

Roll out an engaging CDI program

Teach physicians to work smarter, not harder, and for their own benefit

WHITE PAPER



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● *Editor's note: This is the second article in a two-part series. Part one discussed ways to sell your CDI program as a quality initiative, with physicians as partners. Part two of this white paper focuses on methods to engage physicians in your CDI program.*

Hospitals in a rush to implement a CDI program risk alienating the very physicians they rely on as indispensable partners. In their eagerness to see an immediate return on investment, administrators often whisk a nurse or other CDI professional onto the floor without adequately explaining the concept of the program to physician staff members, says **Glenn Krauss, RHIA, CCS, CCS-P, CPUR, FCS, PCS, C-CDI**, senior coding and charge-master consultant at QHR in Brentwood, TN. The CDI specialist, feeling the pressure to perform to expectations, may place queries in the record without context or explanation. The result is frustrated physicians who are hesitant to participate or who altogether refuse to support the CDI specialists' efforts.

Before a single query hits the charts, sell the CDI program as a medical staff leadership initiative. Don't pitch CDI as a hospital administration request, since physicians often don't see eye to eye with administrators. Kick off your CDI program with a formal presentation to promote the concept to the physician staff. Use a trusted member of the medical staff who recognizes the value of good documentation as a physician champion. Ask for his or her help in this presentation and include him or her in your ongoing education efforts.

"To have lasting impact and affect behavior modification, you need to have a physician to sell how good documentation can affect their practices and profiles," says **Gamal Eskander, MD, MSPH, C-CDI**, medical director at Perimeter Medicare Care in Cookeville, TN, and clinical instructor at Vanderbilt University Medical Center in Nashville.

To launch a successful CDI program, hospitals must develop an engagement plan and involve appropriate departments and personnel. Eskander recommends the following rollout plan:

- **Establish hospital needs.**
- **Identify stakeholders.**
- **Gain support of administration and physicians.**
- **Select key supporters and involve them in quality management.**
- **Identify a physician champion.** Select a champion who is accepted and perceived as a leader among the physician staff. Many facilities offer the CDI physician champion a stipend for his or her part-time/

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per-encounter efforts, whereas other hospitals hire physician champions dedicated full-time to the program. Regardless of the arrangement, Eskander suggests appropriate reimbursement for the physician champion's efforts.

- **Develop query forms with physician support.** These should be clear, concise, and make sense to the physician. The best way to ensure that your forms are useful and practical is to ask physicians to help create them. Develop forms by department—for example, involve your nephrologists when developing queries for acute renal failure, cardiologists for CHF, and pulmonologists for acute respiratory failure.
- **Establish query credibility.** A good way to make queries meaningful is to develop standard definitions of diagnoses such as acute renal failure with the input of your medical staff. “Try to develop a reasonable standard so that CDI specialists have a baseline for queries and physicians know why they’re asking,” Krauss says.
- **Develop methods to track your program’s success.** Too many hospitals focus on case-mix index (CMI) alone, which isn’t always an accurate measure of a program’s success, Krauss says. “You can’t control the number of patients who come in, physicians coming to and leaving the hospital, or declining surgeries due to the economic climate—these all impact the case mix,” he says. Consider analyzing DRG ratios in addition to tracking CMI. “Look at specific DRG pairs or triplets every month to monitor movement in specific ratios as a means of identifying positive trends and results of the CDI [program],” he says.
- **Provide continuing medical education for the medical staff, preferably by the local attending specialist.** The clinical specialists in the hospital (e.g., cardiologists, nephrologists, neurologists, and pulmonologists) can provide educational inservices focusing on advances in treatment of various disease processes, while incorporating clinical documentation considerations into the educational process.
- **Provide feedback to the medical staff.** Report your improvement or areas in need of improvement in quarterly meetings, Eskander says. For example, show physicians the case mix of their monthly discharges. “If their CMI drops from the previous month, ask them what may have happened that month and ask what you can do to help them document appropriate severity,” Krauss says. CMI is an especially important statistic for those physicians whose contracts with the hospital are based on the acuity of care they provide.

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When implementing a program, hospitals should incorporate the quality framework espoused by the Institute for Healthcare Improvement (IHI) in its white paper *Engaging Physicians in a Shared Quality Agenda*, Krauss says. The white paper provides the following six structured frameworks for engaging physicians in hospital quality initiatives:

- Discover a common purpose
- Reframe values and beliefs
- Segment the engagement plan
- Use engaging improvement methods
- Show courage
- Adopt an engaging style

Note: Part one of this white paper series explained how to discover a common purpose and reframe values and beliefs in the context of a CDI program. In the following pages, this paper covers strategies for segmenting the engagement plan, using engaging improvement methods, showing courage, and adopting an engaging style.

Segment the engagement plan

In an ideal world, CDI programs would give equal weight to each payer and leave queries based solely on discrepancies, conflicts, or incomplete documentation in the medical record.

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- But economic pressures and staffing restrictions are a reality. With limited staff members, many CDI programs cannot review every record and must prioritize. New CDI programs need to justify the program to hospital administration. These programs typically choose to focus on Medicare patients, who are older and sicker and therefore result in greater financial rewards for the hospital.

Such restraints push CDI programs to focus on Medicare chart reviews. But should you also narrow the scope of your reviews by targeting certain major diagnostic categories (MDC) or particular diagnoses? The answer depends on what your most pressing problems are, Krauss says. For example, are your medical records lacking diagnoses completely? A typical progress note might say only, "Patient doing better, progressing fine, condition improving, see orders," and not mention any chronic conditions. Are certain departments meeting benchmarks for CC or MCC capture rates, while others, such as surgery, are lagging behind?

Conduct a DRG analysis to determine your CC and MCC capture rates by department, as well as your case mix within each individual MDC. Such analysis provides benchmarks for improvement and allows you to focus educational efforts on departments and individual physicians with the most room for improvement.

Avoid focusing on certain MS-DRGs, Krauss says, since this strategy raises physician and compliance concerns about the CDI program. It makes it seem as though the CDI program acts primarily as a mechanism to collect money for the hospital. As such, physicians will quickly resist CDI efforts, he says.

"Physicians are not interested in hospital payment," Eskander says. "They're interested in, 'What is there for me, how can I improve my quality profile, and how can I provide quality medicine?'"

The following are other problems with an MS-DRG–focused program:

- It's difficult to determine a working MS-DRG based on a census, since provisional diagnoses documented in the emergency department or entered by the registrar are frequently incorrect.
- Focusing on high-dollar diagnoses such as sepsis could potentially open up greater scrutiny by recovery audit contractors (RAC) and other safeguard contractors such as the Comprehensive Error Rate Testing contractor, fiscal intermediaries/Medicare administrative contractors (MAC), and zone program integrity contractors.

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- Ideally, Krauss recommends that CDI programs develop a process for efficient chart review and simply start looking at records, regardless of the working MS-DRGs into which the cases may fall. "Open up the record, and if something is missing, query the physician," Krauss says. "The more cases you look at, the more you learn, and the more impact you have in affecting positive change in physician patterns of clinical documentation."

If a diagnosis affects severity or acuity but may not affect the final MS-DRG, it should still be clarified through a query. However, don't take it to the extreme, since focusing on minute details can turn off physicians. "The point of diminishing returns must be clearly established and followed before the start of the program," Krauss says.

Many hospitals' CDI programs never get on track because they start with baby steps, Krauss says. Some programs look only at certain records of certain physicians, who then perceive the effort as piecemeal and not worth their attention. CDI specialists should consider themselves business people and chart reviews their business, Krauss says. From day one, they should throw themselves into the process, since that's what new businesses do. "If I say to you, 'We don't expect you to run your business very successfully for the first six months,' do you think as an entrepreneur that person is going to stay in business?" he says.

When implementing a CDI program, Eskander recommends that hospitals start with the most common reasons for admission, such as CHF, acute CVA, COPD, and pneumonia. Once physicians improve their documentation of these diagnoses, introduce more in-depth topics. "No physician can learn all the MS-DRG changes in a short period of time, so focus on certain areas and work with them until they master their skills, then take them to a higher level," he says.

Use engaging improvement methods

A CDI program cannot succeed without physician participation, yet hospitals face the seemingly insurmountable problem of engaging physicians whose payment is not tied to that of the hospital.

Despite the obstacles inherent in the current separation of Part A (hospital) and Part B (physician) reimbursement (CMS is working on bundling

reimbursement of hospital and physician services into a single payment, but the industry is far from reaching a resolution), Eskander says CDI specialists need to find creative ways to engage physicians in a CDI initiative.

Many physicians will immediately recoil from CDI programs, fearing that they will have to spend additional time documenting. But that's not necessarily the case. Krauss has reviewed documentation of professional E/M services that was 10 lines or more in length, with no reportable diagnoses—documentation that would not stand up under scrutiny from a reviewer.

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This is a teachable moment, Krauss says. Reinforce to the physician that accurate documentation of the services rendered for the patient's needs determines the level of E/M code, not the volume of documentation. "That is why the thorough documentation of the patient's condition, the services rendered, and the reasons for those services [are] so important," Krauss says.

Explain to physicians that they do not need to change how they practice medicine—they simply need to document the care they provide in a more efficient manner. "What we're trying to tell physicians is that the severity of illness should be proportional to the intensity of service, which is proportional to the consumption of resources," Eskander says. "The best way to justify intensity of service and consumption of resources is to document the severity of illness."

Most CDI specialists will be lucky to have two or three minutes of face-to-face time on the floor with the physician, so when performing verbal queries, cut to the chase and ask simple, direct questions. If a record has two or three places in which a query may be appropriate, prioritize. Ask only the most important question verbally and handle the remaining inquiries in a written format.

If physicians don't agree to use terminology such as "acute," show them references from trusted sources such as *Harrison's Principles of Internal Medicine*, Eskander suggests. For example, it defines acute renal failure as a 50% increase in the patient's creatinine level from baseline. "Physicians are reluctant to use those terms, and that's why physician education is very important," he says.

When you put together your CDI program pitch, stress how good documentation affects a physician's wallet. The reasons may not be immediately apparent, but they exist. For example, Krauss says improving the specificity of diagnoses such as CHF, acute respiratory insufficiency, and pneumonia helps physicians' E/M leveling by securing documentation of medical necessity, which is the necessary precursor to selecting the correct level of service.

“The nature of the presenting problem and the specificity and acuity of the diagnoses being managed are always the governing factor of the assigned E/M code under CPT,” Krauss says.

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- Stress other benefits such as improving physicians’ profiles and maintaining economic credentialing to gain their support (see Part I of this white paper, “Instill a culture of quality to ensure CDI success”). Cite increased scrutiny by RACs and MACs in the physician office setting as another incentive to improve documentation, Eskander says. “In my office, I get a request from the MAC once a month at least, making sure the level of service is comparable to the severity of illness and what I documented,” he says.

Show courage

Every hospital has its outlier—a physician who simply refuses to participate in a CDI program, regardless of how compelling you make your pitch. Eskander says the typical profile for these physicians is as follows:

- Practicing for 20-plus years
- Bombarded by regulations
- Close to the end of their career

It may be tempting to work around such physicians. However, because they have typically been in practice for a long time, they are often heavy admitters to the hospital. CDI programs can’t afford to ignore the volume.

The only way to deal with such physicians is to reach a compromise. Eskander recommends assigning a hospitalist or other mid-level provider to the physician. You can then require this person to be responsible for the physician’s documentation.

A visible and engaged physician champion can help decrease the likelihood or number of nonparticipating physicians. When you develop your physician advisor’s/champion’s job description, include a provision that he or she be responsible for working one-on-one with problem physicians. (ACDIS members may view a sample physician champion job description at the association Web site. Visit www.cdiassociation.com and click on the Forms & Tools button.)

More than respect or professional gravitas, the IHI recommends that physician champions have the courage to speak up against reluctant physicians. “No personal characteristics are more important than both the courage to speak up when the project is about to be paralyzed by one physician’s objections, and the social skill to be able to use one’s voice effectively,” the IHI states.

This champion can also review unanswered query forms in an attempt to discover the root of the problem. Some problem physicians may not like the way CDI specialists write queries and would answer them if they were worded or presented differently.

If these measures don't work, Eskander says the only approach is to work with the medical staff and discuss the suspension of the physician's economic credentialing status.

Adopt an engaging style

Some CDI programs spend too much time on problem documentation and nonresponsive physicians at the expense of rewarding or recognizing physicians whose documentation has improved. Remember to reward physicians for their good work and provide them with positive incentives for participation.

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- Establish an award for physicians—for example, a monthly “excellence in documentation” honor. This plays into physicians’ competitive nature. Ask coding and CDI staff members to select a winner, and reward this person with a gift certificate to the movies or a restaurant. Publicize the award in the physicians’ newsletter or physicians’ lounge with the physician’s photo and a brief write-up.

The IHI recommends that you make physician involvement visible. “Not all physicians need to be involved at all stages, but if they do not know some physicians have been part of the process from the beginning, they will not be as accommodating to the proposal presented to them,” the IHI states.

An easy way to show physicians participating is by celebrating their success. “It’s not the amount of money, and we’re not patronizing them, it’s the fact that physicians are recognized,” Krauss says. ■

Editor’s note: Engaging Physicians in a Shared Quality Agenda is free but requires registration. Go to www.ihl.org/ihl and register at the top of the page. After you are registered, click the Products link at left to download the white paper.

Citation

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Use teaching moments to show physicians what's in it for them

A CDI specialist can use a moment on the floor with a physician to not only ask an appropriate query, but to help the physician understand the importance of good documentation.

The following case study demonstrates how a CDI specialist can use a moment on the floor with a physician to not only ask an appropriate query, but to help the physician understand the importance of good documentation in their own profession, provide education, and help ensure his or her support for the CDI program.

An elderly woman is admitted to the hospital with shortness of breath. Clinical signs and symptoms include an ejection fraction of 35%, 36 breaths per minute, accessory and abdominal muscle use, and blood gases showing the patient is in respiratory acidosis. The patient's PCO₂ and PO₂ are in the 50 range. The physician administers two doses of IV Lasix (80 mg) and writes an order to put the patient on 15 liters O₂ to maintain oxygen saturations above 85%.

The treating physician documents "Dyspnea, was unable to obtain a good H&P" and "acute respiratory insufficiency." She also documents "CHF."

Although most CDI specialists would simply query the physician for acute systolic CHF and acute respiratory failure, these scenarios are a good opportunity to help physicians with their billing and/or profiling, says **Glenn Krauss, RHIA, CCS, CCS-P, CPUR, FCS, PCS, C-CDI**. In this instance, Krauss asked the physician how much time she spent with the patient. The physician said she spent about an hour and a half. He also asked whether the patient had a life-threatening illness. She said yes.

Krauss explained that this encounter could potentially meet the qualifications for billing a critical care E/M level (CPT codes 99291–99292), of which the physician had not previously been aware. He quickly explained the documentation requirements of critical care (minimum 30 minutes of face-to-face time and life-threatening illness). Krauss also explained that the nonspecific diagnoses she provided would not allow her to bill a critical care level, but that improved documentation reflecting the patient's true severity of illness would. The physician was grateful for the brief lesson—and much more likely to answer future queries.

"The outcome is the same, but the approach you use to get there makes the difference," Krauss says. "If you play by the rules, it's a win-win for everybody."

If a CDI specialist is perceived as a physician advocate, he or she will be well received by the physician staff and therefore improve query response rates. "It makes the mission much easier and more successful," Krauss says.