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Outpatient CDI queries: How to introduce physicians in ambulatory settings to the query process

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As clinical documentation improvement (CDI) moves into the outpatient realm, many providers and physician leaders are looking to existing CDI programs for guidance on setting up processes in the ambulatory setting.

But while compliant querying is clearly spelled out in inpatient CDI, where patient encounters can last three to five days, it's more complex in the fast-paced ambulatory world where single patient encounters are shorter and may be spread over a year's time, notes **James P. Fee, MD, CCS, CCDS,** the CEO of Enjoin, a physician-led clinical documentation integrity company based in Collierville, Tennessee.

"So from a query perspective, it's a new frontier," says Fee, who recently completed his three-year term as an advisory board member for the Association of Clinical Documentation Improvement Specialists (ACDIS), which last year released an official outpatient query practice

brief that provides guidance on policy and procedure for compliant physician queries in the outpatient setting.

However, he says, HIM directors are in a great position to leverage CDI successes in ambulatory settings. "It's a similar process, but vastly different in how you interact with providers and how the system is set up," Fee says.

The problem is that ambulatory is so broad in definition, says **Sonia Trepina, MPA,** director of ambulatory CDI services at Enjoin. Some may think physician offices when they envision ambulatory CDI; others will think of hospital outpatient departments or ambulatory surgical centers. The other challenge, she says, is that as the industry considers population health management and puts processes in place for care coordination, there may be a need for a different approach to CDI.

Consider pre-visit planning

One approach that Trepina recommends is for HIM/CDI/coding staff to provide the doctor with the patient's full picture prior to the visit. For example, the information presented may be conditions that the patient has, but that haven't been captured in the current calendar year; they might even be clinical indicators that point to something never before captured in that patient.

"So putting this in front of the provider before the patient comes in the door is an important piece for ambulatory, physician office CDI," she says.

This approach, Trepina notes, is valuable because it helps to remind the physician about everything that has been going on with the patient. So if the physician treats the conditions during the 15- to 20-minute office visit, he or she will know to go ahead and document them. This allows the coder to capture the appropriate codes.

One of the biggest challenges that HIM and coding staff may face is the large volume of patients that go through the office setting, according to Trepina. Most organizations don't have the CDI staff to handle the data capture for every patient. If that's the case at your facility, she says, it may be helpful to prioritize what population of patients you want to monitor.

Another challenge: It may not be easy to find staff members in the ambulatory setting who are ready to move into a CDI role, Trepina says. "You have to

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recruit and train them to get them where you want them to be for your organization. It's not a fast process … it's an evolution of work that has to happen."

For HIM directors involved with expanding into outpatient CDI, Trepina recommends that they pilot the program in a few areas before rolling it out to all settings. "I see organizations that plan and plan and want it perfect, and a year later, they haven't implemented and they've lost a year trying to increase risk scores. You have to start somewhere and evolve over time … the longer it will take to start, the longer it will be to get to your end vision," she says.

Educate physicians about CDI

Dawn Diven, BSN, RN, CCDS, CDIP, a CDI specialist at West Virginia University Medicine in Morgantown, West Virginia, says her organization has found success by first educating physicians about the CDI process rather than bombarding them with queries.

When West Virginia University Medicine decided to expand its CDI program in August 2017 to include the outpatient setting, Diven says she focused on one family medicine facility first, based on overall risk-adjustment factor scores provided by a third-party payer. "We began educating physicians by explaining what was happening in the outpatient world; how CMS was looking at quality of care, rather than fee-for-service and volume; and what that meant from the diagnostic and documentation perspective," she says.

Physicians wanted examples of what was meant by greater specificity and something hand-held to which they could refer when appropriate. So the CDI team developed diagnostic specificity tip sheets on conditions such as diabetes with manifestations, depression, malnutrition, and morbid obesity—putting at physicians' fingertips examples of more specific diagnoses that contributed to the accuracy of the documentation.

"When they understood that we were focused on accurate information, which equates to quality care, we had better buy-in," says Diven.

To further help physicians, CDI staff provided queries verbally and reviewed concurrent visits with providers every Tuesday and Thursday, suggesting ways they could provide more specific or accurate documentation. Then the provider could decide whether the suggestion was appropriate or not.

"It took time to figure out the process," she says. "We found the inpatient setting and services were different; they wanted education on different venues. Some wanted one-on-one, others quarterly reviews or group sessions. In the outpatient setting, they wanted one-on-one to go over the chart because they found the query process was overwhelming with their already-hectic schedules. It worked out better to talk to them face-to-face with specific charts. We had greater compliance and their anxiety level came down."

After the initial pilot, Diven began to expand the program to ambulatory clinics and asked physicians how they wanted the CDI team to approach them. Those physicians wanted CDI staff to review charts and report back to them on what was missing and what was not specific.

Based on West Virginia University Medicine's experience, Diven says HIM professionals should plan on a minimum of six months to get a CDI program in an outpatient setting up and running. It may take a little less time if the physicians aren't resistant or if they have had some inpatient CDI experience.

The key, she says, is educating physicians first so they understand the quality aspect of CDI and what CMS is asking for to capture more accurate and specific diagnoses. In many cases, Diven says, physicians have the information in their heads and are taking these conditions into consideration when treating and diagnosing. Now they need to document those specific conditions in the chart.

"We took the approach that they need the basics to understand why and how it impacts them, how it impacts patients, and how it impacts the facility. They are used to volume, seeing as many patients as they can, and providing the best care. They were never taught to think about documentation specifics related to quality," she says.