Q&A

Physician Engagement

As part of the seventh annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. ***Kristie Perry, RN, MHSA, CCDS, CCS****, a CDI specialist at Erlanger Health System in Chattanooga, Tennessee, and a member of the 2017 CDI Week Committee, answered these questions on CDI physician engagement. Contact her at Kristie.Perry@erlanger.org.*

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

A You've come a long way, baby!" That's how I would start to describe the journey with CDI and the physicians.

I've been doing CDI at my facility for 10 years, and I'm one of the original nurses that started CDI at our hospital. I was assigned to the trauma service/surgical critical care service/general surgery service. Initially, the relationship was nonexistent.

I would write queries, often without any response, and finally, after I built up my nerve, I would do a verbal query when the residents/attendings were rounding. Needless to say, there were a few charts slammed, eyes rolled, calls to my manager, and raised voices.

Just like you have to stay focused when disciplining your children, however, that's how I approached my doctors. I remained calm and was a constant presence. They know now that I have their interests and the hospital's interests at heart.

Q Why do you think so many CDI programs have such trouble engaging the medical staff?

A I strongly believe that the physicians want to do the right thing. After all, they've racked up enormous debt from schooling in order to help others. Just like a stay-at-home mom with multiple children, though, the doctors are being pulled in numerous directions and have numerous responsibilities.

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

A I hate to keep referencing children, but with my physicians I have become that constant motherly support/force. They have come to accept that I'm not going away. I simply try to be kind, give a pat on the back for great documentation, and always say thank you! Using good manners never goes out of style. Or, you could say that I kill them with kindness.

Also, I really try to limit the focus on money and through the years have reported to the individual physicians how their words affect severity of illness (SOI) and risk of mortality (ROM); I even expand that into education about

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Patient Safety Indicators (PSI) and the impact to their profile.

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

A Within the group of six that I spend the majority of my time with, I have one physician who can be a bit hard-headed. I have learned to just step back and assess his mood for the day and decide if I want to interact verbally or via written word. I must admit though, early on in my CDI efforts, I verbal queried him at the bedside one day and received a response with a not-so-nice expletive—one that I responded right back to him with and walked away.

Now, that is not my standard practice at all, but it completely changed the dynamic of our working relationship. In general, I just try to be polite and professional, and eventually they come around.

Q Do you provide formal education to your physicians, one-on-one/informal coaching, or both?

A The education role within CDI is one that I thrive in. There's nothing that I enjoy more than being out on the floors or in the units when the teams are rounding. In my mind, you cannot build that relationship unless you are visible and providing real-time education.

The education that I provide has grown over the years to include the daily education on rounds, but at least once a year I provide education to our new surgery residents as well as the returning/senior residents in a more formal classroom setting. I provide actual charts from our facility and show how their words affect reimbursement, length of stay, SOI, and ROM.

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

A The hard-headed physician that I referenced earlier recently told me, "The major reason I cooperate with you is because you work so closely with us and try so hard." That did not happen overnight. That has come from blood, sweat, and some tears for sure! Persistence will pay off!

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

A In the infancy of our CDI program, I tended to focus on the dollar impact. Over the 10 years, though, that has changed drastically, and the focus is almost always on the quality aspect, such as value-based purchasing or PSI-specific information. I am an original member of the PSI committee, which has given me the opportunity to provide very specific education to the doctors and focus it on their physician profiles.

Some of the doctors couldn't care less about their profile, but most are eager to learn and often seek me out if there is a known PSI issue or question.

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Mel Tully, MSN, CCDS, CDIP, is the vice president of clinical services and education for healthcare solutions CDI at Nuance Communications. In the following article, she discusses how documentation improvement is expanding beyond the traditional setting and how it can improve quality and reimbursement across the healthcare continuum. Contact her at Mel.Tully@jathomas.com.

Achieving the Quadruple Aim with Computer-Assisted Physician Documentation (CAPD)

Providers who use EHRs and computerized physician order entry report lower levels of job satisfaction and higher rates of burnout compared to their counterparts who still use paper, according to a 2016 Mayo Clinic Proceedings study. Documentation workflow templates and cut and paste features in EHRs are supposed to improve patient care and ease physician burden, but if they're pulling physician focus away from the patient, that's not the case.

Hospitals and providers have finally recognized that helping physicians in real time when they are dictating, and enabling them to get all the critical information very quickly into the medical record without these clicks, is going to improve their satisfaction and decrease the risk that documentation doesn't comply with regulations and patient care.

And, computer-assisted physician documentation (CAPD) not only improves physician engagement, but also improves population health, increases patient satisfaction, and reduces healthcare spending.

Improving physician documentation at the point of care

Nuance developed the concept of CAPD in 2011 with the idea that just-in-time guidance provided in-workflow and in line with the physician's clinical thought processes would result in a better experience for the physician, and better quality documentation earlier in the process. That innovation was driven by the realities of modern practices, and hospitals, and ever-increasing regulations, demanding that physicians document patient care in the EHR with as much detail as possible to support financial and quality reporting requirements.

Physicians want the advantage of real-time clinical guidance presented while they are entering their notes, with relevant history that comes forward on that patient, to be able to add sufficient detail to capture the full and complete story for each patient during their visit. They have a kind of remote memory – it becomes more remote the minute they step out the door of the patient's room. And so even documentation improvement efforts that are concurrent, which are much better than after discharge, are still not real time.

Nuance CAPD and the Quadruple Aim

Beyond traditional CDI, which addresses gaps in documentation after the patient has entered the system with concurrent and retrospective record reviews and physician queries, CAPD spans a variety of applications and clinical content designed to bring the right information forward at the right time to the right care provider at the point of decision-making.

As a result, physicians are engaged in creating clinical documentation that contains the most appropriate information to drive the most critical aspects of the healthcare process, improving communication between caregivers, reflecting the accurate quality of care delivered, informing proper coding and reimbursement, impacting proper risk-adjustment for the population of patients served, and driving more value from EHR investments.

Regardless of where the physician sees the patient, speech recognition and real-time clinical documentation guidance is available to help the physician capture the details necessary for reimbursement, quality measures and compliance while telling an accurate patient story. This improves clinician overall satisfaction, and ultimately achieving the Quadruple Aim.

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