is good, but it will likely prompt a query. Often, we know (or suspect) what you're treating—and we know you and your fellow clinicians know—but we can't code it unless you document it in a specific way.

Here, we'd likely ask something like this: "Were you treating the patient for septic shock, hypovolemic shock, or other type of shock, or was shock unlikely/ruled out?" We're not giving you all these options to mess with you, honest. Ethically, we can't lead you by offering only one choice or telling you what to document on a particular case. We have to give all the relevant options we can think of that are supported by evidence in the record.

5: Clinical criteria

If you *didn't* document some kind of organ dysfunction associated with sepsis, please document the clinical criteria you used to make the diagnosis of sepsis. We respect your clinical judgment, but auditors don't have to. Without those criteria and/or your thought process in coming to a documented diagnosis, we may not be able to defend it.

4: Systemic inflammatory response syndrome

Systemic inflammatory response syndrome (SIRS) due to infection used to be coded as sepsis, but not anymore. We have a few options: sepsis with or without organ dysfunction, SIRS due to infection without sepsis, or SIRS of non-infectious etiology with or without organ dysfunction. We don't expect you to know on day one which of these things is most likely, but please document what you suspect it was when you're writing the discharge summary.

3: Discharge summaries

Speaking of the discharge summary, don't forget to mention sepsis—regardless of whether it was resolved on day two or three, or even on day one. If you don't mention it, we're going to query or think it was ruled out and not code it. If we don't query and do code it, an auditor could deny it. If you suspected sepsis early on and then ruled it out, please say so. Mentioning the criteria and organ dysfunctions again is good, too.

If you don't document sepsis until day two, but you suspect it was there all along or the patient met criteria at admission, save yourself a query and document in the discharge summary that sepsis was likely present on admission or that the patient was "admitted with sepsis." If we don't capture that it was present on admission, we may be looking at a hospital-acquired condition or infection, which isn't good for quality measures.

2: Documenting what you're treating

It helps a lot if you tell us what the sepsis was likely due to, especially if there was more than one suspected/possible source. In the inpatient setting, we don't need you to know with 100% certainty, but we do need you to communicate clearly what you were treating.

We struggle with documentation like "initial concern for sepsis. Infectious workup negative. Patient discharged on [antibiotic name] to complete 10 days." This will likely prompt a query. On the other hand, we can code "infectious workup negative, but given presentation we treated patient for sepsis due to bacterial infection of unknown origin" or "likely viral sepsis."

1: We're on your side

The number one thing every coder would like every provider to know: *CDI and coding staff are on your side*. This one isn't just about sepsis.

We want your patients to look (in coded data) as sick as they were before you healed them. If your patient died, we want the patient to look sick enough to have died despite your best efforts. We want your data and the hospital's data to look good, and to be as thorough and accurate as possible. We want the hospital to be paid for the resources that were used—so you can keep healing people with the best equipment and resources at your disposal.

Accurate documentation and code assignment are vital parts of good patient care.

Editor's note: Nehring is the inpatient lead coder at OSF Health Care, St. Francis Medical Center in Peoria, Illinois. Contact her at *nehrings4@gmail.com*. Opinions expressed do not necessarily reflect those of HCPro, ACDIS, or any of its subsidiaries.

CODING CLINIC FOR CDI

Newest publication covers procedures, HIV/AIDS, sick sinus syndrome, and more—all in 37 pages

By Sharme Brodie, RN, CCDS

The First Quarter 2019 issue of *Coding Clinic* was released in late March and is rather short—just 37 pages. Because of the length, I want to spend more time than I otherwise would discussing a few covered procedures.

Whipple procedures

This edition of *Coding Clinic* started by answering questions regarding the Whipple procedure, also known as a pancreaticoduodenectomy. A Whipple procedure is a major surgery often done to remove cancerous tumors from the head of the pancreas; it's also used for treatment of pancreatic or duodenal trauma or chronic pancreatitis. This Coding Clinic clarified the difference between the two general types of Whipple procedures: the conventional Whipple (pancreaticoduodenectomy) and the pylorus-sparing Whipple.

In a conventional Whipple, typically the head of the pancreas, the entire duodenum, the gallbladder, and a portion of the stomach and common bile duct are removed. What primarily differentiates a pylorus-sparing Whipple from a standard Whipple is that the pylorus is preserved, and no part of the stomach is removed. A pylorus-sparing Whipple procedure carries a likelihood of better nutritional status postoperatively and involves a slightly less complicated surgical reconstruction.

Whipple procedures may be performed via an open approach, laparoscopically, or with or without robotic assistance. The open surgical approach is the most common; the laparoscopic and robotic techniques are both minimally invasive, but may require extended operative time. In some cases, a procedure is initially started using a minimally invasive approach, but complications or technical difficulties may require the surgeon to switch to an open approach. Remember that in ICD-10-PCS when a procedure is started using one approach and concluded with another, two codes will be needed for accurate code assignment.

The patient's diagnoses will determine which variation of the Whipple is performed. When reporting codes for Whipple procedures, code assignment is based on what was done. Since the objective of a Whipple is to remove any involved body parts, the appropriate root operations are Excision to capture the partial removal of the pancreas and other body parts, and/or Resection for the complete removal of the pancreas and other body parts. A separate ICD-10-PCS code should be assigned for each body part that is excised or resected.

Although a Whipple procedure may result in alteration of the routes of normal passage, that isn't why the procedure's performed, so Bypass isn't the appropriate root operation. Whipple procedures require that the remaining organs be reconnected; therefore, the anastomosis is inherent and not coded separately.

When reviewing the documentation for these cases, look at the postop note and clarify any questions such as the following: Was only a portion of the organ removed, or was it completely removed? Did the surgeon start the procedure using one method of access and then convert to another during the procedure? Answering these questions in the documentation is critical in order for the coding staff to assign the most appropriate codes

HIV/AIDS

On pp. 8-11, *Coding Clinic* answered a few questions to clarify the coding of HIV/AIDS and related conditions. Let's review a few tenets that can assist coding professionals in accurately reporting HIV/AIDS.

Coding Clinic states that when coding and reporting HIV, HIV-related conditions, and AIDS, coders must "be guided by the provider's documentation" and that code B20 is only used for "confirmed cases" of HIV illness/infection. *Coding Clinic* reiterates that:

Code B20 may be reported for cases when AIDS is documented, the patient is treated for any documented HIV-related illness or is described by the provider as having a condition resulting from his/her HIV status.

However, when the documentation indicates terms such as "HIV positive," "known HIV," "HIV test positive," or similar terminology, code Z21, Asymptomatic human immunodeficiency virus [HIV] infection status, should be reported.

As many CDI professionals know, we must query the provider for clarification if the documentation of a patient's HIV status is unclear or ambiguous.

Ask the Editor

Under the "Ask the Editor" section on p. 12, *Coding Clinic* discussed some scenarios where a patient was admitted for dehydration and acute kidney injury (AKI). The questions were about which condition would be sequenced as the principal diagnosis. *Coding Clinic* gave advice that most CDI professionals already follow: When the documentation is unclear as to which condition should be principal, the physician may need to be queried. Remember that any choices must first and foremost meet the Uniform Hospital Discharge Data Set (UHDDS) definition prior to being assigned as the principal or secondary diagnosis. Also, there's no rule requiring AKI to be sequenced first.

On pp. 13–14 of the "Ask the Editor" section, there were a couple questions about the appropriate code assignment for an infection involving a midline catheter.

Peripherally inserted central catheters (PICC), which are central lines, and midline catheters, which are peripheral lines, are two types of vascular access devices. The PICC is inserted via the cephalic, basilic, brachial, or median cubital veins in the upper arm, and threaded so the catheter tip is located in the lower segment of the superior vena cava.

Midline catheters, which vary in length, are inserted via the same veins used for PICC placement in the middle third of the upper arm; however, the midline catheter is advanced and placed so that the catheter tip is level or near the level of the axilla and distal to the shoulder. Midlines are used for medications or fluids that do not irritate veins. A PICC can be used for prolonged periods of time, or for substances that should not be administered peripherally.

The question in *Coding Clinic* was about how to code an infection involving a midline catheter. The answer was to assign code T82.7XXA, Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts, initial encounter, for bloodstream infection due to a midline catheter, which does not trigger a hospital-acquired condition (HAC 07). If it was a central line, the code T80.211A would be used, which would trigger HAC 07. So, be careful and make sure the correct type of catheter is being coded.

One of the questions in this section asked whether it would be more appropriate to assign a code for the type of catheter (such as a central venous catheter) or to assign a code based on its use in hemodialysis. *Coding Clinic* advised that "code assignment is based on the location of the catheter, rather than its function."

Also on p. 14, *Coding Clinic* stated that for infections following infusion, transfusion, therapeutic injection, or immunization, a code from subcategory T80.2, or code T88.0-, Infection following immunization, should be coded first, followed by the code for the specific infection. "If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned, with the additional code(s) for any acute organ dysfunction," it stated.

Malignant Pleural Effusion

Many CDI professionals know that a pleural effusion isn't coded separately when related to congestive heart failure, but what about when the pleural effusion is related to a malignancy? This *Coding Clinic* verified that coders should assign code I31.3, Pericardial effusion (noninflammatory), as the principal diagnosis in these cases, followed by the code for the type of cancer.

Pancytopenia related to AML

On p. 16, *Coding Clinic* answered a question about how to code pancytopenia when the patient also has a diagnosis of acute myelogenous leukemia (AML). *Coding Clinic* stated that the pancytopenia is not

considered integral to the AML, so the two conditions can be coded separately as long as they both meet the criteria for a reportable diagnosis based upon the UHDDS definition of a reportable diagnosis, which is "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode of which have no bearing on the current hospital stay are to be excluded."

Drug-induced diarrhea

Another question on p. 17 referenced a patient with drug-induced diarrhea related to chemotherapy that was administered during admission. *Coding Clinic* advised assigning code K52.1, Toxic gastroenteritis and colitis, for drug-induced diarrhea. Under code K52.1, the inclusion terms "Drug-induced gastroenteritis and colitis" confirm that this is the correct code assignment. *Coding Clinic* also said to assign code T45.1X5A, Adverse effect of antineoplastic and immunosuppressive drugs, initial encounter, to indicate the responsible drug.

The Official Guidelines for Coding and Reporting, p. 81, for drug toxicity and adverse effects state, "When coding an adverse effect of a drug that has been correctly prescribed and properly administered, assign the appropriate code for the nature of the adverse effect followed by the appropriate code for the adverse effect of the drug (T36-T50)."

Choledochoduodenal fistula

The next question on pp. 17–18 had to do with coding a diagnosis of choledochoduodenal fistula with choledocholithiasis, cholecystitis, and obstruction.

Coding Clinic's answer was to assign codes K80.41, Calculus of bile duct with cholecystitis, unspecified, with obstruction, and K83.3, Fistula of bile duct, for choledochoduodenal fistula with choledocholithiasis, cholecystitis, and obstruction. Even though the Alphabetic Index directs you to K80.41, *Coding Clinic* noted that both codes are needed to fully capture the conditions. There is no Excludes1 note that would prohibit assigning codes K80.41 and K83.3 together.

Varicella-zoster meningitis

We cover coding of meningitis in our boot camps, so I wanted to make sure I mentioned this question on p. 18, which asked about appropriate code assignment when the physician documents varicella-zoster meningitis. *Coding Clinic*'s advice was to assign code B02.1, Zoster meningitis, for varicella-zoster meningitis.

The varicella-zoster virus (VZV) is a member of the herpes virus group and is highly contagious. Primary varicella infection causes chickenpox. After the primary infection, VZV may stay in the body as a latent infection. Reactivation of the virus can cause herpes zoster (shingles). Neurological complications can also occur concurrent to the rash or months after it has resolved.

Sick sinus syndrome

I think this is the most interesting section in this whole *Coding Clinic*. In the scenario, a physician saw a patient (in any setting, according to the question) and evaluates the patient's sick sinus syndrome or other significant heart rhythm abnormality. The question asked whether it would be appropriate to assign a code for the specific condition in addition to a code for the presence of a cardiac device, such as a pacemaker, automatic cardioverter/defibrillator, cardiac resynchronization pacemaker, or biventricular defibrillator.

Coding Clinic's advice in this case actually surprised me: It stated that it is appropriate to code both the condition and the presence of the cardiac device. This goes against previous *Coding Clinic* advice stating that the condition should not be coded separately.

For example, *Coding Clinic* stated it would be appropriate to assign codes I49.5, Sick sinus syndrome, and Z95.0, Presence of cardiac pacemaker. The sick sinus syndrome is still present and is a reportable chronic condition, even in the presence of the cardiac device. Although the pacemaker is controlling the heart rate, it does not cure sick sinus syndrome and the condition is still being managed/monitored. If the condition and the presence of the device both meet the definition of a secondary diagnosis, they are reportable.

According to the *Official Guidelines for Coding and Reporting*, section III, the definition of an "other

diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring any of the following:

- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or monitoring

The *Official Guidelines for Coding and Reporting* for outpatient services IV.I. and J says to "Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment."

COPD/Emphysema

The last piece of advice I want to discuss can be found on pp. 34–37. There were several questions about the coding of chronic obstructive pulmonary disease (COPD) and emphysema. The first question was about a patient admitted due to COPD exacerbation with a history of COPD and emphysema. *Coding Clinic* stated that the Alphabetic Index leads coding professionals to code J44.1, Chronic obstructive pulmonary disease with (acute) exacerbation, for exacerbation of COPD. Then, it referred back to *Coding Clinic*, Fourth Quarter 2017, which advised to assign code J43.9, Emphysema, unspecified, when a patient with emphysema presents with an acute exacerbation of COPD.

The Excludes1 note found at category J44, Other chronic obstructive pulmonary disease, prohibits the reporting of code J44.1 with code J43.9. However, the problem is that if only code J43.9 is assigned, the acuity isn't captured. The question asks for the appropriate code assignment for capturing COPD exacerbation with emphysema.

Coding Clinic's advice was to assign only code J43.9, Emphysema, unspecified, for an exacerbation of COPD in a patient with emphysema, because emphysema is a form of COPD. They continued by stating, "The advice previously published in *Coding Clinic* regarding COPD and emphysema was based on the structure of the classification at the time. Currently codes J43.9 and J44.1 cannot be assigned together because of the Excludes1 note." The problem with this Excludes1 note and the concept that emphysema is a form of COPD is that clinically this is not supported. COPD is an obstructive process that sometimes leads to emphysema, but emphysema is a destructive process that can occur in the absence of COPD.

The Centers for Disease Control and Prevention (CDC)/National Center for Health Statistics (NCHS), the organization responsible for revisions to ICD-10-CM, is aware of this issue and has agreed to consider a Coordination & Maintenance proposal for possible revisions to the instructional note.

What about a patient with emphysema and COPD who is admitted for treatment of acute bronchitis and COPD, with no mention of chronic bronchitis in the documentation? ICD-10-CM's Index refers to code J44.0, Chronic obstructive pulmonary disease with acute lower respiratory infection, when referencing acute bronchitis with COPD. And, again, the Excludes1 note found at category J44 prohibits assigning code J44.0 with code J43.9. How would this be coded? Again, we have the same problem as previously discussed. Hopefully the CDC/NCHS will address this situation.

Finally, there is a question about a patient with emphysema who presents with COPD and pneumonia. Per *Coding Clinic*, Fourth Quarter 2017, COPD in a patient with emphysema is reported with code J43.9, Emphysema, unspecified. But, again, the Excludes1 note found at category J44 means that the two codes can't be coded together. How would we capture the pneumonia in this case? *Coding Clinic* says to assign codes J43.9, Emphysema, unspecified, and J18.9, Pneumonia, unspecified organism. We again run into the same problem with the Excludes1 note, but keep your fingers crossed that change will come.

Editor's Note: Brodie is a CDI education specialist and CDI Boot Camp instructor for HCPro in Middleton, Massachusetts. For information, contact her at *sbrodie@hcpro.com*. For information regarding CDI Boot Camps, *click here*.

MEET A MEMBER

When stepping into leadership, seek reliable mentors

Lakeyshia Moore, MBA, RHIA, is the senior director of coding and reimbursement at Texas Health Resources in Arlington, Texas. She is a member of the Texas ACDIS local chapter and a member of the 2019 ACDIS Conference Committee.

ACDIS: How long have you been in the CDI field and what did you do before entering CDI?

Moore: I have been in the CDI field since 2012 when I became director of HIM and CDI in Louisiana. At one time or another, I've worked in all aspects of HIM in my more than 17 years in HIM operations—from a medical records clerk to senior director—and I have enjoyed every minute of it. I had a goal to be a director who understood all aspects of HIM, so I started from the bottom and worked my way up.

ACDIS: Why did you get into this line of work?

Moore: I wanted to get into this line of work to help others but did not really want to be on the clinical side, so I decided HIM and CDI was the perfect field for what I wanted to do. I also asked my advisor in college to recommend a field with the least amount of math—so here I am.

ACDIS: What has been your biggest challenge?

Moore: These days, my biggest challenge is clinical validation for high-risk DRGs like sepsis and malnutrition. I love challenges because they help me advance my skill sets and allow me to grow.

ACDIS: What has been your biggest reward?

Moore: My biggest reward has been getting to know so many great people in HIM, coding, and CDI. I also really enjoy mentoring those entering the field; helping them figure out what they want to do and helping them develop a plan to get there.

ACDIS: How has the field changed since you began working in CDI?

Moore: I still remember paper worksheets and digging for that one CC/MCC for Medicare/Medicare

Advantage patients only. Now, we are reviewing all payers in an electronic system that prioritizes your reviews for you. The scope has also expanded to assisting with quality initiatives such as identifying potential hospital-acquired conditions and Patient Safety Indicators. We have computer-assisted coding applications that suggest codes for you. Now we're entering a world with artificial intelligence, so I can only imagine where we will be even two years from now.

ACDIS: As someone in leadership, what's been the most challenging thing about your role? What do you recommend to those stepping into a leadership role for the first time (whether that be in CDI, coding, etc.)?

Moore: The most challenging thing about my role as a leader has been learning to adapt to all the different

personalities and people you lead. I think a strong leader is one who can adjust and lead any personality.

I think everyone entering a leadership role needs leadership development training such as what DDI offers. This helps with coaching, interviewing, understanding different generations and personalities, etc. A new leader also needs to network all the time. Make it a challenge to meet someone new at least weekly. Find a mentor to help you along the way. Choose someone who has done what you are trying to accomplish.

ACDIS: Can you mention a few of the "gold nuggets" of information you've received from colleagues on The Forum or through ACDIS?

Moore: I have received so much valuable information from fellow colleagues throughout the years being affiliated with ACDIS. The information I reviewed about future roles of a CDI specialist, starting an outpatient CDI program, and ACDIS Radio have been extremely insightful.

ACDIS: If you have attended, how many ACDIS conferences have you been to? What are your favorite memories?

Moore: I have had the pleasure of attending about four conferences. The education tracks are always very good. I always enjoy seeing the creativity people show when representing their regions at lunch on day 2. I have attended many other conferences but must say that I love the dynamic at ACDIS.

ACDIS: You're currently serving on the ACDIS Conference Committee. What made you want to volunteer?

Moore: This is one of my favorite conferences to attend, so I wanted to be a part of planning it. I also wanted to volunteer in a capacity that means a lot to me. It has been so great to work with everyone on the committee. Everyone was so engaged and contributed their expertise to all sorts of decisions associated with the annual event, from setting the tracks, evaluating the applications, choosing the agenda, and reviewing the final presentations for content accuracy, compliance, and informational value.

ACDIS: What's been the most rewarding part of your committee experience?

Moore: Reviewing presentation submissions was a great experience. There were a lot of great submissions this year. Interacting with the other committee members was great; the process was seamless.

ACDIS: What piece of advice would you offer to a new CDI specialist?

Moore: Learn as much as you can about coding. Work closely with both coding and quality departments. Network as much as possible and find a mentor to guide you along the way.

ACDIS: If you could have any other job, what would it be?

Moore: I really like what I am doing. I always joke, though, and say that my next job will be planting flowers.

ACDIS: What was your first job?

Moore: I was a cashier in a grocery store. After that, I went to cosmetology school and then I went to college for HIM, so I was a nontraditional student.

ACDIS: Can you tell us about a few of your favorite things?

- **Vacation spots:** San Diego is my favorite place in the states. I just love the beach and ocean. My dream vacation is to go to Fiji. I hope to accomplish that in the next few years.
- **Hobbies:** My 8-year-old daughter keeps me pretty busy and I love it! We also love to dance.
- **Non-alcoholic beverage:** Dr. Pepper when I allow myself to have one but mostly it is water.
- **Foods:** Seafood and Chinese are my favorites
- **Activities:** I love to spend time with family and friends, working out, and shopping.

ACDIS: Tell us about your family and how you spend your time away from CDI.

Moore: I have an older son and an 8-year-old daughter who keeps me busy with gymnastics, dance, and church. We love to travel and just hang out with family and friends. Being from Louisiana, everything is centered around food and family.