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CDI Companion for
PHYSICIAN ADVISORS
Notes From the Field

Trey La Charité, MD, FACP, SFHM, CCDS

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for Physician Advisors:
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Dedication

For my wife. None of this would have been possible without her unwavering influence and support. I can never adequately express how much you mean to me and our family.

For my children. My hope is for them to achieve anything and everything they desire.

For Boo and Grandaddy. The best grandparents any child could ever hope to have.

For Lisa and Carla. Two rock-solid compatriots who have weathered every storm with me regardless of severity.

For Lisa, Sherri, Martha, Mack, Rebecca, June, Ginger, and Leah. Thanks for all the past and future efforts for our program.

For Jim Kennedy. Thanks for being my trainer, my mentor, and my friend. In fact, thanks for everything, amigo!

For Patty and Tim Brundage. Thanks for always including the old man.

For the Association of Clinical Documentation Improvement Specialists. Brian, Melissa, Rebecca, Penny, and Wendy. Thanks for all the opportunities and the patience.

For University of Tennessee Medical Center. Thanks for making me the person, and physician, I am.

About the Author

Trey La Charité, MD, FACP, SFHM, CCDS, is a hospitalist with the University of Tennessee Hospitalists at the University of Tennessee Medical Center at Knoxville (UTMC). He is board-certified in internal medicine and has been a practicing hospitalist since completing his residency training in internal medicine at UTMC in 2002.

He is also a clinical assistant professor with the department of internal medicine and serves as the physician advisor for UTMC's Clinical Documentation Integrity Program, Coding, and Recovery Audit (RA) response.

La Charité served on the Association of Clinical Documentation Improvement Specialists (ACDIS) Advisory Board from 2011 to 2013 and has been a frequent presenter at its national annual conference, covering topics including kidney disease, malnutrition, audit defense, and engaging medical staff in clinical documentation improvement efforts.

He also co-teaches the successful Physician Advisor Boot Camp preconference event for ACDIS and frequently presents at the Tennessee ACDIS chapter meetings. La Charité has also presented at the Healthcare Information and Management Systems Society and been featured on the Panacea *Talk Ten Tuesdays* podcast.

His comments and opinions have been compiled from his original writings included in various editions of the ACDIS publication *CDI Journal,* to which La Charité has contributed for a number of years.

The contents of this book do not reflect necessarily the standing, opinion, or assessments of UTMC or ACDIS but are intended as a conversational reflection of practices La Charité, himself, found useful over the years. Contact him at *Clachari@UTMCK.EDU*.

Introduction

When I was unexpectedly called to the administrative offices (the C-suite) of my hospital, every possible reason ran through my head. The actual conversation went something like this: "How would you like to run the hospital's new clinical documentation improvement program? All you have to do is help the medical staff improve their documentation."

They appealed to my sense of altruism. "It's an opportunity to really make a positive impact on the hospital," they said. They stroked my ego. They praised me as a valued and respected member of the medical staff.

I swallowed the whole enchilada—hook, line, and sinker. If I only knew then what I know now.

Those reading this book likely remember a similar conversation. Maybe they offered you a raise, an extra stipend, some time off from clinical responsibilities, a better parking space, a new or additional title, etc. Maybe you were no longer satisfied in your existing role at the hospital and were looking for something new anyway. Maybe you were experiencing some significant change in your life and needed to make a move for personal reasons. Regardless of the circumstances surrounding your involvement in CDI, you are here now.

In my case, I was asked to become the physician advisor for my hospital's fledgling CDI program because I was known for my documentation practices. I was a board-certified flea (i.e., "the last to leave a dead body," as the saying goes about those who, like me, trained in internal medicine and stay to the last to care for the very sick and the dying), so extensive and comprehensive documentation was second nature to me. In fact, I still don't understand how some providers justify calling three lines in a chart a "progress note."

At the time, my biggest frustration with my colleagues' documentation, and greatest motivation to facilitate change, came when trying to resuscitate crashing, near-death patients who resided in other hospital units. In the hospital where I did my residency, the internal medicine residents ran all the codes.

I cannot tell you how many times I was put in a situation where I was expected to rescue a patient from imminent death who had been in the hospital for two weeks, yet the chart contained absolutely no useful information to help me understand what treatment might be needed. If I could get our surgeons to actually put something in the medical record that would help me just a little in those situations, that would be a huge accomplishment. Additionally, how could this not help patient care? Emergent situations undoubtedly go better if you can quickly discern the important points in the patient's history, right? And so the die was cast.

Almost a decade later, I am still standing and still employed as my CDI department's physician advisor. There is no question that my work has been tremendously rewarding. In fact, even knowing the trials and tribulations that have come my way as a result of my program's CDI efforts, I would do it all again. With that in mind, however, by relaying what I have experienced, I hope you can avoid, or at least mitigate, some of the problems I have run into.

After all, in my opinion, there is nothing proprietary in the realm of clinical documentation integrity. By the way, I call it "integrity" rather than "improvement"

because our goal is the same regardless of the facility in which we work—to help our medical staff make the patients in their care appear in the medical record as sick as they actually are in reality.

As one of my residency mentors once said to me, the definition of wisdom is learning from the mistakes of others without actually having to make those same mistakes yourself. Needless to say, I have made a lot of mistakes over the years. Therefore, my hope in writing this book is to help make you wise from the start, potentially saving you from making some of the same mistakes I made in my CDI journey.

What follows is a compilation of some of the experiences I have had and some of the solutions my CDI program developed over the years. It's for the larger "you"—my fellow physician advisors to CDI, the CDI managers and directors of the world, and those doing concurrent record reviews who are walking the unit floors day after day trying to effect change in your facilities.

Please understand that I do not consider myself an expert in the field of CDI, and my CDI program is certainly not the best in existence. However, if you are open to new ideas, you can learn as much from a one-room schoolhouse (or a local bumpkin) as you can from the biggest and best university.

A Bucket of Cold Water: Starting a CDI Program

So how I did get started? Fortunately, before I was ever asked to get involved, my hospital had already chosen a CDI program vendor with a proven record in getting new CDI programs up and running. In fact, as far as I am concerned, the six weeks of training the new CDI nurses in my program received was unsurpassed in quality and content. To this day, they still talk about it, and I am still impressed and amazed by what they know.

How was my training? If you hadn't guessed, it was a little less extensive.

We contracted with a leading physician trainer for my education (see "Dedication"). Unfortunately, during his initial visit to my hospital, I was only lucky enough to have four hours of his time. Yes, you read that right—four hours. I spent all of one Friday afternoon in a conference room with my now mentor as he frantically told me everything he could about CDI and everything he knew about being a CDI physician advisor. Neither of us thought that amount of time was even remotely sufficient, but it's all we were given.

Immediately after that, my hospital deemed me ready for prime time. In other words, while my mentor did all he could with the time he was given, I had to learn a great deal about what constitutes CDI best practice on my own. Over the

years, I have continued to lean on him, and he has always graciously made himself available to help.

Yet, I needed to know more. In particular, I quickly found myself needing additional training in basic inpatient coding, the working of the international classification of diseases, and the inpatient prospective payment system.

A few months after our CDI program began, my facility started receiving denials related to diagnosis-related group (DRG) validation. I couldn't stop the onslaught of claims denials without knowing what the auditors knew. Please understand that you, as a CDI professional or physician advisor, certainly do not need to be fluent in coding to be effective in the role. I am not a coder. However, you do need to know a little more than the average bear.

Once I realized this was a true deficit in my education, I started asking my hospital coders where they trained. The recognized mecca of coding education in my region, it turns out, is a community college in an adjacent county. Almost all our coders graduated from this program, and several recognized regional coding experts taught at that facility. So, this was the place I needed to go. I went back to school and signed up for their semester-long ICD-9 coding class.

While I knew coding wasn't easy, it didn't take long for me to realize that coding is *hard*. I mean really hard. Add in a little dose of physician competitiveness to a hard subject and a hard class, and you can imagine what that semester was like. While I definitely learned what I needed to know, I will never forget how much work it required. (I'm pretty sure I still owe my wife some form of restitution for those months. I am sure I was a real pill.) Would I have taken the same path to improved coding knowledge if given the opportunity to go back in time? Yes. Nothing holds a physician's feet to the fire like an impending letter grade. However, I had no idea how difficult the International Classification of Diseases coding system can be. I share that experience with you in order to give our coders, and likely your coders, too, the credit they deserve for the work they perform.

Too often, we, as physicians, don't know and don't give credit to these professionals for their expertise. We should.

Keeping the Doors Open

It didn't take me long to fully understand the importance of our documentation improvement efforts. The healthcare market is extremely competitive in Knoxville, Tennessee. The 22 counties and approximately 1.5 million people in this region receive care from nine large hospitals that are organized into three systems, as well as several smaller outlying county facilities. Please note that there were 10 large hospitals until one of them suddenly closed in mid-2008. Even though that facility had 250 beds, none of the other facilities blinked at its closure. Not one of them stormed off to the state capital frantically waving new certificate-of-need requests demanding more beds. In fact, the other hospitals in my area did not mind the increase in their censuses whatsoever. In other words, there were already too many beds in my market that weren't filled.

Hospitals want, and need, patients in their beds to keep the doors open, so competition among healthcare facilities is real and always fierce. No patients in the beds means no more hospital. Period. Facilities need revenue, and you, as the CDI specialist or CDI physician advisor, need to help physicians document the care provided and resources used by your facility in order to secure accurate reimbursement. With appropriate reimbursement coming in, your facility will be able to keep the doors open and maintain its mission of caring for the sick.

Now, all these years later, I've seen this competition intensify. First, our providers' and facility's performance data are increasingly publicly available. The never-ending monotony of billboards that plaster your local major thoroughfares and the constant litany of magazine, television, and newspaper ads touting how much better one facility is at managing a particular disease than the rest of their competitors is testament to this phenomenon. Second, payers and employers, be they

private or governmental, actively herd patients to the providers and facilities with better performance data. And by herding, I mean intentionally steering patients to providers and facilities that provide better outcomes at reduced costs. Known modalities employed to facilitate this patient herding include copay manipulation, covered service alterations, provider visibility management, and provider performance rating systems.

CDI efforts ensure provider documentation captures patient acuity. That helps ensure patients *choose* our providers and facilities because they see how good our performance data appears. Furthermore, patients are then *allowed* (if not actively encouraged or "herded") to use our providers and facilities because the people who foot the bills (the payers and employers) want those patients to come to us. Once again, if you don't have patients in your facility's beds or in your outpatient offices visiting your providers, you will eventually be looking for a new facility to work in. And it just might be the facility that managed to stay open by attracting those same patients away from your doors.

Picturing UTMC

I'm a hospitalist. It is what I do and, usually to my wife's chagrin, it is how I define myself. I work in an academic medical center and serve as a ward attending for our internal medicine residency program.

My facility is currently licensed for 625 beds and, due to continued demand for our services, we plan to increase that number further. We are a Level I trauma center. Our emergency department (ED) sees approximately 85,000 visits per year. We have 10 residency programs and 11 fellowships with over 200 residents and fellows per year. Did I mention that we are a regional referral center and act as the local safety net hospital?

It goes without saying that the University of Tennessee Medical Center (UTMC) is a busy place. Our ED is frequently filled with admitted patients waiting for hospital beds, which further creates epic stays in our waiting room. We have even boarded admitted patients in ambulances outside because there was simply no other space in the proverbial inn.

I paint this portrait of where I work to reinforce the challenges that we face in CDI. If nothing else, you must grasp the one constant pressure in the minds of providers—time. It is the most valuable commodity to any healthcare practitioner. If you can give your providers any kind of tools to reduce the amount of time required to perform some part of their daily routine, they will jump all over it. Conversely, ask them to perform a time-neutral task or (heaven forbid) actually increase the time they must spend on a given task, and you'd better have a very good reason. If not, you will not succeed regardless of what you are asking them to do.

Like it or not, all your providers hear when CDI staff (yes, even the CDI physician advisor) start talking is "this is going to add to the length of my day." Therefore, since the tenets of CDI include improved, if not additional, documentation, you are already behind the eight-ball.

Remember how those administrative folks said, "All you have to do is help the medical staff improve their documentation?" It's a phrase that repeatedly echoes in my head. What was I thinking?

As if all this isn't enough to worry about, let me remind you that everything encompassing CDI is simply *not* within your control. Despite your best intentions and efforts, the results of your program almost entirely depend on the cooperation of your medical staff. And, while you can drag a provider to the Kool-Aid fountain as often as you like, you cannot make them imbibe.

Furthermore, you must realize that you will never reach all of them. Ever. However, you will reach most. And "most" is what matters.

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When it comes to clinical documentation, physician advisors have a range of important responsibilities, from query escalation to denials management and everything in between. With all these tasks on their plate, physician advisors are constantly pulled in different directions, making it hard to make the best use of their time. CDI Companion for Physician Advisors: Notes From the Field is designed to help physician advisors structure their time properly and carry out their CDI duties effectively and efficiently.