

**Q&A** **CDI WEEK** 

**Fostering physician engagement**

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As part of the second annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. **Michael H. Baumann, MD, MS**, the chief quality officer for University Hospitals and Health System at the University of Mississippi Medical Center and an actively practicing pulmonary and critical care physician, answered the questions below about fostering physician engagement. Contact him at [mbaumann@umc.edu](mailto:mbaumann@umc.edu).

**Q** *What are some of the reasons why some hospitals have such a hard time getting their physicians to answer queries and participate in CDI initiatives?*

*There's not any one answer—it's usually multi-faceted.* One is the culture of the physicians. They don't understand the CDI program. Also, many physicians aren't taught to be team players, and they don't understand that being a part of a CDI program is being part of a team, often older physicians more so than younger physicians. They feel that [CDI and queries are] questioning their ability.

Number two, it's the issue that physicians are taught one language, and billing/coding and documentation is in many respects a completely different language. We're trying to join two different languages. My favorite example is urosepsis. We're taught that in medical school, but it's not a codeable diagnosis. You need to teach "sepsis due to a urinary tract infection."

So you combine the problem of the culture of team players with a whole different language and it makes it tough to sell. It comes down to how well you've rolled out your program.

**Q** *What is the best method you've used to get physicians on board with your CDI program?*

*One of the things that works well is having a physician champion.* Not just one, but groups of champions. It helps bring the CDI message to other physicians. Physicians, rightly or wrongly, like to hear information from another physician—and then for some reason they'll believe it.

At our facility we've added a fairly large medical director program and we're tapping into them for help. A medical director just yesterday was helping translate documentation to his peers in the ICU. It also helps in his case that he's a pretty articulate, imposing guy. As people get to trust him, they get to trust the program, and then you get the buy-in. We call our CDI specialist nurses the "green sheet ladies" (due to the query forms they leave) even though we've gone to EPIC, but now we need less and less queries because the physicians have bought in and understand what the role of CDI is.

We've also helped the physicians with their data, doing data mining for them and educating them on their mortality index and things of that nature. One of our neurosurgeons had less-than-optimal mortality ratings, but it wasn't a mortality problem,

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it was due to a lack of documentation. The O/E ratio (observed to expected deaths) in our database has improved as our documentation improved. With such success, then they're more willing to listen when you're talking to them about something else. Also, some of the docs in an academic medical setting understand that the better the documentation, the better the reimbursement for the hospital, and that there can be a legitimate funds flow from the hospital to departmental support. In other words, if the hospital's bottom line is better, that piece of equipment you needed in the cath lab, for example, can be purchased.

outcome/sentinel event occurs, physicians begin to understand very intimately how much their documentation means when they have to sit before the risk committee and explain an outcome, or during a root-cause analysis when they're explaining an outcome. The better the documentation, the easier it is to explain what was going on. Also, from a very palpable standpoint, if they ever end up on the stand—i.e., in a litigation—they understand quickly the value of good documentation.

We're moving more and more to pay-for-performance model, so in the future answering queries will potentially be part of physicians' pay-for-performance measures. They don't have to agree with the query, but they have to answer it. Our goal is 100% compliance with at least answering the query. So if you are or are not compliant within a reasonable threshold, that could be used as a carrot and a stick, respectively, in the future. Because if you comply, you get some type of remunerative reward, and if you don't comply, your payment may not be as good. But by and large, the balance should be more on the positive side than the negative.



***Can you explain how effective documentation benefits not just the hospital, but the physician as well?***

***In an academic environment—and this may be different than a community-based hospital—if you improve your bottom line for the hospital, those dollars in various legal ways (legal gainsharing) can actually come back.***

Not directly into the physician's pocket, but to their program, and basically make their program better and make it more fun to be doing what they're doing.

The other way it helps is that the better they document, the better we can do service-line analyses. So with orthopedics, for example, how well they document in their H&P improves their mortality statistics, resource use, and length of stay statistics because we have better data to provide them for improvement efforts. So when we're working with them on an improvement project, we know what we're working on is more spot on because the documentation is better. That's true of any hospital, whether it's academic or community based.



***How do you handle very difficult physicians that refuse to listen or answer queries?***

***In our hospital system we take the tack that we really want everyone to play ball.***

Similar to our EPIC/EHR system that was just deployed, you can either be a part of EPIC or you can find a new job.

We're definitely not quite as forceful with CDI, but we've taken the approach that we want everyone to do this. Recalcitrant physicians we work with—we don't ignore them. We work with our medical directors to have direct conversations with them. Occasionally I have direct conversations as the chief quality officer.

I don't know of any case that has moved up to what I call the "master of disruptive behavior," our chief medical officer, the man who frequently manages our physicians with adult aberrant behavior. But we would not have a problem escalating to him if we really had a problem. CDI is part of our programmatic change of physician culture here; it's part of what we're doing here to improve our overall care. You have to have a system where you hold people accountable. You can't shy away from difficulties. It's what I call the "broken glass theory." The way New York turned itself around was that they didn't ignore graffiti and they didn't ignore



***We've heard of the carrot and the stick approach; do you find that physicians react more favorably to positive reinforcement or negative reinforcement? Is there a place for both?***

***CDI doesn't so much get into the carrot and the stick.*** But from a larger perspective of quality and safety and risk, it does. For example, UHC has a Patient Safety Net, which is what it uses to follow occurrence reports. When a bad

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broken glass windows. If you let the little things slip, the big things become a problem. We're trying to create a culture of safety and quality, and CDI is part of our quality program. But the first step is a conversation over a cup of coffee with difficult physicians who don't want to play in the CDI program—a lot of the physicians just don't get it. A constructive and informative nonthreatening personal conversation often is all it takes to turn a skeptic into a participant in our CDI program.

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## Keep on the cutting edge of CDI by embracing change

*Jon Elion, MD, FACC, president and CEO of ChartWise Medical Systems, Inc., in Wakefield, R.I., says that obtaining physician engagement is the "holy grail" of CDI efforts—but getting that engagement can be as simple as showing physicians how CDI efforts benefit them, rather than just the hospital. His comments follow.*

Obtaining physician engagement in CDI programs is the holy grail of CDI, isn't it? Unfortunately, too often the whole process is perceived by physicians as benefitting the hospital and not them. They think, "Why bother?" But that is a grave misconception. Documentation improvement does matter; it does benefit the physician, as well as the facility. Companies are creating portals that profile physician outcomes for the public. Insurance companies are profiling their physicians. Hospitals are profiling physicians.

There are wonderful anecdotes about poster boards with this month's "physician documentation expert" and stories of how CDI specialists reward physicians with brownies or other goodies when their records are clear. I find no joy in that approach. I find no joy in the thought that physicians need to be bribed to get them to do their jobs. Instead, I appreciate a CDI specialist who goes the extra mile to show me how my documentation could improve and how that will help me take better care of my patients. Physicians respond to professional pride. They're bothered by the core measures and other items, but they want to show they are taking good care of people. CDI specialists can assist them in that by helping physicians capture the appropriate documentation.

People are often surprised that physicians receive little if any training about how their documentation is used and what it means for coding and reimbursement. Start explaining the CDI process to residents and hospitalists, since they already have a vested interest in hearing more about the program. Once you have their support, that effort spreads to the other physicians. For example, a community physician may come into the dictation room complaining about a query and come across the hospitalist, who's sitting there answering a query himself. When the hospitalist explains the process to the community physician, the buy-in for the program grows and the good word starts to spread.

Too often physicians feel like they take care of the computer and the cart more than they take care of their patients. CDI specialists need to show how their efforts can actually help the physician. Sometimes technology can play a part. For example, one of our clients learned how to get his queries via his iPad® and started completing them at breakfast in the morning. He got a big kick out of that. Helping the physicians doesn't necessarily mean purchasing fancy gadgets, but CDI specialists do need to offer solutions and guidance to help make an onerous task simple. If you make it easy for the physicians, they'll be engaged.

