Q&A

CDI and Electronic Queries

As part of the first Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. **Robert S. Hodges, BSN, MSN, RN, CCDS,** *clinical documentation improvement specialist at Aleda E. Lutz VA Medical Center in Saginaw, MI, answered the following questions from ACDIS regarding electronic queries.*

Q *In what ways has electronic querying made life easier for CDI specialists?*

A *The main advantage I have seen to an electronic query system is the ability to track queries and to generate reports.* Depending on the software you use and the capabilities for reporting, you can track your abandoned queries, provider response rates, CDI query rates, as well as what type of queries are being sent out. All of these can help you focus education for providers as well as staff to improve your processes.

For example, if you see a large number of queries for anemia, you can focus provider education on that topic and then monitor to see if your query rates for anemia are staying the same or dropping. The same is true with providers; if you have particular providers who do not respond to queries in a timely manner or at all, you can arrange to meet with them individually to identify opportunities to improve communication and hopefully increase your query response rates.

These reports can also be shared with leadership to show how your program is doing and where you may need their support to improve response rates or timeliness of responses by providers. But when doing this, you also need to present what you are doing or have done to improve your own CDI program practices before going to upper-level management or medical staff for assistance.

Q *Do you find physicians more likely to answer an electronic query, or less so?*

A *In my experience, electronic queries are not as effective as verbal queries, but a lot of that depends on the provider.* I have providers who prefer an electronic query so they can continue patient care and then address the query when they have some downtime. Patient care is what we are all here for, so that has to come first. I have other providers who prefer a phone call, but if they are busy I tell them I'm sending the query electronically so they can review it later, or I will call them back later depending on their preference. No matter how you present a query, you should log all of them for reporting and follow up.

CDI specialists shouldn't rely only on electronic means of communication. You need to make sure you have some face-to-face time with providers. It is very important to develop and maintain the professional relationship you have with them so that they know the importance of what you are doing and the key role they play in that process themselves.

Q **A** *How do you educate the physician without having the constant face-to-face interaction?*

Education is an ongoing process for providers as well as for those CDI staff who are sending out queries. I still use the phone call or talk to physicians during grand rounds, but I also have found four other methods equally effective.

First, I get to meet all of the providers during their orientation. I give them an overview of the CDI program as well as tips regarding documentation items to watch out for.

I also have a variety of booklets available on a shared intranet site, which providers can access. I will include these in queries or send them to providers if I see trends in documentation that can have opportunities for improvement.

I have a newsletter, which I e-mail to all providers approximately every two weeks. This includes issues that coders, billers, compli-

ance officers, or others have identified that can be affected by improved documentation.

Finally, I perform individual provider reviews. I take a sample of 10 charts from each provider here and review for missing note elements, specificity of diagnoses, potential missing diagnoses, legibility, copy-and-paste use (since we have an electronic record), and abbreviation use. These reviews are only educational in nature and are only shared with the provider. I've gotten some good feedback from providers on these, and most seem to appreciate that someone is providing guidance on how they can improve their documentation.

Don't forget that the query forms themselves can serve as great educational tools, too. Queries are there to tell the provider what information the coder needs to accurately capture a condition. As we already know, coders and providers don't always speak the same language, so every interaction is an educational opportunity.

Electronic queries a piece of the puzzle, not the solution

Jon Elion, MD, FACC, president and CEO of ChartWise Medical Systems, Inc., in Wakefield, RI, says that electronic queries can be a valuable arrow in a CDI specialist's quiver, but that they won't ever replace the need for face-to-face interaction and education. His comments follow.

Before you can answer what is an electronic query, you have to define what it is not. It's not taking a paper query, scanning it as a PDF, tacking that into the electronic medical record, and then sending a text message to the doctor saying, "Hey, go to the EMR and look up the query." An electronic query is created electronically and answered electronically. Many CDI programs are paper-based in an environment that is going paperless.

The plusses [of electronic queries] are the ability not to have to carry around large numbers of sticky note pads with pre-printed queries on them. You can have a pick list of the latest and greatest library of queries laid out in front of you and keep track of them. And they allow you to conform to guidelines for queries. In a properly done, fully integrated electronic query environment, much of the information is filled out for you ahead of time. As a CDS it saves you some work and increases your accuracy. The huge payoff is to have the physician responding electronically, and to have that response populating your tracking metrics and your database.

But there is a very meaningful downside to electronic queries, and that is if it eliminates the face-to-face communication. There is nothing that can make up for that. Here's an example: A patient comes in whose heart failure kicks up, so they came with acute-on-chronic systolic heart failure. They were huffing and puffing down in the ER, so they were put on BiPAP—a mask that delivers oxygen under pressure—and an hour later the Lasix kicks in and the mask is taken off. To a physician, that is not acute respiratory failure. If you queried for that, you'd get a "no" back. We didn't get a blood gas, we didn't show they were retaining $PCO2$, so we didn't meet the doctor's medical criteria. But if you sat and talked with the physician about their treatment and what was going on, and why they put on the BiPAP, they would meet all the coding criteria for acute respiratory failure. It's not about looking at a query form, it's getting the physician to tell you what he was up to and have the discussion.

Q **A** *Is there any additional danger of "leading" queries due to performing them electronically? Or can standard templates/automated prompts make querying safer?*

Presenting a leading query is always a risk and needs to be monitored. Using a standardized query with established and approved language can certainly help minimize the chance of a query being leading in nature. That is one of the reasons why the Veterans Health Administration is developing standardized queries as well as a provider query practice brief.

When a verbal query is used, our policy is that it must use the same verbiage that is in the written query specifically to minimize the chance of a query being leading. Of course you always have the occasion when a provider says, "Just tell me what to write," but as you know, we can't do that. You have to make sure you are presenting options to the provider, avoiding "yes" and "no" answers to questions, and reminding them that their decision should be based on their own clinical judgment. Again, that's an educational opportunity for the provider and should be presented as such.

Q **A** *Will electronic query systems ever replace the skills of a CDI specialist?*

I know you should never say never, but in my opinion, no electronic system will ever fully replace the skills of any person. There is a lot more than just preparing and presenting queries to the CDI specialist role. The primary goal of the CDI specialist is to ensure that the medical record is as accurate and complete as possible to ensure continuity of care for the patient and complete and accurate coding of the chart. An electronic query system is only a tool that a CDI specialist can use to help achieve that goal.

If an electronic query system identifies query opportunities by scanning for key words in an electronic medical record, and I'm not aware of a system yet that does that, you still have to review the documentation to determine if a query is appropriate. For example, if congestive heart failure is documented along with a note that an echocardiogram has been ordered, I wouldn't query until the test has been performed and the results are available to the provider. The CDI specialist is there to look at things in the context of the patient and to provide expertise and clinical judgment on whether a query is appropriate.

Education is again a critical component of the CDI role. You just can't go blindly sending queries to providers and expect a response unless they understand why they are being sent and why their response is needed. It truly is a team effort that can't be replaced with an electronic system.

Hodges started the CDI program at the Aleda E. Lutz VA Medical Center in 2008. He served as a colead of the Veterans Health Administration Health Information Management Service (HIMS) team, which is developing standardized queries and a Veterans Health Administration HIMS Practice Brief for provider queries for use at all Veterans Administration Medical Centers. Hodges has more than 27 years of nursing experience with a BSN and MSN in nursing informatics from the University of Utah. He also served for 15 years as a member of the U.S. Army Nurse Corps in a variety of clinical and leadership positions. Contact him at **Robert.Hodges2@va.gov.**