

CDI physician advisors: Two MDs share their experiences

A good physician advisor/champion is a boon for any CDI program. An advisor can provide credibility and a much needed physician-to-physician dialogue to help get reluctant doctors on board with a program. But finding the right physician advisor isn't easy. It's critical to define clear expectations for physicians who are busy practicing medicine.

Below, two physician advisors provide their experiences and position descriptions.

Feeling an obligation

When **Trey La Charite', MD**, a hospitalist who specializes in internal medicine and physician advisor for the CDI project at the University of Tennessee (UT) Medical Center at Knoxville, was asked to assume his current role as physician champion eight months ago, he already had many of the desired prerequisites for the job.

"It helps that I already happen to be so anal-retentive in my documentation that I already write more in the chart than most people to begin with," La Charite' says. "I'm sort of notorious for my note-writing."

La Charite' says he accepted the position because he felt an obligation to the hospital and wanted to give something back. "As far as I'm concerned, UT made me the physician that I am," he says.

Selling the benefits

UT selected FTI Consulting to implement the clinical documentation program. FTI recommended La Charite' for the role of physician advisor, provided training, and scheduled several meetings, during which he could meet with various physician groups in the hospital to spread the word about the program. La Charite' provided lectures on how physicians could improve their documentation and demonstrated the benefits of doing so, including how it improves the following:

- » Publicly available quality reporting data
- » Physician pay-for-performance data
- » Facility funding, which in turn provides benefits for physicians, including better equipment and workspace and more staffing

La Charite' explains to physician groups that documentation is a patient-care issue. "In the middle of the night, when

someone crashes, you need to be able to pick up the chart and immediately glean what is going on with this patient at baseline," he says, adding that many physicians don't do this.

Making a time commitment

La Charite's role as a physician advisor requires approximately 40 hours per month and includes:

- » **Developing educational lectures/PowerPoint materials.** La Charite' says he tries to tailor his presentations to certain physician groups to make them more effective.
- » **Creating pocket cards.** These provide physicians with definitions of various diagnoses and appropriate language that coders need to report specific ICD-9 codes, as well as CDI golden rules, La Charite' says.

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- » **Fielding questions from CDI specialists.** UT currently employs three nurse clinical documentation specialists who review Medicare claims only. When they have a question regarding a query or receive denials from physicians, La Charite' assists them.
- » **Participating in weekly meetings.** La Charite' meets with the nurse specialists, the head of medical records, and the coding manager every Wednesday morning to discuss opportunities and difficulties. The meetings are an important part of sustaining the program's momentum, he says.

La Charite' is a salaried UT physician and receives an hourly rate for his physician advisor role. He says his time commitment has been significant in the early stages due to choosing a program direction, creating lectures, and rolling it out.

Each month, La Charite' and the rest of the CDI team receive a CDI dashboard that lists UT's case-mix index (CMI) and CC/MCC capture rates. La Charite' says the results have been promising. A year ago at this time, UT's CMI was 1.6128. In a May report, UT's CMI had grown to 1.8747.

Overcoming obstacles

Despite the programs' early successes, La Charite' continues to encounter physicians who are reluctant to adopt the program. He says physician documentation is specialty-driven: Physicians who already write reasonable notes in the chart (e.g., internal medicine, family practice, nephrology, and medicine-related subspecialties) are generally amenable to a CDI program and can buy in to better documentation practices. However, surgeons are much more difficult to recruit because their documentation is often minimal or nonexistent.

"The general obstacle I've seen so far is surgical services," La Charite' says. "Not only are you asking them to change what they're writing in the chart, you're asking them to document at all, which they don't even do in the first place."

La Charite' says he hopes to have more speciality-specific data down the line to educate surgical physicians and to show the benefits of documenting additional, appropriate documentation that demonstrates the severity of patients' illnesses.

The most effective way to get physicians on board is to show them what they documented in each chart versus what they could have documented based on the patient's clinical indicators, La Charite' says. Including the monetary and profiling effects of any secondary diagnoses also helps support the need for more specific documentation.

"Physicians are completely result-driven, and a lot of times, you don't get responses unless you affect their wallet," he says. "Surgeons, in particular, are very concerned about their report cards, whereas medicine specialists don't really care."

In general, surgeons tend to document only the main problem for which the patient presents for surgery, and they ignore secondary diagnoses and complications, La Charite' says. One idea is to work around surgeons, when possible. For example, UT's neurosurgeons and orthopedic surgeons rarely document in the chart; however, they almost invariably consult with medicine specialists. This latter group has proven receptive to the program and often provides the necessary documentation for the surgical patient's chart.

Finding the right advisor

For existing CDI programs that don't currently employ a physician advisor, La Charite' recommends finding a candidate who has the facility's best interests in mind—which

isn't easy, given the current hospital/physician dichotomy. "Unfortunately, I think there's still a lot of that old mentality where people say, 'The hospital be damned. I don't care if the hospital makes money as long as my patients are taken care of,' which is an outdated attitude," he says. In fact, a hospital where La Charite' used to work officially closed its doors.

La Charite' also recommends finding a physician who is relatively recently trained, aggressive in his or her patient care, and respected by the staff.

La Charite' says clinical documentation supervisors who employ a physician advisor should not expect that the advisor will be a magic pill for the program. "The bottom line is that not everyone is going to come on board, and you need to pick and choose where you are going to place your efforts," he says.

Taking a physician-first approach

James Pappas, MD, MBA, is vice president of quality and patient safety for Loma Linda (CA) University Medical Center. An internist and clinical pathologist, Pappas became medical staff president five years ago. Midway through his tenure, the hospital's CEO put out a request for a vice president of quality and patient safety. Pappas was interested and left his med staff presidency to take the position.

In late 2007, a new recruit under Pappas who had a previous successful experience as a clinical documentation specialist asked Pappas about starting a program at Loma Linda. With help from a consulting firm, Pappas helped sell the program to physicians (not hospital leadership) as a quality initiative. Loma Linda's authority rests with a dean who was extremely supportive of the CDI program—a critical first step in the newly launched program's development.

"That was probably the single most important thing because then he gathered his chairs and said, 'This is required. You must go to this, and your attendings must go to this,'" Pappas says. Nearly 400 physicians turned out for the initial training.

The program, which has been in place at Loma Linda since April, was also pitched as a safety issue. Framing the program in this way helped garner support because the diagnoses that physicians had documented were making them

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look poor on paper, as well as on Web sites such as www.hospitalcompare.com, which compares expected versus observed rates of mortality. “What hit the physicians was when we saw that you could go to the Internet and pull up various Web sites, and compared to other physicians in the same community, we didn’t look very good, when in fact we knew they were darned good physicians,” Pappas says.

Serving as a champion

Loma Linda is a four-hospital system, so Pappas placed a physician champion in each hospital, including two in the university hospital. Each champion, referred to as a multidisciplinary quality committee chair, attended a daylong training session that included coding and documentation education.

Part of Pappas’ role is to follow up with reluctant ordering physicians who don’t respond to queries. “It can be a yes or a no response, but what you don’t want is a nonresponse,” he says. For those departments whose physicians don’t respond to queries, Pappas develops solutions to increase their response rate. For example, surgery hasn’t had nearly as much success as medicine, and Pappas is currently working to help educate that group.

“We had to do that [additional work] with surgery because surgery didn’t get their residents to the education sessions,” he says, noting that Loma Linda’s residents issue 90% of the orders. Pappas says the hospital also employs a large group of residents who began their residency in July. Newly

employed residents can pose a challenge, he says, because they are unfamiliar with the CDI program. “Any place with teaching residents is going to have to reteach that group every year,” he says.

Pappas says a physician champion should be someone who is respected, influential, and well-known in the institution. “It’s not necessarily any particular specialty, it’s more person-dependent,” he says. “That’s what works here really well.”

Pappas says his role as physician advisor was initially time-consuming due to several kickoff meetings when the program began. However, he opened a clinical documentation section within the quality improvement department and has since received assistance from a clinical documentation nurse specialist who provides most of the physician education.

“[The time commitment] varies, based on the size of your institution and how well-functioning your CDI department is,” Pappas says. “At first, it was a sizable chunk of my day, but now, it’s starting to take off on its own.”

Pappas is salaried by the hospital as its vice president of quality and patient safety, a position that includes his duties as a physician champion. The other four hospital-specific physician champions are paid 40 hours per month of their particular specialty’s hourly pay.

Loma Linda’s three CDI specialists review 60%–70% of all Medicare claims. The hospital has also given approval for the addition of a fourth specialist due to the early successes.

“The financial benefits have been profound in the short-term,” Pappas says, noting that the cost of the consulting firm has already been paid for. ■

Respiratory failure: Recognize clinical indicators and query opportunities to capture this difficult diagnosis



by William E. Haik, MD

Respiratory insufficiency. Hypoxemia. Respiratory distress. Its names are numerous and, unfortunately, often result in nonspecific codes and inaccurate DRG assignment. The offender: respiratory failure.

Respiratory failure is problematic for CDI specialists and coders for several reasons, including the following:

- » Definition (confusion about what constitutes respiratory failure)
- » Sequencing (when to sequence respiratory failure as a principal diagnosis)
- » Documentation (how to combat insufficient or nonspecific documentation that includes terms such as respiratory insufficiency, hypoxemia, and respiratory distress)

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