

Q&A

Physician engagement



As part of the 10th annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics.

**Audrey Murray, BSN, RN, CCDS**, CDI specialist at Memorial Hermann Northeast Hospital in Humble, Texas, a member of the 2020 CDI Week Committee, answered these questions. Contact her at [Audrey.murray2@memorialhermann.org](mailto:Audrey.murray2@memorialhermann.org).

**Q Can you describe the engagement and collaboration of the medical staff at your organization with CDI?**

**A** We have implemented many strategies in an effort to establish rapport with our physicians. When on-site, we round on our units and engage both physicians and staff in order to establish ourselves as part of the team. We distribute educational materials and attend departmental meetings to get to know the physicians and to ask or answer questions when opportunities arise. We met as a team with the head of our hospitalist group in order to properly introduce ourselves and to offer assistance, and this has led to the opportunity to present CDI education to the group in a series of ongoing sessions.

The emergence of COVID-19 has created unanticipated challenges with physician communication since we are currently working remotely. We continue to attend meetings and confer with our chief medical officer (CMO) via Zoom®. Our organization utilizes a communication tool called PerfectServe® that allows us to reach out to physicians in the method of their

choosing (text versus call) in order to securely discuss patient queries.

We were fortunate to be able to engage the majority of our physicians in person prior to our shift to remote work, and I believe that this has played a major role in our physician response and agreement rates.

**Q According to the 2020 CDI Week Industry Survey, the percentage of respondents who reported that their medical staff is “highly engaged” jumped from roughly 13% in 2019 to over 20%. In your opinion, why is physician engagement seemingly increasing year-over-year?**

**A** I believe that recognizing the correlation between physician engagement and physician query compliance has led to successful CDI strategies. Every facility is different, and I think that each team has to tailor strategies that make the most sense for them. Many factors influence these strategies, including (but not limited to):

- Is your team onsite, remote, or a hybrid?

- Which physicians do you most commonly query (e.g., hospitalists, individual practitioners, internists, surgeons)?
- Is your department well-established within your facility, or are many of your physicians unfamiliar with CDI and how we benefit them and the organization?

I think that by evaluating these factors and determining the course of action that potentially has the greatest impact, a team can accomplish major strides in physician engagement.

**Q Even Even though more people say their physicians are highly engaged, there's still 80% who say they aren't. Why do you think so many CDI programs have trouble engaging the medical staff? What have been your biggest challenges with gaining physician engagement, and what have you done to address them?**

**A** In my experience, there have been two major factors that contribute to challenges with physician engagement. First, our hospitalist group changes regularly. Unfortunately, we often lose hospitalists that are both excellent documenters and receptive to queries. Then, new physicians come aboard, and we have to start from scratch to ensure that they know how to answer our queries and they can trust our clinical judgment in order to understand that our queries serve a purpose.

Secondly, we struggle with our independent practitioners because they recognize that there are no punitive consequences for neglecting to answer queries. We have an excellent working relationship with our CMO, and we escalate independent practitioners to him so that he can contact them and request query responses. But the reality is that our escalation process ends there, and some of these physicians still refuse to answer. Fortunately, these physicians comprise a small percentage of our overall queries, but their refusal to engage does negatively impact our metrics.

We have worked as a team to develop a CDI education folder that aims to reach both new providers as well as those that are established but noncompliant with query response. Our goal is to distribute these folders so that we can establish rapport and share useful

information that they will hopefully be able to use as a reference when needed. We have seen that both new hospitalists and our intensivists have been very receptive to these folders, and query response rates for these groups have increased.

**Q According to the Industry Survey, the majority of respondents currently have a physician advisor or champion. Does your department have a physician advisor or champion? If so, what has been the result of that relationship, and how much time does that person devote to the CDI department?**

**A** Our CMO is our physician champion, and we meet with him monthly to review physician compliance as well as case-mix index trends and financial impact. He is very supportive of our efforts, and as previously mentioned, he reaches out to independent practitioners when we are unable to obtain query responses ourselves. Without a physician champion, we would not have a physician on our side to have those peer-to-peer conversations that are sometimes necessary in order to achieve our objectives.

**Q Do you track physician query response rate at your facility? Why or why not? How have you gone about improving your query response rate?**

**A** Our manager runs a monthly report that captures physician response rates for review. He can amend the report to capture as many previous months as he chooses in order to track trends. We discuss this report with our CMO monthly. He also creates a report specifically for the hospitalist group that we share with their director. These reports are very helpful in identifying physicians that consistently fall short in query response.

Then, we can focus on reaching out to these physicians to determine the reasons for this. Sometimes, we find that it is simply a matter of educating the physician on the process for answering queries in the system. Other physicians can be more challenging and require ongoing efforts to earn their respect and to educate them on the benefits of query response for them as well as the organization.

**Q The largest group of Industry Survey respondents said their physicians have two days to**

### **respond to a query. What is the query response time frame at your facility, and why did you choose it?**

**A** Our policy is to reach out to physicians and request query response after 48 hours, but ultimately they have up to 14 days after discharge to answer the query before we close it out as a no response. If queries are closed out too early, we'll miss opportunities to impact the chart.

For example, our hospitalists work seven days on and seven off. Sometimes we send a query to a hospitalist on their last day and then the patient discharges home. At that point, that particular hospitalist was the last one to see the patient, so it would not make sense to forward the query to another physician. We then have to wait for that physician to start his or her next rotation to ask that they address the query. It requires follow-up on our part, but our policy allows enough time for us to get that response and potentially impact the case.

Alternately, there are downsides to giving the physician too much time. If they don't answer queries promptly, we can miss out on opportunities to impact the DRG while the patients are still in-house and potentially give the patient care team a longer length of stay in order to treat them. Another downside is that our coding department has their own timeline for coding discharged accounts, and sometimes we receive query responses after they have done so. This leads to

a multistep process between CDI and coding to ensure that those diagnoses are captured before the chart is sent for billing.

We find that everything runs much more smoothly across both departments when queries are answered before the patient is discharged. Therefore, we make it a priority to educate our physicians on the importance of answering queries in a timely manner.

### **Q Do you provide formal education to your physicians, one-on-one/informal coaching, or both? How have your physician education/engagement models changed due to the pandemic?**

**A** We provide both formal and informal education to our physicians. We present more formally when we are invited to speak to different groups at their monthly or quarterly meetings. Sometimes, we get the opportunity to educate informally when questions specific to documentation come up during those meetings or during patient rounds.

Naturally, this has become more difficult since we are currently working from home. We don't have the face time that we were accustomed to, and therefore we are reaching out to see about continuing formal education via Zoom. It's not ideal, but we recognize the importance of keeping the lines of communication open however possible.



## Physician engagement: More critical than ever

by Robert Budman, MD, CMIO

Access to care combined with physician engagement is more critical now than ever. Here is a real-world example of a health facility that established a CDI program and what they were able to achieve as a result.

Magnolia Regional Health Center (MRHC) is a 200-bed acute care community hospital located in Corinth, Mississippi. The hospital wanted to support its physicians with artificial intelligence (AI)-powered speech recognition to make it easier to navigate and create comprehensive documentation within the electronic health record. Upon implementing Dragon® Medical One from Nuance, their chosen speech recognition solution, MRHC “rapidly and overwhelmingly” embraced it, saying the platform not only was easy to use, it also improved the quality of patient documentation.

Because of the success of speech recognition, MRHC expanded its investments in AI-driven tools to support their CDI program, which was designed to further improve the quality of documentation and more accurately reflect patient acuity and the level of care provided.

Although quality metrics are essential, “doctors aren’t driven by case-mix index. They’re driven by quality outcomes and patient outcomes—taking care of the patient as a whole,” says Jill Tays, BSN, MRHC’s director of case management. But today, armed with Nuance CDI technology, MRHC’s team has been able to prioritize the more complex cases that offer the most opportunity for improvement, making the entire CDI process more efficient and effective.

Not only has MRHC been able to cover more cases and expand payer coverage, they’ve also improved case-mix index and other quality scores. This shows how AI-powered documentation solutions can improve providers’ ability to spend time at the bedside. Together, MRHC’s efforts have contributed to an improvement of more than \$4 million in appropriate reimbursements.

There’s no question that CDI programs can have a tremendous impact on hospitals across the country, regardless of size. MRHC’s program can serve as a road map for many healthcare organizations. Just imagine for a moment the impact of an additional \$4 million on your organization—what could you do to help advance the health and well-being of your community?

**Robert Budman, MD, CMIO, is board certified in family medicine and informatics. He focuses on efficiency, safety, and quality initiatives with global experience in multi-EHR and service line care delivery. His work involves implementation, workflow adoption, and optimization. Budman earned multiple clinical awards and speaks extensively on healthcare IT topics.**