Q&A Physician engagement

Clinical Documentation Improvement Week

As part of the fourth annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. **Sam Antonios, MD, FACP, FHM,** *senior administrator of medical information and ICD-10 physician advisor for Via Christi Health in Wichita, Kansas, answered the following questions regarding physician engagement. Contact Antonios at* samantonios@outlook.com.

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

A ***I'm a physician advisor for the CDI team and the advisor for our ICD-10 program.*** I'm also senior administrator of medical information for the hospital. We just rolled out a big go-live with our new electronic health record on June 1 with five hospitals and 25 clinics. That's taken a lot of my time. Previously I also was medical director for UR and did some denials appeals for medical necessity.

In my inbox right now, I have five denials for coders they're asking my opinion on. I help out by looking at denied cases based on coding and try to support the appeal based on the documentation on the chart. I take a look at the case and see if metabolic encephalopathy is justified by the documentation, for example, and if it is, suggest an appeal based on the evidence.

I'm a hospitalist. I work closely with the hospitalist team—and all of the medical staff—but I have a special relationship with our hospitalists. I was doing regular updates and training with them when we were full steam with ICD-10, but that's been put on hold a bit with the delay. I do chart reviews and provide feedback, I do data analysis and identify high-risk areas in need of documentation improvement, and I also help create electronic templates.

I engage with the medical staff through department meetings; in doctors' lounges we'll set up a sign, do a meet and greet with the CDI team, distribute pamphlets, things like that. I also do group training. I go to grand rounds with residents, our surgery residents. We're a nine-hospital system and have two small hospitals I travel to for conferences to go over the importance of ICD-10 and its ties to quality, PSIs, quality measures, and reimbursement under value-based purchasing. I always use that angle of quality when it comes to documentation. I rarely focus on reimbursement. I always make the case that good documentation makes for better capture of the quality of care that is being delivered.

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

A ***It's always a challenge, but we have a robust CDI program that started eight and a half years ago.*** I wasn't here when it started, but we are one of the older programs. We have enough time in town that the medical staff are used to it and have learned over time what it is. It takes a while for physicians to learn what CDI is, what a query is. It's always good to renew that relationship with new residents and new physicians.

My biggest goal is to work with the med staff to explain to them CDI is their friend; that it's there to help them so their documentation is clean and accurate and reflects the quality care they provide. We ask our CDI nurses to round on the floor in order to establish relationships, so the physicians can see their faces

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and know who they are, so it's a collaborative effort. The majority of our physicians now recognize what a CDI query clarification is. There is no magic recipe; it just takes time.

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

It comes when you personalize the education and the discussion. When you actually get personal data, personal CMI, personal CC/MCC capture rate, and talk to the individual doctors at the individual level. It's fine and great to do mass education, grand rounds is great, but it doesn't always reach them. On the other hand, showing CMI compared to the rest of the medical staff spikes the interest of people. It almost doesn't make a difference what data you show—it could be the number of patients seen—it's that comparison to peers and benchmarks that spikes the interest of people. Once you show them that, they come back to you. However, when you think of a medical staff of 900 people, you can't do it all. You have to do some specific targeting—specialties at a higher risk, or certain physicians.

I also go to Healthgrades, show them PSI data and how public data does reflect the hospital to the public, and that if you work in the hospital, it reflects on you. There is no one single best approach; you have to do a little of everything. Some like one on one, some read information on their own, some listen in grand rounds, others don't. Some like the CDI queries and hearing from the CDI nurses. There is no one size fits all.

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

Lack of time is one challenge. Actually, more and more it's how busy clinicians are getting and the competition with what you're trying to do. A typical doc over the last 15 years has to see more patients and do more paperwork and has less and less time. You talk to them about antibiotic stewardship, VBP, ACOs, the EHR, whatever is changing in the hospital from a workflow perspective. There are so many initiatives now, HIPAA, you almost need a whole day with a clinician sitting down listening to all these things. Meaningful use, PQRS, core measures, patient satisfaction, insurance, reducing readmissions. If you count it all, competing for time, and almost everyone has seen a decline in reimbursement, so you have to see more patients in less time. I could talk to them for four hours about all our initiatives—people almost have initiative fatigue. "And by the way, when you're documenting, please do it this way."

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? Can you describe its effectiveness?***

We don't have this—not yet. We're considering it internally, but no policy has been established. We're considering a mandatory training for onboarding physicians as part of the credentialing process, a mandatory course on documentation with orientation, and as part of ongoing CME/OPPE. The new physician assistant coming on is part of our target audience because they do lot of documentation in the hospital.

We have been pretty good with query response—almost a 100% response rate, and our agreement rates are at the highest JA Thomas benchmarks. We do well, but it doesn't mean success lasts forever. The challenges are keeping people up to date, and we're considering expanding CDI to some of our smaller hospitals as staffing allows. We never sit down and relax.

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