Querying Through the Chaos: How to Get Docs' Attention Amidst the Digital Healthcare Haze

By Mary Butler

It wasn't that long ago that online dating—and resultant marriages—carried a stigma. There was a sharp divide between the people who believed in meeting their loves the old fashioned way, and those who felt that online dating was a natural extension of their already Internet-centric professional and personal lives.

Now, more than 20 years after the invention of the World Wide Web, nearly everyone knows a married couple who met online—their ages as varied as their interests. There are still holdouts of course, romantics at heart holding out for the perfect "meet cute," while their friends compose carefully crafted online profiles that paint pictures of their personalities.

Clinical documentation improvement (CDI) specialists fall into similar camps when it comes to finding the best way to match a physician's preferred communication style in the age of electronic health records (EHRs). While a majority of physician offices and hospitals use EHRs, there are still health systems using hybrid paper/electronic systems, or purely paper-based records. Each approach poses unique challenges for CDI teams trying to get physicians to respond to queries, especially as CDI professionals are increasingly working remotely.

Without the benefit of face-to-face interactions with physicians and other members of the care team who document in a patient record, CDI specialists, like those online daters, have to painstakingly draft physician queries to get the desired documentation into a health record. For some, that still means leaving physical sticky notes on a patient's progress note for doctors to eventually see, while others can send text messages, e-mails, make phone calls, or use EHR vendor-based queries.

Though CDI has been around for years, it's more important than ever. The move to ICD-10-CM/PCS means coding professionals need more detailed documentation to code claims and submit bills, and the industry's transition to value-based care through regulations such as the Medicare Access and CHIP Reauthorization Act (MACRA) and Merit-based Incentive Payment System (MIPS) demand solid documentation.

"If you have inaccuracies in your coded data because of insufficient or lousy documentation, you're sending the Centers for Medicare and Medicaid Services (CMS) poor data about your patients and you're going to have poor information about your outcomes," warns Leigh Williams, RHIA, CPC, CPHIMS, the administrator of business systems at University of Virginia Health Systems.

At the same time the rise of EHRs has led to "note bloat" in documentation, when providers use copy-and-paste to pull forward unnecessary clinical details each time they record information in the record. "You have a lot of duplicate data, repurposing data in the EMRs that bloats the records to the point that it takes many, many more hours per day for a CDI specialist or coder to actually read the information because so much of it is duplicative," says Michelle Wieczorek, RN, RHIT, CPHQ, senior manager for healthcare at Dixon Hughes Goodman. "And you have a hard time discerning whether it's current state information or old information that's been pulled forward."

Whether CDI professionals work on hospital floors, in a cubicle in another hospital building, or a hundred miles away in a remote set-up, they must use technologies old and new to forge fruitful relationships with clinical care teams to produce robust documentation.

Succeeding with CDI Off-site

Depending on how one plays the online dating game, long-distance relationships are either deal breakers or enviably workable. The same is true for providers who have fully embraced EHRs and developed a streamlined query process for their CDI

department. As with any new technology, an optimal process is usually determined through trial and error.

Pamela Hess, MA, RHIA, CDIP, CPC, regional coding manager for himagine solutions, says that because of EHRs physicians aren't necessarily charting at the nurse's station or even in the hospital, which means the CDI specialist doesn't need to be there either. When they need to query the physician, a CDI specialist can do it through e-mail or an EHR vendor interface.

Hess says that some hospitals with EHRs are struggling to fill CDI specialist positions. But having a remote CDI team means that providers can look beyond their own backyards to find the most qualified candidates. Being a remote CDI specialist, however, means mastering a skill set that is an "art form," according to Hess.

"Being able to develop a personal relationship when you're remote is very challenging if you're not used to it," Hess says. "You need to design ways of combining live discussions with electronic communications and make sure there are introductions before you start these communications. We know physicians prefer to speak with someone they're comfortable with."

Hess's ideal team features a hybrid on-site/off-site staff, where there are CDI specialists working on-site to help put a "face" to those CDI specialists behind the scenes and smooth over conflicts in-person when an off-site CDI specialist can't get their query responded to.

Having a remote CDI team also eliminates the universal problem of having enough office space, Wieczorek says. She says she's never worked in a hospital where doctors, nurses, pharmacists, residents, and CDI professionals weren't all jockeying for space.

"We know space in hospitals is at a premium; if square footage isn't allocated to patient use, it needs to be maximized from a revenue perspective. The other thing with remote reviews is that you're not sneaking paper all over the place," Wieczorek says. "You can review a record and get a query launched pretty seamlessly, and that should help, in theory, from a productivity perspective."

Even when technology works perfectly and both the clinical and CDI teams function at their most professional, however, face time is incredibly important in building trust between the two teams, Wieczorek says. That doesn't mean CDI specialists have to be on the floor with physicians 100 percent of the time. But given the complexity of ICD-10 coding and how new regulations need to be conveyed to physicians to achieve compliance, in-person interactions can't be beat.

"It's really hard to have a solid, credible CDI program if there's no touch point or face time with providers," Wieczorek adds.

The health information management (HIM) department at Children's Medical Center of Dallas (Children's Medical), in Dallas, TX, worked extensively with their EHR and natural language processing (NLP) vendors to design a new query process that works for their organization. Fifty percent of their CDI staff work on-site and 50 percent are remote.

Although the organization has had a CDI program since 2012, Katherine Lusk, RHIA, MHSM, FAHIMA, chief HIM and exchange officer at Children's Medical, and Launa Fackrell, director of coding and CDI at Children's Medical, oversaw the overhaul, which has reduced query response time from an average of 50 hours down to 24 hours in 2015. Additionally, the query response rate jumped from an already satisfactory 95 percent to an average of 98 percent. What's more, when ICD-10 came along their team saw no productivity or quality impact, nor was there any impact to the facility's case mix index (CMI).

One of the most labor-intensive parts of the process involved Fackrell working with members of the pediatric care team and their vendor to customize and standardize all the query templates so that they're populated with pediatric content. This standardization has helped improve productivity and accuracy.

While health IT can make a CDI specialist's job more complicated, it can also help in new and exciting ways. The NLP tool used at Children's Medical is constantly running in the background of their EHR whenever someone is working on a patient's chart, and it will query users in real time for instances where more specificity is needed. For example, if a clinician types that the patient has asthma, the NLP will generate a query asking if the asthma is mild, moderate, or severe, and prompt for more details for each of those diagnoses. Additionally, there are separate workflows for when a provider goes in to document in the record on a retroactive basis, and another for concurrent documentation.

Having an NLP that auto-generates queries for specificity frees up CDI specialists to look for what's not being said in the record, Fackrell says, such as the kinds of equipment being used and resources a coding professional might not think about.

"What are those things we are treating and utilizing resources on that the provider isn't saying in a way a coder can translate? The CDI [specialist] is looking to clarify and to collaborate to make sure all the hard work we are doing is actually being documented in a way that a coder could pick up," Fackrell says.

An example of that, Lusk says, is if a patient is transfused but there's no documentation or diagnosis of anemia.

"So a CDI person will then move to a higher level rather than querying for things that are already diagnosed to specificity," Lusk says.

What Doctors Want in a CDI Relationship

Unlike dating, where each person is constantly trying to guess what the other person wants or thinks, doctors are pretty clear about what they want out of a CDI program. Mostly they want to be left alone. Taking pains to make sure their documentation is up to snuff is just one of numerous tasks doctors have to focus on each day. Yet, they genuinely want to help, argues Dr. James Fee, MD, CCS, CDIP, CCDS, vice president of the consulting firm Enjoin. Fee works full-time for Enjoin but spends some nights and weekends as a hospitalist.

Fee says that because of his day job, which is consulting on coding and CDI topics, he takes it as an insult if he gets a query—which he says he hasn't received in nearly five years. He says physicians are trained to investigate the cause of a problem as well as the solution, so getting a query that doesn't make clear what the problem is can be frustrating. CDI teams also have to put in the work to build trusting relationships with physicians—especially if they are remote.

"I don't want to be asked the same question 15 times as a physician—what I want is to be taught why it's so important and how I can make a difference and do it efficiently," Fee says. "…Now it doesn't mean you can't do remote CDI work and send queries out, but if you're completely remote and don't have that contact with a physician, they become disinterested. I think there needs to be a mixed approach. Doctors need to know your [CDI specialist's] name and face, and when you approach a physician you need to educate them at the same time."

Fee says that some physicians who receive queries feel as if their diagnosis is being challenged, rather than as requests for additional specificity. For example, he says, the way malnutrition is documented can vary from facility to facility. Some hospitals still rely on albumin and prealbumin levels as criteria, whereas others follow the ASPEN (American Society for Parenteral and Enteral Nutrition) criteria for malnutrition. "That will always be a challenge, bridging the gap between terminology and the regulatory world," Fee says.

If a query about malnutrition is sent electronically, he says it would help if the CDI specialist attaches their preferred criteria to a query, which can help avoid confusion and prevent future queries. He says it's easier to avoid this kind of back and forth with on-site CDI, but better CDI workflow design can alleviate this frustration, too. The drawback of some EHRs and query programs is that they weren't designed by physicians and as a result functionalities don't meet their needs. Fee and many others advocate for using a physician adviser, preferably an MD, in a CDI program to help mediate misunderstandings between physicians and CDI staff. Physician advisers also come in handy when CDI needs to escalate an unanswered query.

Dr. P. Roger DeVersa, MD, MBA, CPE, CDIP, CCS, is a physician adviser for CDI, HIM, at Erlanger Health System. Although his organization still uses paper charts for documentation, the challenges of CDI aren't much different in a hybrid environment.

At one time, Erlanger had one of the busiest trauma departments in the country and the trauma physicians were very resistant in responding to queries—if they did at all. As a result, one of the trauma nurses was brought into the CDI team due to her strong rapport with the physicians. DeVersa says the nurse was successful because she was able to do face-to-face documentation education in small increments and because doctors trusted that she wasn't just trying to get more money for the hospital with queries.

"She could tell doctors 'Your documentation is at risk for being recorded as a complication' and that was a hook for surgeons because they want their complications documented appropriately," DeVersa says.

All of the CDI queries done on paper at Erlanger are recorded on a standardized form that is white with a purple border, so that the query doesn't get confused with the rest of the health record. An additional sticky flag along the edge makes it easier to find. CDI nurses review the charts and submit inpatient or concurrent queries and coding professionals do post-discharge queries, which are typed up and sent to a physician electronically.

DeVersa has found that the younger the physician, the quicker they take to CDI—so he makes sure to target residents for CDI education so they start off on the right foot.

"Particularly with procedures and proceduralists, they're the ones doing 90 percent of documentation anyway," DeVersa says. "Regardless of title, you want to hit [focus training on] the people writing in the chart. You're more likely to be successful if you target the resident to get the H&P complete, and accurately painting the correct picture of the illness."

That Escalated Quickly: Getting Responses to Queries

Writing a documentation query that gets a physician's attention is infinitely more nuanced than drafting a dating profile. You can't provide superfluous information that doctors have to wade through to get to the relevant bits.

Whether you're trying to elicit a response from an electronic query or a paper query, Wieczorek recommends testing out query forms with physicians on an experimental basis before deploying a new system. It's important to make sure that doctor-speak is encouraged and translated into query forms and templates.

"For example, if you're an organization that sets up all your paper or electronic queries just so that a coder can understand what they mean, you'll have fewer queries being answered by providers because they're not clinically attuned to medical practice," Wieczorek says.

She says if an organization uses query templates this is extra important—if you want a physician to respond, templates must be succinct and clinically oriented. It's important not to load them with extraneous information paired with a million different checkboxes—especially the kind that requires more mouse clicks in an EHR. A good CDI specialist seeks to eliminate clinical ambiguity in the record, and to get all of the clinical diagnoses that are noted documented to the degree of specificity required for proper coding, Wieczorek says. A good query is one that eliminates the odds that it will be returned to the CDI specialist with information that can't be used.

"For example, if I ask a provider about heart failure, I have to be very specific: What is it about the heart failure diagnosis that I need clarified?" Wieczorek says. "…I'm a big fan of some checkboxes. I'm also a fan of giving a physician room to write in a diagnosis, but give them a little room, not a lot of room."

Another tactic is creating a workflow in which the CDI specialist has the option of querying the whole care team, including the attending physician, a resident, an occupational therapist, a nurse practitioner, or whichever team member spends the most time documenting on a patient.

The University of Virginia's Williams says that in larger facilities she worked with, service lines such as neurosurgery or orthopedics preferred to have queries sent to the team, and then the team would decide who to delegate the queries to. One service line preferred to have residents respond to queries. Then, if the resident didn't know how to respond to the query, they could escalate the query to an attending. The other service line thought nurse practitioners should respond to the initial query. Giving providers a choice about who responds can help increase compliance, she says.

In another facility where Williams worked to overhaul the CDI program she sat down with physicians to have a dialogue about delinquent queries. This discussion led to having CDI specialists round with physicians and the care team—a technique that's becoming more popular. Additionally, she found that one of the biggest barriers was that queries were sent via e-mail only. This meant that doctors were not receiving queries when it was best for them—when they were charting. The physicians she spoke with preferred to receive queries through their EHR vendor.

"And when you think about it, that's just the way they did it before EHRs. So when you had a paper chart, we'd leave a note in the chart and the physicians would answer it when they went to work on that patient. Almost like going backwards to what we had done before," Williams says.

After all, communication—whether over the Internet or over a drink—is the cornerstone of any relationship. This is also true with CDI. Whether remote or in-person, on paper or digital, queries will get answered only after it is ensured the message can be clearly interpreted by both parties—and the mutual motivation for corresponding is in place. And that, like anything, involves putting in the proper work and effort to build a communication system that works.

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