One of the few constants in the CDI industry is the problem of physician engagement. Year after year, ACDIS members report that their biggest challenge is physician engagement and education. In fact, 57.43% of the respondents to ACDIS’ 2019 membership survey cited physician engagement as one of their top three challenges.

While many familiar ideas are often discussed—newsletters, tip sheets, organizational clinical definitions, and the like—not every physician responds the same way to the same educational techniques. For this edition of the CDI Journal, ACDIS put out a request for members’ best physician education and engagement tactics. Here’s what the CDI community had to say.

**Bring backup**

While the CDI team can make significant progress on its own related to physician engagement, having backup for particularly difficult cases, or even simply for instilling the importance of the CDI education provided, can make a big difference. At the onset of the CDI department’s efforts, organizational leadership support (or lack thereof) can make or break a program’s success, according to Tammy Vidal, network CDI manager at St. Luke’s University Health Network in Bethlehem, Pennsylvania.

“Senior leadership support and proactively addressing the basis for excellent clinical documentation are the best tactics for ensuring physician engagement,” Vidal says.

“If upper management doesn’t consider CDI a priority, neither will the physicians. If the C-suite doesn’t understand the importance of CDI—the effect on hospital reimbursement, quality outcomes, public reporting, and so forth—they won’t be able to defend CDI activities when physician questions arise. Conversely, an engaged administration can carry CDI efforts further by enlisting key medical staff leaders to serve on the CDI steering committee, creating cross-departmental focus groups for emerging process improvement concerns, and working with the CDI team to delve into data that illustrates obstacles, opportunities, and successes.”
Employ a physician advisor or champion

According to ACDIS’ physician engagement survey, 36% of respondents with a physician advisor said their physicians are extremely or very engaged. In contrast, only 28% of respondents without an advisor indicated positive physician engagement. (To read the full survey results, see p. 8.)

A physician advisor’s job description may include clinical oversight of documentation needs; providing education to physicians and holding them accountable to answering CDI queries; identifying trends in documentation and developing strategies for improvement; reviewing clinical denials and writing appeal letters; developing organizational clinical criteria for common diagnoses; and more. (For a sample physician advisor job description, visit the ACDIS Resource Library.)

Adding a physician advisor to the CDI team not only brings a physician perspective to documentation initiatives, it also allows the advisor to be an advocate for CDI among the other physicians. Because of this visibility and positioning, the individual chosen to be the advisor should be liked and respected by his or her peers.

Those unable to employ a physician advisor should attempt to recruit a physician champion. Physician champions take a much less formal role in the CDI department and may only help on an as-needed basis. Advisors, on the other hand, are often compensated for their work with CDI and have set hours devoted to the department each week. (For more information about physician advisor compensation, see the survey results on p. 8.) By demonstrating support of the CDI team, illustrating exemplary documentation skills, and serving as an extended resource for their peers on documentation concerns, champions can serve as liaisons between the clinical and CDI worlds. They can also work as intermediaries when CDI staff encounter an uncooperative physician, offering tips to the team for how to handle the situation.

“We have a very involved physician champion, and without her push and support, we would not be where we are today,” says Tami Brees, RN, DQC, CCDS, supervisor of CDI with MedPartners at an academic facility in St. Louis. “She has just really, really gone over and beyond for us. She just gets it and sees how important CDI is.”

That physician advisor or champion can also listen to physician concerns and questions and relay that information to the CDI team for process improvement, according to Alyssa Riley, MD, MEd, pediatric nephrologist, CMI provider, and physician advisor at Dell Children’s Medical Center at Ascension in Austin, Texas.

“Especially when they’re frustrated, I listen and try to be a sounding board,” Riley says. “I think it helps a lot to empathize with them. I tell them that I understand how this effort can seem like an additional burden and that I also need to respond to queries. I try to explain to them that we’re all in the same boat working to improve outcomes for our patients, our practices, and our facilities.”

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Alyssa Riley, MD, MEd

Get them early

If your organization is a teaching facility, a great way to instill physician engagement is to get in front of the new residents when they arrive on campus for the first time. Often, these newly minted doctors are the primary ones documenting in patients’ records, and they may even be responding to queries in some cases, so their understanding of CDI’s purpose is paramount. (See p. 33 for a sample onboarding document for new residents.)

While CDI should work with the director of the resident program, department heads, and hospital leadership to build CDI into the
orientation program, once you’re in front of first-year residents, it’s easy to engage them in the CDI process, says Jeanne O’Connor, RN, MS, CCDS, CDI specialist at Partners HealthCare Coding, North Shore Medical Center, in Salem, Massachusetts.

“We orient the first-year residents within a month of their arrival,” she says. “It really is a great opportunity because they are so willing to learn and do the right thing. They’re so enthusiastic and ready to go full-throttle ahead into their first year as an MD.”

This is another area where a physician advisor or champion can come in handy, according to Brees. “When new residents come in July, [our advisor] does an actual in-service with every group and teaches them about CDI and why documentation is important.”

That first meeting, according to Amanda Just, RN, BSN, CCDS, system manager of CDI at Integris Health in Oklahoma City, also helps the CDI team know how to best contact the new physicians. “CDI is included in our new provider hospital orientation,” she says. “It gives CDI a chance to provide specialty-specific CDI education and introduce our team to new providers.”

With current technology, providers use multiple avenues to communicate, so catching them on the floor can be a challenge, Just says. She requests providers to complete a slip listing their communication preferences (e.g., email, phone number, name/contact info of “gatekeepers,” etc.).

Of course, all communication options must be secure. The team maintains a shared drive that stores each provider’s communication preferences for CDI reference.

O’Connor says the CDI specialists also meet with all new hospitalists during their orientation. “It’s only 15 minutes long,” she says, and although brief, one of the main purposes is a secondary gain. “We get to meet them in person. Later, if there is a question or concern we have on a patient or a question about a query response we may have received, we can meet them on the unit and they’ll know who we are and our role.”

Create resources

Developing resources and references for physicians to use in their daily work and refer to when the CDI team isn’t available represents an additional touch point for engagement. Such resources may take several forms, but likely the most ubiquitous is the tip card or tip sheet. These cards help to reinforce CDI education when the physician is out on the floor by providing a quick reference. (For sample tip cards, visit the ACDIS Resource Library.)

CDI staff can carry the cards with them while rounding to hand out as needed. This approach, according to Julie Fenton, RN, BSN, CDI specialist at St. Mary’s Healthcare in Amsterdam, New York, often yields the best results because the physician is in a position where the card will be immediately helpful. In contrast, handing them out during an educational session may just prompt physicians to leave them in the room after the presentation is done.

“We carry the tip cards with us and attend multidisciplinary rounds,” says Fenton. “Whenever we have a physician interaction with an opportunity for education, we provide it to them.”

Abandoned tip cards led Brees in another direction altogether, taking the concept into the 21st century by creating a CDI phone app open to any provider at the organization.

“In order to track how many people use it, [the physicians] need to have a pin that comes from the [CDI team],” says Brees. “The more we push it, the more emails we get wanting the pin.”

The team worked with an external app developer to create and roll out the program to their physicians. The content of the app mirrors previous hard-copy tip cards. It’s organized by body system and includes frequent types of queries that fall under those systems.

There are also examples of incorrect phrasing followed by examples of specific, precise documentation
options. Brees and her team developed the content in roughly six months, with additional time spent editing and adjusting the information for ease of use.

Since the tip cards are essentially digitized, the CDI team can push updates to the clinical criteria and documentation tips to all the physicians at once without worrying about redistributing a bunch of paper tip cards, and without worrying that physicians might accidentally pull out an old card and erroneously use that outdated information.

When putting such programs in place, Brees says CDI staff need to pay attention to the formatting of the education to ensure it’s user-friendly and accessible. “We knew if we made it too confusing, the physicians wouldn’t use it,” she says.

**Make yourself visible**

One of the best ways to build engagement among the physicians and medical staff is simply to make the CDI team visible, put faces to names, and ensure CDI specialists are available for physician questions. There are a couple of ways to accomplish this goal.

First, CDI teams should participate in grand rounds if possible, says Cheryl Richardson, RN, CCDS, CDI specialist and physician liaison at Hardin Memorial Hospital in Elizabethtown, Kentucky.

During rounds, a multidisciplinary team, usually consisting of a CDI professional, a case manager, social worker, and nurses, share an office work space. Physicians come and discuss each patient’s current clinical status, updating all departments simultaneously. The various team members in the room can ask questions, offer insight, and provide status clarifications.

“The rounding model has been extremely successful for us,” Richardson says. “We’ve cut the length of stay by about a day, and the nurses are extremely happy with it.”

Those unable to participate in rounds should seek alternative face-to-face interaction and educational opportunities, such as attending physician service line educational sessions. Typically, the CDI representative at these meetings would be the manager or team lead, but this can vary depending on the service line.

“Approximately three to four times per year, we meet with the hospitalist group through the help of our physician advisor and present a clinical documentation topic,” says O’Connor. Last year, for example, members of the CDI team presented quick, 15-20-minute overviews of pneumonia and encephalopathy from CDI’s perspective, O’Connor says.

If attending service line meetings and the like proves infeasible for a CDI team, simply being available and visible can make a world of difference. Whether this means the CDI team members sit somewhere on the units to do their work, attend rounds, or turn to designated physician educators/liaisons, the team will be positioned as resources for the physicians and help providers put faces to the names of query authors. (For more information on physician educators, see the article on p. 22.)

“I think one of the reasons we’re successful is that we’re not sitting behind a desk,” says Brees. “The CDI specialists are out on the unit, out in front of the physicians. Our role is to be available and answer any questions the physicians have, especially when it comes to queries.”
**CDI PHYSICIAN ONBOARDING**

This document was submitted by Deanne Wilk, BSN, RN, CCDS, manager of CDI at Penn State Health in Hershey. It’s part of Penn State Health’s physician onboarding manual. For academic facilities, new interns and residents will arrive at the facility in July. For those CDI teams wishing to catch the new physicians when they’re young, consider including something similar to this document in the onboarding materials.

**Contact Information:** ____________________________________

<table>
<thead>
<tr>
<th>Definitions</th>
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<td><strong>Clinical documentation improvement (CDI)</strong></td>
<td>The link between physician documentation and its translation into coding/administrative data. This data is used for quality improvement, reimbursement, public reporting, quality patient care, and population health initiatives.</td>
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| **Clinical documentation improvement specialist** | A specialty trained registered nurse or physician (editor’s note: or coding professional) in the clinical and coding concepts of provider documentation.  
  - Clinical resource that reviews documentation to assist providers in obtaining accurate, specific, complete, compliant, and quality documentation.  
  - CDI staff meet face-to-face with providers and also communicate via a “query” process to clarify documentation. |
| **Principal diagnosis** | That condition, which after study, is found to be chiefly responsible for occasioning the admission. |
| **Secondary diagnosis** | Those conditions that coexist at the time of admission, or develop subsequently, and that affect the patient care for this current episode of care. |
| **Secondary diagnosis** | Those conditions that coexist at the time of admission, or develop subsequently, and that affect the patient care for this current episode of care. Those conditions that are (MEAT):  
  - Monitored  
  - Evaluated  
  - Assessed  
  - Treated  
  - Extend length of stay (LOS)  
  - Require increased nursing care  
  - Chronic diseases should be documented in the past medical history of the History and Physical (H&P) or at least one time within the medical record. |
| **Present on admission (POA)** | It is essential to document and clinically support those conditions that were present on admission.  
  - **Hospital acquired conditions:** Adverse events attributed to hospital care.  
  - **Hospital acquired infections:** CLABSIs, CAUTIs, VAPs, C. diff  
  - **Patient safety indicators:** Adverse events primarily surgical in nature.  
  - **Never-events:** Serious adverse events with potential of patient harm. |
Query
A question posed to a provider to obtain documentation clarification. Queries are communicated via verbal discussion or Cerner Messaging Center. Queries are a part of the patient’s permanent medical record and are considered physician documentation. Queries should be answered within 24 hours and the information carried into the patient’s medical record.

Clinical diagnoses and data reporting through coding

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<thead>
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<th>Able to report from</th>
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<td>ED summary</td>
<td>Pathology report</td>
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<td>H&amp;P</td>
<td>Laboratory report</td>
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<td>Progress notes</td>
<td>Radiology report</td>
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<td>Physician orders</td>
<td>Ancillary staff reports</td>
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<td>Operative reports</td>
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<td>Discharge summary</td>
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Documentation tips

- Support diagnoses with clinical criteria or clinical assessment
- Document the etiology or underlying condition
- Capture acuity, type, stage, degree and laterality of conditions
- Make the link between conditions
- Possible, probable, likely and suspected are acceptable as a diagnosis and should be used in place of “rule out” and carried throughout the record to time of discharge/discharge summary
  - If ruled out or resolved, document as such

Avoid unapproved abbreviations

It is the policy of this organization (editor’s note: name policy and where to find it) that abbreviations are generally not recommended. Only organizationally approved abbreviations may be used. The list is available at (editor’s note: list location and provide link).

Avoid copy and paste

It is the organization’s policy (editor’s note: list the name of the policy and where to find it) that the EHR copy/paste functionality is to be used with caution. Overuse of this feature risks errors including, but not limited to:

- Copying problems that are no longer active
- Copying medications that are no longer current
- Indicating levels of intensity or severity that apply to earlier visits rather than the current encounter
- Failure to identify the original documentation author