

Q&A

Physician engagement



As part of the ninth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. Rachelle Buol, RHIA, the director of coding and CDI at UW Health in Madison, Wisconsin, and a member of the 2019 CDI Week Committee, answered these questions. Contact her at rbuol@uwhealth.org.

For more information about CDI's role with physician engagement, read the [2019 CDI Week Industry Overview Survey Report](#) today.

Q Can you describe the engagement and collaboration between the medical staff at your organization and the CDI team?

A Prior to having a CDI physician advisor, we struggled with providers answering and understanding the significance of a CDI query. Over the course of two years, however, we increased our team from five to 30 full-time employees and hired a physician advisor, thereby increasing our coverage from 20% to well over 95% of all medical records. The physician response rates to our queries is now at 99.8%.

Q According to the 2019 CDI Week Industry Survey, only 12.71% of respondents said their medical staff is “highly engaged.” Why do you think so many CDI programs have such trouble engaging the medical staff?

A Providers are being bombarded with “asks.” It’s not always intentional when they don’t engage or respond. I have seen tremendous changes in provider behavior when a department chair is involved, providing the reimbursement effects, and severity of illness (SOI)/risk of mortality (ROM) metrics. For a CDI program to be

successful, senior leadership must support documentation integrity efforts and recognize the overall effect the program has on publicly reported data.

Q What has been your biggest challenge and most successful approach with gaining physician buy-in?

A Surgeons responding to queries has been our biggest challenge. For several years, the CDI team had been meeting with faculty, and there has been some engagement on that front.

Additionally, in our organization, we don’t send queries to the residents, and this is one of our biggest gaps.

With support from senior leadership, we have been able to effect change with the surgeons, but our current goal is to get this in front of the residents.

Q According to the Industry Survey, 63.37% of respondents currently have a physician advisor or champion, and 69.32% of those respondents said their physicians are either highly or mostly motivated and engaged. Does your department have a physician advisor or champion? If so, what

has been the result of that relationship, and how much time do they devote to the CDI department?

A In the last year we recruited a physician advisor from within our organization who is passionate about the program. He's been incredibly effective when it comes to providers that simply don't want to answer queries or have concerns about those queries. I would say he is working three hours a week for the team right now.

Q Do you have uncooperative/unresponsive physicians, and how do you handle them?

A If we have one, we provide the statistics to the physician advisor, who then takes it to the department chair. When necessary, he does meet individually with providers.

Q Do you have an escalation policy of sorts to deal with noncompliant physicians? If so, what does that escalation policy entail?

A Nothing formal. If we have an issue, we handle it individually. We monitor trends, share statistics, and communicate concerns with our providers.

Q According to the Industry Survey, roughly half the respondents have a 91%–100% physician query response rate and 2.43% of respondents don't track the rate at all. Do you track that rate? How have you gone about improving your query response rate?

A We absolutely track the response rates. At one point, response rate decreased significantly due to providers not understanding what we were asking. This was when we took the data to senior leadership to help with messaging. We wouldn't have been able to engage the right people to improve without the data.

Q When it comes to physician query agree rate, 61.87% of Industry Survey respondents have an 81%–100% agree rate and 4.11% don't track that metric. Do you track physician agree rate to queries? Why or why not? What can that metric tell you about CDI's efforts and success?

A Yes, we track the agree rate. The importance of this metric is to simply monitor trending because we know that not all queries result in a new diagnosis or the answer we necessarily wanted. When a provider has many "unable to determine" responses, this tells us that there is an education opportunity for

the provider—maybe they're a new provider who was missed in our initial training. This metric can also tell you if there is a problem with the query template or the context of the query by the CDI specialist is incomplete.

Q Could you tell us about an experience you had winning over a physician to CDI?

A I recently had an experience where you could see on the provider's face that he had never heard that urosepsis was not a codable diagnosis. I felt like he was trying to remember all the times he documented it. Going forward, I know he will use the tip card and/or use the phrase "sepsis due to urinary tract infection (UTI)" or "UTI."

Q How has the changing reimbursement and denials landscape affected the way you interact with physicians?

A We have a program that is based on completeness of record, so the way we have trained our physicians has not changed drastically. Our philosophy encompasses ensuring that the SOI/ROM of the patient is described in the record.

By making sure the clinical indicators support the diagnoses by obtaining any necessary additional documentation through our queries, we have had success preventing denials based on clinical validation concerns as well.

Q Does your program regularly share CDI data with its physicians (either one-on-one or in group format)? Does your program leverage publicly reported data in its physician education? Why or why not?

A Yes, we share data as often as we can—both one-on-one and in group format.

We talk about publicly reported data, and I explain that codable diagnoses directly affect their "scores." I challenge them to look themselves up on Physician Compare and/or Leapfrog. We talk about Vizient, and how big data is becoming more accessible for patients to help them make healthcare decisions.

I personally think data is absolutely necessary to share with physicians and leaders. Physicians are trained to think critically and make decisions based on the information in front of them. Showing physicians data is speaking their language.

Mel Tully, MSN, CCDS, CDIP, is the vice president of clinical services and education at Nuance.

Today's technologies and artificial intelligence (AI) solutions are designed to support CDI teams in their quests for efficiency. Consider a CDI specialist who has 100 patient charts in their workflow. Research suggests that only 30 of those charts require follow-up or clarifications—but which 30 should you spend your time on? In the past, each record would need to be manually reviewed to uncover only those charts that represent quality improvement opportunities. Today, however, the right technology can help CDI specialists hone in on those more complex cases automatically, allowing CDI professionals to apply and use their skills more effectively and spend their time in ways that can make the most impact.

Similarly, AI can be applied to the front end of the documentation process, supporting providers and physicians as they add specificity where it matters most. A healthcare virtual assistant, for example, is one AI-powered platform that augments providers' knowledge, recognizing natural language to make chart searches, EHR navigation, and CPOE more intelligent, simpler, and voice-powered. By helping providers create more complete and compliant documentation upfront, these technologies are creating efficiencies on the backend, giving even more time back to CDI specialists and coders. Now, they're able to dive deeper into patient records, free from the weight of retrospective queries and rework.

Denials remain a costly burden for healthcare organizations, both in terms of financial impact as well as

the amount of time coding and CDI specialists must dedicate to addressing denials as they arise. The rules around denials are fluid, and it can be difficult to keep up with them; this is complicated by the fact that once a claim has been denied, there is typically a short time-frame in which to address it. The process chews up time and other resources and requires extensive knowledge of the appeals process.

It is in this area that today's clinical documentation technologies are well-positioned to support organizations' denial prevention strategies. CDI and coding specialists can rely on tools that capture greater specificity in clinical documentation, mitigating the risk of denials up front. On the backend, the right technologies will also include appeals templates to help CDI teams effectively and efficiently address denials as needed.

While the technologies themselves are designed to support any organization's denial prevention strategy, adding a guidance and educational program will optimize the impact of these investments. These programs can drive toward organizational goals by keeping all clinicians and specialists on top of changing payor requirements and processes, helping continuously improve the quality of documentation, and engaging the entire organization in quality improvements.

In other words, the combination of educational programs and technology solutions helps improve the quality of documentation up front, which alleviates the burden of rework while also helping to prevent denied claims going forward.