Provider engagement and education

As part of the sixteenth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. Jenna Prisciandaro, RN, BSN, CCDS, CDI manager of quality documentation (CDI) and inpatient coding at Lee Health, answered these questions. Prisciandaro is a member of the ACDIS Furthering Education Committee. For questions about the committee or the Q&A, contact ACDIS Editor Jess Fluegel (jess.fluegel@hcpro.com).

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Q: According to the 2026 CDI Week Industry Survey results, 50.35% of respondents reported their medical staff are "somewhat" engaged (meaning they understand CDI concepts but inconsistently put them into practice or do so incorrectly), a notable decrease from the 57.12% who reported the same in 2025. This seems to indicate a positive trend, however, given that 42.70% reported their medical staff is "very" engaged in CDI this year (meaning they understand the importance of CDI and actively participate in documentation integrity efforts), a large jump up from 32.16% in 2025. What is the engagement like at your organization? Do you have any thoughts on why the jump seen in the survey responses occurred? What advice would you give to help CDI professionals move the needle from having "somewhat" to "very" engaged medical staff?

A: We have had a steady growth of provider engagement in our department over the last few years. Seven years ago, when I first joined this department, provider engagement was a constant uphill battle. The CDI-provider relationship needed improvement to help foster a more collaborative approach. I still remember a provider saying, "You are the unnecessary hair I have to pluck" when I reached out to him regarding a query response. Then COVID hit, and everything changed. Our providers were forced to utilize virtual options for education, continual medical education (CME), meetings, etc. Our department had to adapt to the virtual world as well. This stopped in-person interactions from occurring and allowed us to reflect on the pros and cons of our approach at the time. We updated our education processes and created an education team that virtually presents sessions for providers. With more formalized education, we were also able to add CME credits for the providers. This entices them to join the sessions, furthering the engagement. We also partnered with our physician advisor team. Instead of having one of our staff members reach out to the provider regarding query responses/education, the physician advisor reaches out for peer-to-peer discussions. With the increased education sessions and partnership with physician advisors, we have seen our engagement rise

I think the national rise is partly due to the forced virtual flex that COVID caused, and a general national push and awareness of the positives that CDI can bring to the health system. C-suites are noticing the increase in key performance indicators that a well-established CDI program can generate.

Q: When asked how frequently they conduct physician education sessions, 33.52% of respondents

reported monthly, in line with 2025, while almost 14% said they do so quarterly, a small increase from 2025 (11.56%). How often does your CDI program conduct such sessions, and what successes and/or challenges have you seen? What advice would you give CDI professionals on how to educate outside of formal sessions?

A: We created an education team consisting of five legacy staff with CCDS credentials: consistent faces for the providers to get used to. Instead of trying to find the provider on the hospital floors, we opened education to a virtual realm. They were 2.5-hour invites, but the team provides the education in 15-minute intervals. This allows the provider to "stop in" virtually when they have a moment in that 2.5-hour time slot. There are two sessions each month, but they cover the same topic. Our providers do week-on/week-off schedules, and this allows us to engage with more providers on the same topic.

The team also provides 1:1 education for all newly employed hospitalists within our organization. This in-depth session starts the provider off on the right foot and further captures that provider's engagement. We have found this to be very successful at starting the CDI-provider relationship within our organization. We provide them with all the information needed to be successful with documentation and continue to encourage that through our monthly sessions.

Q: According to the survey results, the number of respondents that have either a part-time or full-time physician advisor stayed steady year-over-year (71.63% in 2026 compared to 71.22% in 2025), as did those with a physician champion (46.03% in 2026 compared to 45.21% in 2025). Of respondents with a physician advisor or champion, 56.74% reported sharing that person with another department. Does your CDI program have a physician advisor or champion, and if so, in what capacity do they assist your CDI efforts? What benefits and/or challenges have you noticed in working with (or without) a physician advisor or champion?

A: Our department works with the physician advisor group, which is composed of eight full-time physicians. Two of those physician advisors are full time with peer-to-peer denials. Their group is currently going through changes, with the end goal of having two full-time physician advisors fully dedicated to the CDI team. Currently, the advisors assist us with a multitude of query-related issues. They reach out to providers when the queries remain unanswered after seven days. They also conduct peer-to-peer discussions with providers surrounding poor query responses.

Some of the challenges we have seen revolve around obtaining the "undivided" attention from the physician advisors. They are pulled in so many different directions between utilization management, CDI, and case management. We are hopeful that their current restructuring will provide us with more dedication from the advisors.

Q: When asked how they measure the effectiveness of their CDI provider education program, the most common measurement selected was improvement in CDI metrics (76.5%), followed by feedback from providers (51.88%) and reduction in documentation errors (35.61%). 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: We monitor our specific agree rates surrounding different query topics. If we notice a dip in agree rates, we try to highlight that topic in upcoming monthly education sessions. We also have certain topics that we feel need to be given on a yearly basis, such as pneumonia specificity and sepsis. We continue to find this measurement difficult to assess, as our system is so large.

Our CME program also produces surveys that providers are required to answer after each educational session. These surveys point out some of our strengths and weaknesses in our education program and allow us to pivot and change to adapt to the providers' needs and wants.

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

A: Our department provides a variety of educational sessions for providers. Each month, we provide a

monthly topic to the hospitalists. These sessions are held virtually during a two-hour window, with the session lasting 15 minutes. We also provide an initial new provider orientation that lasts about one hour. This virtual, one-on-one session between provider and CDI staff is essential for long-term engagement and success.

We also reach out to various ancillary groups, such as ICU and infectious disease and cardiology, to provide education to their groups. We deep-dive into their documentation to find opportunities and provide focused education.

Our models have changed over the years due to department and provider growth. We partner with a third-party vendor to assist with auditing and the ancillary group education. We find this beneficial as it is another "voice" of education for the providers to hear. Our system team provides the monthly and ongoing education, but our vendor assists with specific consultant provider groups.

Q: The majority of respondents (57.30%) reported a 91%–100% physician query response rate, which was also the most common goal response rate for CDI departments (58.97%). What do you think these departments are doing to achieve or exceed their goals? Do you have any advice on query wording, policies, collaboration, etc., to help CDI professionals and providers achieve a higher response rate?

A: I believe departments that have high query response rates are well supported within their systems. They are not usually succeeding because of one intervention, but due to a collective culture where CDI is integrated into the clinical workflow rather than viewed as an administrative task. When a system has a well-thought-out and streamlined approach to unanswered queries, providers quickly realize the query is easier to answer than going through a system escalation process where their privileges may be revoked if they continue to leave queries unanswered. Medical bylaws and policy structure are also very important to query response rates. Clear, concise, and well-established rules help maintain provider accountability.

Q: When asked if their organization tracks physician query agree rate, 41.03% of respondents reported a 91%–100% agree rate, and 23.23% reported an 81%–90% agree rate. Also, 41.72% said their department had a 91%–100% goal query agree rate, an increase from the 38.5% in 2025 who said the same. Does your department have a query agree rate goal, and if so, how was it decided on? What efforts has your CDI program made, if any, to achieve a higher physician query agree rate?

A: We have an agree rate of 94%. Our goal of 90+% was decided upon utilizing the ACDIS survey. We looked at what the trends were at other systems and agreed upon a rate. We focus on our provider education and query quality to help achieve a higher agree rate. Outside of our education process, our leadership team performs quarterly query audits on our staff. These query audits allow us to ensure the quality needed to help providers answer the queries appropriately. Appropriate clinical evidence and compliant and clear questions are both essential parts of a quality query that help keep higher provider agree rates.

Our hope is that, with a more streamlined, collaborative approach with our physician advisor group, we can get even more successful agree rates.

Q: Provider engagement will always be a relevant CDI topic, but how have you seen the conversation evolve in recent years? What external factors do you anticipate influencing provider engagement and education in the future?

A: Provider engagement has been a wild ride in CDI for our system! As more providers are joining the CDI teams, whether as advisors or champions, I see engagement continuing to rise. Having that peer-to-peer time to help sell the "why" of CDI is so beneficial. A CDI department that is well established can really go to the next level with the involvement of providers.

As we continue to see artificial intelligence (AI) and further technological advancements within the EHR, I anticipate further growth in CDI departments, letting AI obtain the low-level fruits of opportunity and allowing our highly educated and trained CDI staff to look for more impactful documentation opportunities. AI should be approached cautiously and should be well vetted before implementation within a system. A collaborative approach with CDI, providers, compliance, and IT will help ensure that any AI utilized will be compliant and reliable.

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Closing the Loop Between the Query and the Provider

by Marena Hildebrandt, DNP, RN, PHN, NEA-BC, product marketing manager of Provider Solutions

Succeeding at prospective risk adjustment in value-based care takes more than technology. It takes technology, provider engagement, and provider education together. A well-written query only works if the provider on the other end trusts it. CDI programs have spent years refining query compliance, but compliance alone does not build trust. Trust comes from a provider seeing, quickly and clearly, why a query was generated and what it is asking them to confirm. When that reasoning is missing, providers disengage, and disengagement shows up everywhere: rising query denial rates, slower turnaround, and physicians who treat every alert as one more interruption in an already compressed day.

Provider distrust of AI they can't verify has become a primary barrier to adoption: 93% of providers say fear of AI hallucinations hinders adoption, and only 35% of organizations have a documented process to catch AI when it gets something wrong, according to Reveleer's 2026 State of Technology in Value-Based Care Report. That distrust lands on clinicians who are already stretched—burnout remains a critical, unresolved problem, with nearly half of physicians reporting burnout symptoms, according to Medscape's educational activity Clinician Burnout and Mental Health: Critical in 2026 and its companion report. CDI leaders did not create that pressure, but every workflow decision either adds to it or relieves it. A query stripped of clinical context adds to it. A query that shows the supporting documentation alongside the ask relieves it, because the provider spends seconds confirming instead of minutes investigating.

This is where explainability changes the equation. AI-assisted CDI tools that surface a confidence score without the underlying evidence ask providers to trust a black box, and clinicians have good reason not to. What builds adoption instead is a visible chain of reasoning: the chart excerpt, the clinical indicator it supports, and the specific documentation gap it points to. When a provider can trace a suggestion back to its source in a few seconds, the query stops feeling like an audit and starts feeling like a second set of eyes.

Provider education follows the same logic, and in ambulatory CDI it is where prospective programs succeed or stall. A single query resolves one chart. A pattern, shown back to a provider group over time, changes how that group documents going forward. CDI programs that pair individual queries with group-level trend data, missed HCCs, recurring specificity gaps, and documentation patterns tied to particular visit types can see where providers struggle most and direct education there, giving providers something to act on before the next encounter.

Real-time visibility matters as much as the content of the feedback. Providers who can see their own documentation and RAF capture performance on a rolling basis, rather than in a retrospective report weeks later, engage with CDI education while it can still change behavior. CDI teams and leadership need technology

that surfaces where provider engagement is low, trends it over time, and shows whether engagement and education efforts are working. In a Reveleer prospective risk adjustment case study, a large not-for-profit health system gave providers real-time, point-of-care suspecting, improving its provider address rate by 34% in a single year, generating six times its return on investment and $18.5 million in additional revenue capture. The mechanism: less friction figuring out what to do and why.

None of this replaces the CDI specialist's clinical judgment. It changes what providers see when a query lands in their queue, and it changes how much friction stands between a documentation gap and a corrected chart. As outpatient CDI programs mature and physicians face queries across more settings and more specialties, the programs that scale sustainably will be the ones that treat provider trust as infrastructure.

Reveleer works with health plans and provider organizations to bring clinical evidence, provider engagement, and provider-level education together in one prospective risk adjustment workflow, reducing the abrasion that erodes engagement and giving providers a reason to trust what shows up in their queue. Together, these capabilities give CDI teams the insight to take a coordinated approach to prospective risk, combining the technology, provider engagement, and education that value-based care demands.

Learn more about Reveleer's approach to provider engagement at ***reveleer.com/cdi-week***.