Provider Engagement

As part of the fourteenth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. Maricus Gibbs, PhD, RN, CDI specialist at Atrium Health Wake Forest Baptist in Winston-Salem, North Carolina, answered these questions. Gibbs is a member of the ACDIS Furthering Education Committee and the ACDIS Florida local chapter. For questions about the committee or the Q&A, contact ACDIS Editor Jess Fluegel (*jess.fluegel@hcpro.com*).

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Q: Can you describe the engagement and collaboration of the medical staff at your organization in CDI?

A: The engagement and collaboration of the medical staff at my organization is measured by the percentage of query responses, the time it takes to respond to queries, and the complaints or pushback from providers reported. Over the past four years, the engagement has increased slowly with dips during periods with high census and use of locum providers.

Q: After years of little change, the percentage of respondents who reported their medical staff as "highly engaged" saw a notable increase from 13.45% to 16.76%, according to CDI Week Industry Survey data. Have you seen this at your own organization in the past year? What advice do you have to help CDI professionals move the needle and join this trend of increased engagement?

A: Our query response rate trends between 85% and 95%. It drops during high census and use of agency physicians. Overall, the engagement has increased as CDI use has become a mainstay of most outside healthcare organizations. CDI services are introduced during provider orientation with a brief presentation by a CDI professional and time for questions for the CDI department. Constant check-ins are mandatory on a weekly basis as face-to-face discussions between the provider and CDI staff, even though the CDI department is mostly remote.

Each campus within our organization has an assigned CDI specialist as the face of the department to which the providers become familiar and develop a relationship with. The CDI specialist is encouraged to attend huddles or care conferences in which other departments interact with the providers and each other to develop a sense of teamwork. Many of the seasoned CDI professionals bring candy or snacks for the providers because they often engage with them during provider downtime reserved for charting.

Q: When asked how frequently they conduct physician education sessions, 30.05% of respondents reported monthly and 26.86% reported quarterly, though 26.86% said they do so "as needed." How often does your CDI program conduct such sessions, and what advice do you have to make the most of these educational opportunities? If your program conducts them as needed, how is that usually determined?

A: The physician education sessions are provided monthly, during new provider orientation, and as needed. As needed is determined by increased

denials of particular diagnoses or when engagement percentage drops. This seems to keep multiple members of the healthcare team in the loop about financial and quality responsibilities of the entire organization. The information requires coders, physicians, administrators, dieticians, and clinical documentation specialists to be on the same page and collaborate for the benefit of the organization and those being served.

Q: Each year, we hear that provider engagement is a top concern or problem area for CDI programs. Why do you think CDI programs have such trouble in general engaging the medical staff? What have been your biggest challenges with gaining provider engagement? What have you done to address and improve this?

A: To many outside the CDI department, clinical documentation as a specialty is a newer concept and seems to add to the provider's suggested responsibilities. "Suggested" means not entirely important or relevant to what the providers do daily. Overwhelming the provider with unnecessary queries to maintain quality documentation has become a growing weed within the CDI department that requires discussion. Sometimes physicians may feel queries are only there to get the organization more money. Such concerns must be addressed immediately within the CDI department, with providers, and among an interdisciplinary group of teammates responsible for health integrity. Follow-up and maintaining a trusting relationship between providers and CDI professionals has kept our CDI department constantly engaging through face-to-face weekly meetings, provider orientation, and online chats with providers. As mentioned, a trusting relationship between CDI, coders, and providers is a must.

Q: According to the survey results, about 61% of respondents have a full-time or part-time physician advisor, a small decrease from about 64% in 2023. Just 9.0% plan to engage one in the near future, while 15.16% have no plans (an increase from 12.75% in 2023). Why do you think fewer CDI programs of late might have a physician advisor or plans to engage one? Do you feel a physician advisor or champion is beneficial to CDI? Why or why not?

A: A physician advisor is very necessary as a bridge between providers and CDI. Just as providers must be encouraged and engaged by the CDI department, the CDI department must at times be encouraged to be more empathetic to providers. The physician champion is an opportunity to provide buy-in for provider engagement and to educate CDI about the mindset of providers.

Q: When asked how they measure the effectiveness of their CDI provider education program, the most common measurement selected was improvement in CDI metrics (77.79%), followed by feedback from providers (52.26%) and reduction in documentation errors (34.84%). How does your organization measure its CDI provider education? What advice do you have to help CDI programs better track their success in this area?

A: Feedback from providers and reduction in documentation errors are great additions to CDI metrics to help track CDI provider education. Provider feedback has been lacking in our organization, but I feel will help improve communication between provider and CDI as well as education for the CDI department. Provider feedback helps very few if kept only in administrative files and discussions. Having frequent check-ins within the CDI department has been a way we track success and learning opportunities at our organization. Having weekly CDI group meetings in which the CDI specialist is allowed to be open and honest about experiences, expectations, and learning has also helped our organization track the success of CDI education.

Q: Do you provide formal education to your providers, and if so, how (i.e., one-on-one, group presentations by service line, informal coaching, tip sheets, newsletters, etc.)? How is education content decided (i.e., based on hospital standards, individual provider needs, etc.)? How have your provider education/engagement models changed over the last few years?

A: The formal group education is done by the more experienced CDI specialists, but every CDI professional is encouraged to provide education to providers within as many interactions as relevant. A major opportunity inherited in being a clinical documentation specialist at our organization is having the

opportunity to have discussions with providers where teaching goes both ways. Mandatory weekly face-to-face meetings have helped take advantage of these opportunities through informal meetings with providers within the hospital. This model has changed from daily to weekly meetings overtime because of COVID, time restraints, and employee feedback, but secure chats and telephone engagement has increased to replace the face-to-face interaction.

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Three questions on physician engagement with Solventum's Kaitlyn Crowther

Q: How have you seen strategies for physician engagement change over the past few years?

Crowther: First and foremost is the continued rise of physician advisors. I am seeing the physician advisor role continue to grow, and health systems are seeing a return on investment, and wanting to hire and invest in that role. Often these are physicians who still practice, with a percentage of their time spent on physician advisor activities.

I think it's excellent that we have physicians at the table who have peer-to-peer discussions with other doctors working on CDI issues and using our solution. We've gotten a lot of feedback from our end-users that when they have physician advisors who champion the solution and train and support their peers, it helps them achieve better outcomes.

Q: What's an example of how CDI teams partner with physician advisors?

Crowther: A good example relates to the clinical insights delivered through our 3M™ M*Modal CDI Engage One™ solution. While we have a tremendous library that uses the latest best practices from the industry, such as ACDIS and AHIMA, CDI teams can also customize those clinical triggers. We see physician advisors being a huge part of those customizations. For example, if they want to alter the heart failure trigger to include some specific criteria for their health system, it gives them some ownership over how the clinical triggers function.

Also, often when we put out this content for physicians, we segment it by subspecialty. Having a leader in each subspecialty who is signing off on the content that is enabled and working with their peers to participate has been key.

Q: A cornerstone of successfully engaging physicians is the "why." What have you seen to be the most important reasons motivating physicians to participate in CDI and use your solutions, and how do you engage them in those?

Crowther: The physicians we work with care about the outcomes they and CDI drive for the health system. They want to look good to their peers. They want to show they're delivering high quality care—and that's done through the documentation. By getting the documentation right and producing a high quality note—based on specific goals the hospital has targeted—quality and risk-adjusted measures improve, showing this is a high quality hospital and high quality physician. That's the validation they're looking for in doing this work.

The best way to engage them in these outcomes is through data. Physicians naturally have an evidence-based mindset. Actionable analytics underpin everything we do. For physicians, we look at operational reporting and see who's engaging with the content, who's ignoring it, who's getting queried, who's answering queries, what's the turnaround time, etc. This tells us where and how we need to target interventions—it's a very data-driven approach. We want to show physicians the outcomes they're getting as well. When they see

quantifiable data, it's very helpful in engaging them in ongoing improvement.

In addition, physicians care about improvements in their documentation experience: How can we reduce the number of clicks in a day? How can we reduce rework that they're required to do? How do we speed their documentation process? I was at a conference recently, where we were really validated to see independent research from one of the hospitals that is using our solutions, comparing the experience of physicians using the 3M CDI Engage One application to their peers who were not using it. Physicians using our solution were more likely to be able to complete their charts either during or right after rounding; those who were not using it were more likely to have to spend time on their documentation later. The cohort using our solution also felt a larger sense of personal accountability around patient safety and quality documentation because the solution was nudging them about those concepts in real time. This hospital had enabled nudges around PSIs and protocols their patients should be following. So having our solution nudging them on this information proved to be very helpful. ■

Kaitlyn Crowther, RHIA, is an experienced product management professional responsible for Solventum's clinical documentation improvement solutions. She has spent much of her career focusing on using technology and natural language understanding in the clinical documentation improvement cycle.