

Q&A

CDI  
WEEK 

Physician  
engagement



As part of the sixth annual Clinical Documentation Improvement Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. **Karen M. DiMeglio, RN, MS, CCDS, CPC**, director of CDI at Lifespan and ACDIS' 2016 CDI Professional of the Year award recipient, answered these questions regarding physician engagement. Contact her at [KDiMeglio@Lifespan.org](mailto:KDiMeglio@Lifespan.org).

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

**A** Our program started in 2009 and incorporated a CDI steering committee. The committee included many of our physician leaders as well as our executive leadership. Having the physician leaders on the committee assisted with them understanding the role of the CDI specialist along with what we needed to accomplish. In addition, I met with physician leaders of certain departments every month. We would discuss engagement, identify the best way to educate, and determine documentation opportunities. We have always been flexible, and we work with each department to figure out what is going to work.

We don't do one-size-fits-all for education and engagement. We developed specific guidelines for each department that we use to guide our query processes and target education opportunities. For example, we don't schedule education or query orthopedics before 2 p.m. because they're all in the operating room at that time, whereas other departments may want monthly

education on top diagnoses and CDI processes. A few of our department leaders may opt to do the education themselves, so we give them the information and they relay the information to their staff. Then they tell me what they've communicated so I can let the CDI staff know and the CDI specialists can reference the education when they query. Our providers rotate between the different units, which can make education a challenge. However, the top queries are often similar, so education does cross over, and CDI can help fill in the gaps.

We do have two days remote, so for the three days when the CDI staff are in the office, they are on the units making contact with physicians and other providers. In July, when we have a lot of new residents, we allow staff to work one day remotely so the staff could be more visible in the units. Our hope is that if we do a huge push for education from the beginning, our providers will be prepared because we're teaching consistently.

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

**A** We tailored education to each department's needs, but we also partnered with their leaders to determine the best way to deliver the education and include the leader in delivering the education when possible.

Our most successful approach has been giving them their data. They didn't care about their response and agree rate, or their top five diagnoses. They cared about how they benchmarked against other medical centers. When they saw their benchmarking data and it wasn't what they expected, they took a step back. They said, "Wait a minute—we give great care; we do great things here. Why are we ranked so far below this hospital that we know we're better than?" That really was the turning point for our program.

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

**A** Like many facilities, we struggled with how to leverage the data we were collecting to motivate our physicians. The data that's important to us, as CDI specialists and our CDI program, physicians don't really care about. They don't care about the case-mix index, and they don't care about the capture of comorbid conditions (CC) and major CCs (MCC). That's great for CDI and shows how we're doing, but they care about how they rank for morality, length of stay, quality, and complications against all of these other hospitals.

I had one provider who came to me and felt that pushing CDI education on his staff would overwhelm them, since they are already asked to do so much in addition to patient care. I kept meeting with him and finally showed him his data. He now partners with us and does the

education alongside us for his department. He's a leader, and his residents respect him. He's standing with us, giving examples, and working with us to provide the education that they need for documentation. We need to use data that's important to them and position ourselves by saying CDI can help them get the credit they deserve when their documentation and data is improved—that's what is going to allow us to partner with physician leaders and engage departments in CDI.

**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** We do not have a formal policy that requires providers to answer a query. From the beginning, we set the expectation that a concurrent query needs to be responded to within 24 to 48 hours. Once the 48 hours passes, and the patient is still here, we'll give them every chance we possibly can before escalating up the chain. If it's an intern, we go to the resident; if it's a resident, we might go to the chief resident; and if we're still not getting anywhere, we go to the attending physician. If we have any type of discourse where the resident doesn't agree or doesn't want to answer at all, then we'd go to the program director and let them know.

We try to do everything we possibly can before it gets to that point. So, for example, if the resident that's not responding says they'll get to a query and they never do, either myself or the department manager may contact that person. Face-to-face is better than a text, email, or call. In most cases, that gets it all settled. I've only had to go to a program director about five times since our program started, but the option is there if we need it.



## What is the most effective way for CDI to work with physician advisors to engage with providers?



In the beginning, CDI was still in its infancy, so we decided to structure our program using our chief medical officers and our program directors as the physician advisors. We struggled with whether or not we needed one person for the system, one person for each facility, and what we should do. Over time, we worked with the physician leaders, and it worked well. However, these leaders were only familiar with their specific service. Luckily, we found a physician who happened to be passionate about CDI, so without any formal role we worked with her and recently gave her the title of “physician advisor.” She has done a great job because she’s well-respected. Our providers listened before, but with her

involvement, they take even more notice. Your physician advisor has to be passionate about this, and they have to be well-versed in CDI. You don’t want someone going to your providers who doesn’t understand the goals of CDI and isn’t passionate about how it can improve a facility’s documentation, a physician’s data, and ultimately patient care.

We send out monthly tips to providers with CDI education, and our physician advisor helped us strengthen this effort so that physicians could understand it better, and her involvement gave it more credence. The terminology we use isn’t necessarily how the physicians learned it. Having a physician advisor that understands the clinical, coding, and how physicians think is what pushed our program to the next level and got us to a better place.