

## PROACTIVE CDI: TACKLING THE PROBLEM OF PHYSICIAN ENGAGEMENT

Leadership research survey indicates that improving documentation at the point of entry requires a blended approach and staff commitment



## The Participants



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A membership survey issued by ACDIS put into numbers what is probably no surprise: The No. 1 problem facing CDI departments nationwide is physician engagement. Some 57% of the respondents to ACDIS' 2019 membership survey cited physician engagement as their top challenge. While many familiar solutions are often discussed—newsletters, tip sheets, educational sessions, organizational clinical definitions, and the like—not every physician responds the same way to the same educational techniques. Some respond best to quality or financial data, others to emotional appeals or impact on patient care. Physician engagement is as much art as science.

Many organizations still practice CDI reactively, sending out queries without providing context or the “why” behind the clarification. As a result, physician documentation practices at these organizations might not change over time; worse, burned-out physicians might grow jaded and less apt to answer queries or respond to new initiatives. Fortunately, there are many solutions to the issue, including tailored service line education, CDI educators, computer-assisted physician documentation (CAPD) tools, and user-friendly EHR modifications and prompts.

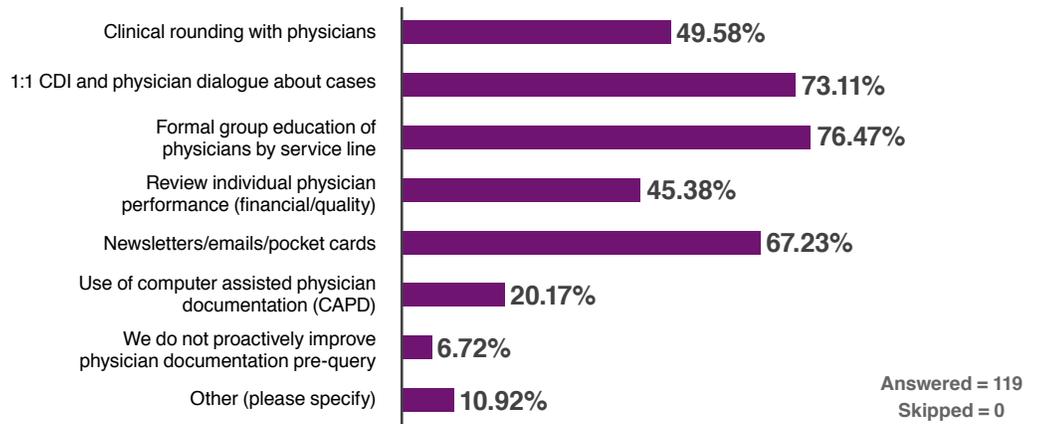
CDI leaders (supervisors, managers, and directors) implementing these physician-friendly tools, prompts, workflows, and education must be willing to rethink the mindset of CDI—to no longer view it as a productivity game with chart review volume as the principal metric of success. We asked seven CDI leaders to evaluate the results of a nationwide CDI Research Series survey on proactive CDI and discuss their best practices in moving CDI from a reactive (query-driven) model to a proactive physician engagement model. Following is a review of the survey and a summary of that discussion.

### Engagement methods

The 119 respondents to the 2019 CDI Research Series survey were asked to describe their efforts to proactively improve physician documentation prior to the query/clarification process. The most common tactic is conducting formal group education by service line, with 76% of respondents indicating that they employ this strategy. Some 73% of respondents engage in 1:1 CDI-to-physician dialogue about individual cases, while the third largest bucket (about two-thirds of respondents) use newsletters/emails/pocket cards as educational tools and daily reminders. See Figure 1.



**Figure 1.** Please indicate your efforts to proactively improve physician documentation, prior to the query/clarification process. Select all that apply.



Less common but still valid strategies include clinical rounding, with just under 50% of respondents asking staff to perform this function. Some 45% of respondents review individual physician performance (financial/quality) and use the data to support changes in documentation habits.

Only 20% of respondents to the survey presently use CAPD. And a small minority (7%) do not improve any physician documentation pre-query.

The CDI program at Boston’s Brigham and Women’s Hospital recently experienced success developing documentation templates for its preoperative center, focusing on surgical preoperative notes, says Deborah Jones, RN, MSN, CCDS, director of CDI at the organization. Nurse practitioners (NP) typically formulate the history and physical, and CDI specialists worked with the NPs to modify their templates. The goal of the strategy was to improve the up-front capture of chronic conditions such as history of COPD, CHF, and CKD.

Abby Steelhammer, MBA, MHA, RN, director of clinical documentation excellence for Novant Health in North Carolina, experienced similar success educating her organization’s women’s services team, including labor and delivery nurses, its physician champions, and close collaboration with the service line’s clinical excellence director. The CDI team also leveraged its organization’s Epic experts to enhance documentation templates in the system’s EHR, which has helped increase accuracy and streamline secondary diagnosis capture.

Novant also incorporates case studies of actual physician documentation with educational offerings to demonstrate where gaps typically occur. The organization employs a standard case study format with organizational



branding and consistent messaging to promote consistency and capture physicians' attention. A second-level review team finds complex cases that make for interesting teaching points, and a dedicated CDI educator helps facilitate the education and targeted use of case studies systemwide.

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— Colleen Garry, CDI Director, Beth Israel Deaconess Medical Center

Joy Coletti, BSN, RN, MBA, CCDS, system director of CDI for Memorial Hermann Health System in Houston, says her organization has seen strong early success with registered dietitian templates that allow for easy reporting of ASPEN malnutrition criteria. These templates are then routed to the attending physician for review and co-signature. Beth Israel Deaconess Medical Center employs the same process and has also found success.

The most impactful tool for Beth Israel’s CDI program is its quality benchmarking database, says Colleen Garry, RN, BS, CDI director at the organization. This database provides meaningful data on physician performance, including high-volume surgical DRGs, which CDI staff can deliver prior to service line and subspecialty meetings. Beth Israel has experienced the best buy-in from its cardiac surgery team and the mid-level providers and advanced practice providers in that unit, as well as its colorectal surgical unit.

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### **The power of data**

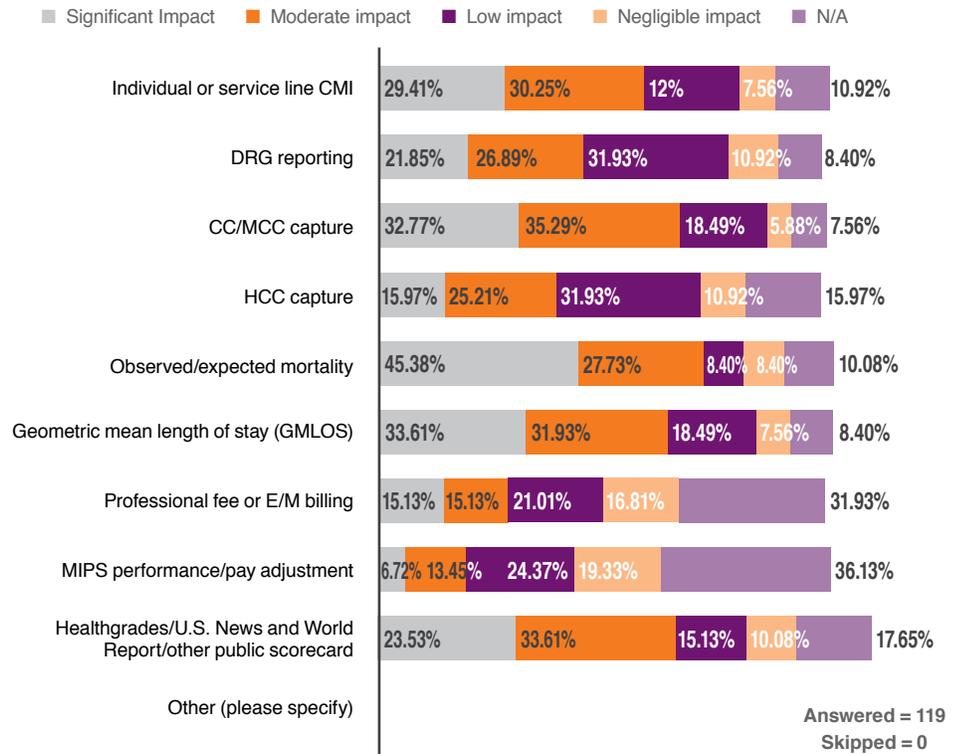
Indeed, according to survey respondents, observed/expected (O/E) mortality data makes the largest impact on their organization’s physicians, with 45% describing it as a significant source of physician buy-in and another 27% describing its impact as moderate (see Figure 2).

Geometric mean length of stay (GMLOS) and CC/MCC capture ranked more or less equally, with 33% of respondents describing each as providing significant impact when shared with their physicians. Some 35% described CC/MCC data impact as moderate, compared with 32% describing the impact of GMLOS as moderate.



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**Figure 2.** Of the following data types, reports, etc., please indicate how they each impact your organizations’ physicians, when used to ensure buy-in to CDI efforts.



Healthgrades/*U.S. News and World Report* data also rated highly, with 58% of respondents reporting that these public sources of data deliver significant or moderate impact when shared with their physicians.

Jones says her hospital hovers in the top 20% of the top 100 hospitals in *U.S. News and World Report* and is always looking to move up in these coveted rankings. “What we have identified is that CDI can impact these scores through improving documentation of expected mortality, which is one of the main points we share with [physicians],” Jones says.

Ranking comparably to these public data sources is individual or service line CMI, with 59% describing these as possessing significant or moderate impact.

“Truly, data speaks,” adds Deanne Wilk, BSN, RN, CCDS, CCS, CDI manager for Penn State Hershey Medical Center in Hershey, Pennsylvania. “We started seeing a big jump in our buy-in when we started sending monthly data to the docs. They really do care about patient quality and patient care concerns in the data. That’s where CDI is moving to.” Wilk notes that physician engagement jumped when the organization’s physician advisors started



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rounding, attending huddles and interdisciplinary/patient safety meetings to discuss how various diagnoses impacted patient care.

NYU Langone Medical Center wanted to ensure the data it used to evaluate physician performance was accurate and reliable. The organization desired an “apples to apples” comparison to ensure that surgeons managing patients without a procedure were not being evaluated against surgical DRG-driven benchmarks, for example.

CDI managers at NYU Langone worked for two years to hire a dedicated CDI data analyst with the expertise to source and create accurate reports. The investment paid off: NYU Langone now has a custom dashboard with reliable metrics, including CC/MCC capture rate, expected length of stay, and expected mortality, says Briggs Strelow, MD, CCDS, associate director of CDI for the organization. Improving physicians’ O/E ratio—with a message that this can be done by improving their expected rate of mortality and driving down the denominator—resonated strongly.

“We’ve gotten a lot of cooperation from different departments who now request quarterly scorecards,” Strelow says. “The department heads will look through everyone’s data and they will meet with individual providers on their team, and then bring us in to discuss where the opportunities are with that specific provider.”

When opportunities for improvement are identified, the key to changing behavior is helping the physician improve his or her unique documentation workflow, not implementing a top-down, one-size-fits-all approach, Strelow says. This may involve becoming “EHR support” and getting comfortable sharing screens in close proximity with the provider.

“I know CDI doesn’t really like to take on being elbow support for IT, but if we want to get the documentation we’re asking for, our chief quality officer always says that we’re ambassadors of the problem list and we’re ambassadors of Epic provider use,” he says. “We sit down with the providers one-on-one and ask them, ‘Go through your typical workflow on this patient,’ and I



will identify where along that path we can squeeze in something to get what we're asking for, rather than asking the providers to do something completely different and assuming everybody does everything the same way.”

Beth Wolf, MD, CCDS, CPC, medical director for HIM at Roper St. Francis Healthcare in Charleston, South Carolina, and physician consultant for 3M Health Information Systems, agrees. “We have put significant resources into educating on the ‘why,’ and we are seeing the ‘how’ becoming a larger barrier to CDI success. Documentation workflow engineering that coordinates the needs of quality, case management, compliance, and revenue cycle is where CDI has opportunity to align with physicians,” she says. “We [CDI] are in a unique position to recognize, facilitate, and show return on investment for solutions—whether it is time-saving templates, problem list improvements, scribes, nurse practitioners in the preop clinic, or at-the-elbow support.”

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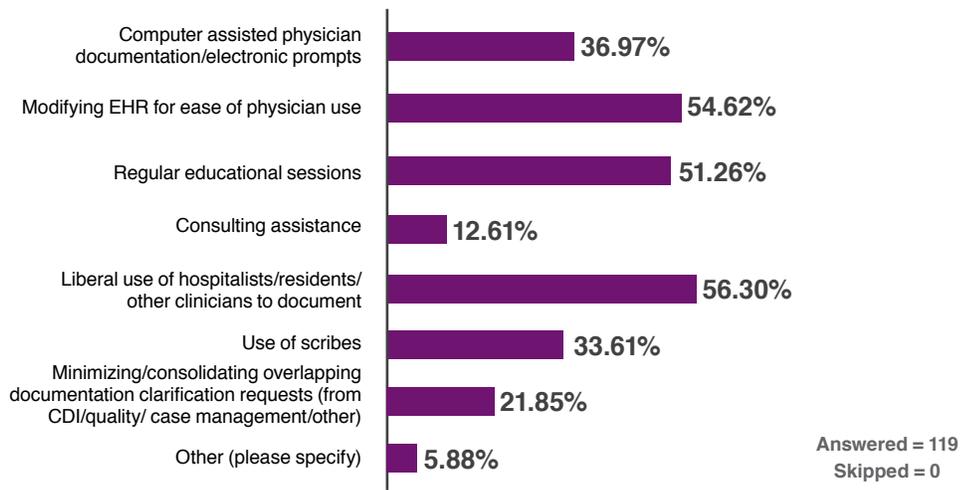
Compared to the above sources of data, MIPS and E/M billing data performed poorly. Only 15% of respondents indicated that professional fee or E/M billing reports made a significant impact with their physicians, with another 15% reporting that data as moderately impactful. MIPS performance and its corresponding pay adjustment performed even worse, with only about 7% reporting these as meaningful sources of data and 13% describing them as moderately impactful.

### **Tools, extenders to the rescue**

Respondents to the 2019 CDI Research Series survey described enlisting a variety of tools, services, and processes to ease the documentation burden on their organization’s physicians. Most organizations reported leveraging hospitalists/residents/other clinicians to document in the chart (56%). A few years ago Roper St. Francis did not have a large extender presence, says



**Figure 3.** What tools, services or support do you use to ease the documentation burden on your organization’s physicians? Select all that apply.



Wolf, but now the hospital’s numbers of physician assistants and NPs have exploded, providing documentation support to ease the burden on surgeons and proceduralists.

An equal amount of respondents reported modifying their EHR (55%) to help their physicians’ documentation burdens. About half of respondents use regular educational sessions, while a third use scribes—professionals who work at the elbow of physicians to enter documentation at the point of service, which the physicians often dictate.

Some 37% reported using some form of CAPD or automated physician-facing prompts (see Figure 3). NYU Langone rolled out such a physician-facing tool in the H&P, a table of common conditions that are often underreported and are frequent subjects of CDI queries. Although the tool supported the prompts with clinical indicators from the record—GFR scores, for example, along with a prompt asking whether the patient may have AKI or CKD—the organization ran into some early obstacles.

“Sometimes it was a resident who always said no, and the attending would attest the H&P and not comment on anything that was in there,” says Strelow. Queries increased as a result of having to clarify such conflicts. “But now that it’s settled down, we have seen a tremendous increase in diagnosis capture, and our team is able to focus on other things like querying for quality indicators,” he adds.



### Proactive CDI professionals

Survey respondents also weighed in on efforts to make their CDI staff more focused on proactive approaches to documentation improvement, specifically efforts to prioritize review efforts. Results varied widely.

Only 23% of respondents stated that they have no need to prioritize because they review 100% of cases, a clear indication that most CDI departments cannot touch all records due to a lack of staff and/or technology. Only 11% do not prioritize at all and get to “whatever cases (they) can.”

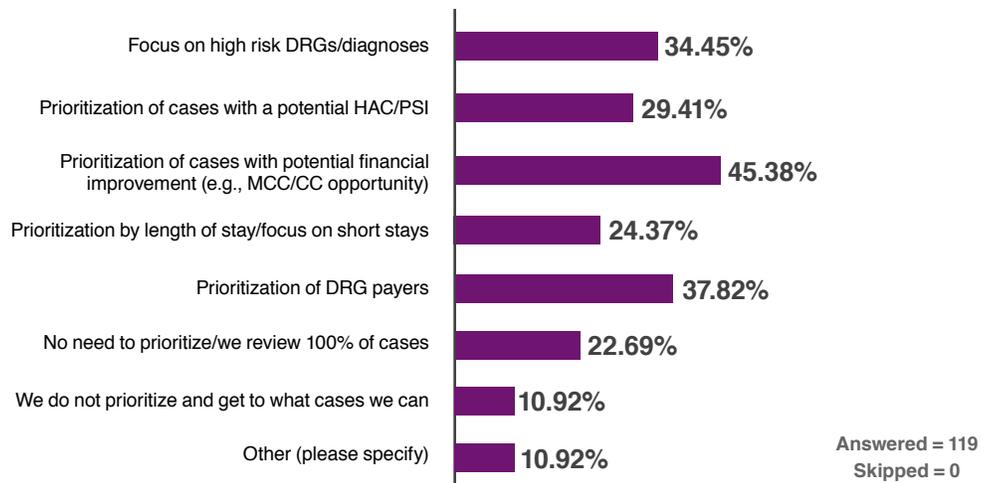
The largest group of respondents (45%) reported prioritizing cases with potential financial improvement, with the next largest group (37%) prioritizing DRG payers, and the third largest group (34%) focusing on “high risk” DRGs/diagnoses.

Less common prioritizations included cases with potential HACs/PSIs (29%), or cases with an excessive length of stay or short stays (24%). See Figure 4.

With 77% of respondents indicating that prioritization is needed, but a wide dispersal of efforts, some panelists believe that technology has yet to fulfill its promise and potential. “It truly is a reflection that our CDI software programs are not good at prioritizing,” Wilk says. “We need to get to where the impact can happen. We lack the ability to truly identify and analyze where the impact can occur.”

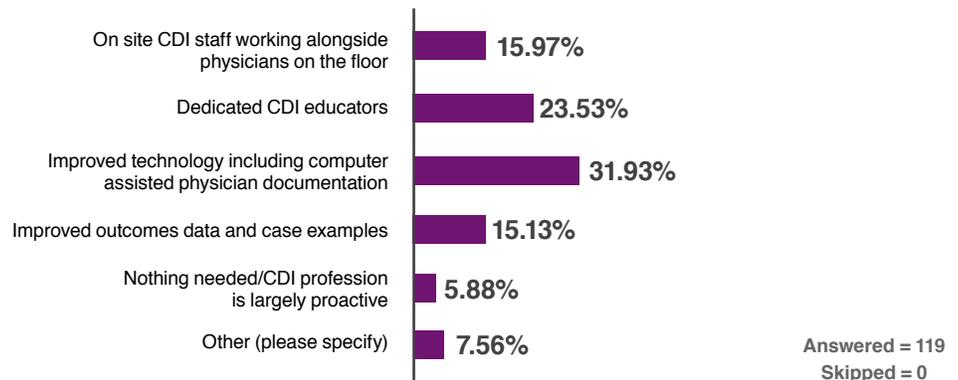
Survey respondents were asked to speculate on what the industry needs in order to move CDI from a reactive, query-driven process to one that is proactive and conducted at the point of documentation. The clear winner (32%)

**Figure 4.** Please indicate your efforts to prioritize your CDI staff’s review efforts. Select all that apply.





**Figure 5.** What does the industry need in order to move CDI from a reactive (query driven) to a proactive/point of documentation effort?



was improved technology, including CAPD. Dedicated CDI educators ranked second at 24%, while 16% proposed greater clinical integration with on-site staff embedded on the floor alongside physicians (see Figure 5).

Garry asks her staff to track educational time with providers and considers that time well spent.

“We’ve got to move away from these old metrics and toward impact metrics,” Coletti says.

Only 6% of survey respondents said that nothing was needed, indicating that there is still much work to be done to improve the efficiency and physician friendliness of proactive CDI efforts.

All panelists agree that the CDI profession is much more than maximizing record review productivity, and its future is one of clinical integration and provider education. Instead of charts reviewed, Steelhammer says, the true metric of CDI success is overall positive trends in organizational data. “That’s truly where we need to focus,” she says. “If you focus on those old metrics, you feel like the hamster in a wheel.”

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