

## CASE STUDY 3



**Series introduction:** Provider engagement is a core function of the CDI profession. In addition to record review, CDI specialists also teach the why behind the need for accurate, complete, and specific documentation, and assist providers in their day-to-day charting and EHR workflow. But there is no one-size-fits-all model. This series provides case studies of organizations at all ranges of the engagement spectrum, including full clinical integration, remote CDI, and hybrid models. Its objective is to offer models of success from which ACDIS members can consider new ideas to implement, and to supply best practices for provider engagement that work regardless of organizational size, type, or budget.

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### Cooper University Health Care

Remote CDI has its champions and its detractors, but the staff of Camden, New Jersey–based Cooper University Health Care fall squarely into the former camp. While its CDI program is perhaps best described as a hybrid model, more CDI specialists work off-campus (in most cases very distantly) than on-site.

Leadership would not have it any other way. To say that providers at Cooper Health are engaged in CDI is an understatement. Last year the system boasted a near-100% response rate to CDI clarifications. Staff wrote 8,816 queries in 2019, and providers answered 8,784 of them—a 99.63% response rate.

Cooper’s CDI staff follow the rules for compliant querying as outlined in the AHIMA/ACDIS joint practice brief, “[Guidelines for Achieving a Compliant Query Practice \(2019 update\)](#).” They use a multiple-choice format with diagnosis options, and add “other explanation” and “unable to determine” choices to each query. All response types are tracked. This allows for easy reporting of agree and disagree rates, and rates of “other explanation” and “unable to determine.”

Staff are held to a benchmark of an 80% agree rate and above. “If it’s below that, we’re not writing good clarifications, but if it’s high above that, you’re running the risk of physicians just checking a box and trying to get you out of their hair,” says **Rebecca Willcutt, BSN, RN, CCDS, CCS, CRC, CCDS-O**, the organization’s CDI director. That is not the case at Cooper, as physicians will often elaborate on their choice of “disagree” with a paragraph of explanation. “Sometimes, in their other explanation, they’ll actually give us another answer that we need,” she says. “I have never felt any inkling whatsoever that physicians at Cooper are just checking boxes. When they check ‘disagree’ or ‘other explanation,’ they consistently tell us why.”

What makes the response rate even more remarkable is that the majority of the organization’s CDI staff work off-site—including Willcutt, who spends about 10–12 weeks on-site and the remainder remote. The CDI program at Cooper began in January 2014 with an on-site model, and CDI responsibilities during the first year included extensive physician rounding. But new technology, coupled with a need for highly qualified CDI specialists and limited office space on-site, prompted a redesign to a hybrid model.

Today, 14 CDI staff work 100% remotely in 10 states (and counting). Six on-site staff keep a visible presence for the department. Meanwhile, the response rates to queries issued by remote staff and on-site staff are identical. Cooper also has an ambulatory CDI program that houses five on-site physician coders/physician educators, and is planning further expansion.

Cooper's entire CDI staff still keeps in touch with physicians, albeit in targeted ways. For example, on-site CDI staff that reduced rounding after the program was established are now incorporating the practice once again, albeit for shorter duration and with more targeted, service line-based education. "In a hospital our size, I don't think weekly rounding year after year with physicians is necessary—it may be for other hospitals, but not here at Cooper," Willcutt says, noting that all clarifications go directly to the attending physicians, not residents or physician assistants, which dramatically decreases the need for ongoing new and refresher training.

**"We live in an EHR world, and CDI programs must step up to the plate and not only accommodate, but thrive in that world."**

"I think you need to design, implement, and establish a solid on-site program first, then expand remotely with certified experienced CDSs. I would never try to train a new CDS remotely. I think you can be successful with a minimal on-site team who are awesome at education when you add established smart off-site CDSs, coupled with a strong physician advisor presence," Willcutt says. "Let's face it, rounding or interrupting a physician on their rounds can be intrusive and is labor intensive for the CDS. That old world of physicians sitting on the unit and charting is gone. We live in an EHR world, and CDI programs must step up to the plate and not only accommodate, but thrive in that world."

### Remote, but physician focused

**Nicole Fox, MD, MPH, FACS, CPE**, associate chief medical officer, associate professor of surgery, medical director of pediatric trauma, and medical director of the CDI programs, credits the organization's remote CDI success to implementing a physician-focused model, from its objectives to its workflow and its tools.

Fox defines a physician-focused model as one that recognizes what it feels like to be a physician receiving clarifications. Every step, process, and tool—from the way CDI staff communicate about CDI initiatives to the format of the queries and query templates—has been developed with a busy physician in mind.

"When people are designing their program, it really has to be physician focused in terms of how you design your queries, how you best utilize your EMR, making it as painless as possible for the physicians to want to answer them," she says. "The only way you're really going to achieve a close-to-100% response rate is to design it in a way where physicians don't have to do a lot of research to answer them." To that end, Cooper's queries are straightforward and contain no extraneous language or over-explanation. The queries are complete and provide all the information up front, precluding the need for providers to go back into the record for research. Providers make an educated decision to check a box and sign the form, and it becomes a permanent part of the medical record.



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“Soft” metrics are also important to Cooper and are tracked along with response rates. For example, the CDI program monitors how often it is asked to attend department and division meetings held by the medical staff. Its ambulatory CDI program tracks the number of educational sessions it holds, how many hundreds were educated, and any feedback received from the providers.

Fox takes the lead on educational efforts but strives to include CDI staff. For example, she often gives lectures together with Willcutt, and when CDI staff run meetings, she’ll attend in a galvanizing role. She runs a quarterly CDI steering committee that includes physicians and APNs from the organization, and these physicians take back education and findings to their peers. The CDI department reports its metrics to the medical executive committee twice annually, with Fox presenting the data.

“It has far more clout coming from Dr. Fox than from me or anyone else,” Willcutt says.

Cooper providers now seek out CDI to provide education. “That just shows you that the team is embedded in the fabric of the organization, when people know to seek them out and ask without prompting,” Fox says.

Fox also credits a clear and consistently followed escalation policy for Cooper’s high response rate. Here is how it works:

1. If a physician does not respond 72 hours after receiving a request for clarification, he or she receives a templated escalation email from CDI. It goes to the physician in question only.
2. If the physician does not respond within 48 hours of the first escalation, the physician receives a second escalation email, similar to the first but with an updated “second notice” header. Fox is copied on this second email. Within minutes, Fox will send an informal follow-up email to the same physician.
3. If the physician does not respond to the second escalation within 48 hours, CDI sends a third email to the physician, copied to Fox and the department head. Rarely is this third step required, largely due to Fox’s influence.

“Whoever does [escalation], it should be a physician,” Fox says, adding that the physician should still be in clinical practice, for the sake of credibility. “A lot of programs don’t have a medical director, but you really need to engage a physician to kind of own it and chase people down if they don’t answer queries. That takes organizational commitment to the process.”

### Takeaways

**Make your CDI processes and program physician focused.** Don’t develop your processes in a vacuum and then spring them on physicians. Instead, use physician input to make them provider-friendly. Use physicians to support and promote CDI efforts. The informaticist who designed Cooper Health’s query



process is a hospitalist, for example, while Fox herself is a trauma surgeon. At launch, hospital leadership made the investment of a 30% FTE medical director to run the CDI program, which turned out to be Fox, and paid a consultant to provide her with training. “We have a lot of physician leadership here at Cooper who were engaged early in the process,” she says. “It’s not going to be successful without physician engagement in the program itself. I don’t want to sound elitist, but physicians like to hear from other physicians.”

**Use tools to keep in contact.** Despite being largely remote, Cooper’s CDI department enjoys high engagement scores. Instant messaging between staff members as well as regular virtual meetings helps with team cohesion. “They’re happy, they’re cohesive; we jabber all day long and talk on the phone,” Willcutt says. “The tools are there.”

**Don’t overclutter queries.** Cooper discovered after a couple of years that bulleted queries are far more digestible and quick to read than traditional narrative formats. Today, the organization’s CDI queries employ a general generic query template that includes clinical indicators, risk factors, treatment, and check boxes for various choices. The CDI specialist then populates the form with easy-to-read bullet point information. The only time narrative is used is for post-discharge queries, when a brief reminder synopsis of why the patient was admitted is added.

**Put a well-defined escalation policy in place.** Willcutt recommends the use of templated emails so that providers recognize escalations for what they are (i.e., something more important than typical CDI communication). Because all escalations are done via email, remote staff can send them just as easily as on-site personnel.

**Find what resonates with your providers.** Cooper’s providers are employed by the hospital and must comply with the program, but Fox provides education for other facilities where this is not the case. She recognizes that teaching physicians the “why” is critical to engagement, regardless of their employment status. “If they’re not employed, it’s not going to be the health of the health system, but it may be their own paycheck, it may be RVUs, it may be quality,” she says. “You have to find the selling point for your institution. That means knowing your culture, how the physicians are paid, who employs them. You have to do your homework on that, and find out how you’re going to sell it [CDI]. It is a sell at the beginning.”

#### About Cooper University Health Care

Cooper University Health Care is the leading academic health system in South Jersey. Cooper includes South Jersey’s only Level I trauma center (Cooper University Hospital), a leading cancer center (MD Anderson Cancer Center at Cooper), the only Level II pediatric trauma center in the Delaware Valley (Children’s Regional Hospital), one of the largest physician groups in the region, four urgent care centers, and more than 100 outpatient offices throughout South Jersey and Pennsylvania. The system employs more than 7,000 staff, including more than 1,250 nurses and 630 physicians (mostly hospital employed) in more than 70 specialties.

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