# Q&A CDI WEEK Physician engagement

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*As part of the fifth annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics.* ***Maria Eugenia Petrini, MD, FAAP,*** *is a general pediatrician and CDI/Utilization Management Physician Liaison at Nemours AI DuPont Hospital for Children in Wilmington, Delaware. Petrini answered the following questions on physician engagement and the role of the physician advisor in CDI efforts. Contact her at Maria.Petrini@nemours.org.*

**Q Can you describe your role as a physician advisor to CDI?**

A I would describe my role as the bridge between the providers and the CDI specialists. I have the benefit of seeing both perspectives: I understand the importance of accurate and complete clinical documentation but also understand the numerous challenges that the providers face in today's clinical world. I try to simplify the CDI message for the physicians by explaining the importance and implications of accurate clinical documentation, and making it as easy, straightforward, practical, and convenient as possible. It is not about documenting more (quantity), but rather it is about documenting well (quality).

**Q Can you describe the engagement and collaboration of your medical staff in CDI?**

A It continues to be a work in progress for us, but since we implemented our program in 2012, we have come a long way. The majority of our physicians are engaged and actively collaborate and cooperate with us. We took a team approach as we want to be considered part of the care delivery team. We do have our challenges, particularly with surgical services and rotating residents as we are a teaching hospital. We learned that early education, especially for those who are in training, (i.e., residents) is crucial. Face-to-face participation in daily rounding and use of verbal clarifications are definitely critical to increasing provider engagement and collaboration.

**Q What has been your most successful approach for obtaining physician buy-in?**

A I think we have a few, starting with education. We take any and all possible opportunities to educate. We believe that if physicians understand the reason for accurate documentation, compliance increases remarkably. Education has to be time sensitive, pertinent,

on-demand, and specialty-oriented. It has to be constructive rather than painful. Verbal education during clinical rounds is the key. As a physician, I believe that the majority of physicians are high achievers. Physicians want to excel regardless of the setting. In my role on the CDI team, I try to give them a good foundation with which to excel in clinical documentation.

**Q Does your medical executive committee have an escalation policy or other policy requiring physicians to respond to queries/CDI clarifications in a set time?**

A I do not believe we are quite there yet. Although we count on support from the medical executive committee, no escalation policy has been created. However, providers are expected and strongly encouraged to respond to CDI clarifications within 24 hours.

**Q What are your biggest challenges with getting physician buy-in?**

A Physicians went to medical school to take care of patients. Medicine today seems to be much more than that. Time constraints, patient load, lack of understanding, multiple sign-offs, frustration around the lack of appropriate pediatric codes, rotating residents/fellows are definitely a few of them. Surgical services and more seasoned physicians seem to be more reluctant to change old habits.

**Q What do you think the role of the CDI physician advisor is/should be in terms of program advancement and analysis?**

A I think the physician advisor's input is key to the success of the CDI program. Physician advisors can see the facts from both perspectives, having both clinical documentation and clinical bedside patient care knowledge.

Physician advisors should participate in data analysis and analysis of complex situations to bring potential solutions and new modalities to the table. Feedback in the way of recognition and opportunities for improvement should also be delivered back to the physicians by the physician advisor.

We review our data monthly (number of clarifications, responses to clarification, agreement with clarifications, topic clarified by services and by providers). We also review case mix index data twice a year as we get our reports. Physicians, like everybody else, like to know when they are doing a good job, which certainly helps to keep the spirits and the motivation up.

**Victor Freeman, MD, MPP is a CDI consultant and Regional Medical Director for Nuance. Here he discusses the importance of engaging physicians in a value-based healthcare economy.**

Collaboration among clinicians – and with CDI teams – is more important than ever.

The CDI model has changed. Data is richer and shared more widely. Reimbursement models increasingly are based on quality and value, not volume. More accurate data drives better quality of care. As the shift from volume to value transforms CDI from a coding and revenue cycle initiative to a quality of care mandate, precise severity of illness (SOI) and risk of mortality (ROM) documentation will equal the quality scores that are the yardsticks by which CDI success is measured.

Most physicians understand that documenting to better capture medical necessity, SOI and ROM on every admission will positively impact reimbursement, clinical care, and quality metrics. The key is to educate them about the benefits of getting pre-discharge documentation feedback. Nearly all physicians will value any effort to minimize post-discharge queries, which is disruptive to their workflow. They also need to understand that, when tied into real-world clinical workflow, the documentation process allows more collaboration, helps identify patients at risk of potential complications, and helps them implement preventative measures sooner. This improves discharge planning and reduces hospital readmissions that escalate costs.

**Physician-engaged CDI: a clinical initiative.**

Physician-engaged CDI must be supported at the medical executive committee (MEC), not just at the beginning, but throughout the life the program. Ideally, the MEC should have ownership of the program, since program results are the best reflection of program performance at the individual, group, department and full medical staff levels. CDI outcomes data is the very data that Medicare, Medicaid and managed care are using to evaluate the institution. It is the data used to measure the SOI and ROM of the patients hospitals are treating today, and institutions and those institutions will care for in a population health scenario.

In addition to the MEC, executive support from either the Vice President of Medical Affairs (VPMA) or the Chief Medical Officer (CMO) and other c-suite executives is essential. This is important both for CDI staff morale and for medical staff engagement. The VPMA/CMO must have ongoing peer-to-peer conversations with medical staff leaders in order to show support for both the CDI program and for any CDI physician advisor(s). The VPMA/CMO often works to keep medical staff leaders accountable for supporting the overall CDI program, and even for their respective departments' CDI Program results.

**Walking the talk.**

One of the most important roles for the physician advisor is to champion the CDI staff and the program in all clinical departments, while intervening as needed, with resistant physicians. While many physician advisors split their time between CDI support and clinical practice, some sites use physicians who split their time between CDI and Utilization Review (UR) or Case Management (CM). Many physicians have found that these roles truly complement each other; some find they are in conflict. The conflict usually arises because the UR/CM role often comes across to medical staff as a policing role. When CDI "advising" feels like "policing" to medical staff, they often resist CDI efforts. Effective CDI advising is best presented as an educational and medical staff support role.

CDI physician advisor effectiveness usually is in direct proportion to the ability to build physician-peer relationships, to intervene with resistant physicians and to advance the CDI program with peers. It is crucial that the physician advisor promote CDI as a valuable educational support service that the hospital is proving to the medical staff. Building physician-peer relationships helps generate allies who can help promote the CDI program, and also help in intervening with resistant physicians.

Successful CDI programs use the physician advisor to promote both the visibility and importance of the program. This includes providing quarterly (or other periodic) CDI performance reports, education, training and recognition events at departmental and medical staff meetings. Of course, the most successful CDI physician advisors also know there are times when "it is hard to be a prophet in your own land," and recognize when it is good to have outside physicians come in to bolster their CDI messages, with examples and best practices from colleagues around the country.