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Association of **Clinical Documentation Integrity** Specialists

PHYSICIAN ENGAGEMENT AND MOVING CDI "UPSTREAM"

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No matter how much the CDI industry grows, physician education and engagement remain one of its top concerns. A lack of physician buy-in will stymie even the most rigorous CDI efforts. While the problem remains front and center, CDI teams now have significantly more tools by which to tackle it. From physician-facing artificial intelligence (AI) solutions and other technology, to expanded educator roles, to sophisticated physician advisor programs, today's CDI leaders leverage a multitude of methods to improve physician education and engagement.

In partnership with 3M, the Association of Clinical Documentation Integrity Specialists (ACDIS) CDI Leadership Council asked several of its members to evaluate the results of a nationwide survey on the ways CDI leaders are moving physician engagement in document integrity "upstream," closer to physicians' real-time documentation practices. The Council members were then asked to discuss their organizational approach to this topic. The following is a review of the survey results and a summary of the discussion.

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—Kaitlyn Crowther, RHIA, chief product owner at 3M Health Information Systems

Responsibility for physician education

While physician education is an essential part of CDI's work, different team members at different organizations may provide that education, depending on staff bandwidth and priorities. According to 56.87% of survey respondents, the CDI specialists themselves provide physician education, followed by 52.61% who said their physician advisor/champion provides education and 51.66% who said their CDI manager conducts education. A few of the "other" responses said that a subset of the CDI team conducts education instead of a particular job title holding the responsibility. (See Figure 1.)

According to **Jessica Risner, BSN, RN, CCDS,** CDI director at Banner Health in Phoenix, Arizona, the team approach means you can ensure all the experts are present at the educational table. It also centralizes and systemizes education, ensuring that the message communicated to physicians is consistent and clear while freeing up CDI specialists' time to focus on reviews. Of course, the approach has potential cons as well.

"We try and bring the experts to the table when we're delivering education: Leaders, educators, and auditors. This group of individuals is privy to enterprise information, data, and the inner workings of certain initiatives we are trying to drive," Risner says. "However, a con with this approach is I remember working as a CDI specialist and part of my duties was physician education and I really enjoyed it. Yet operationally, we needed specialists to focus on chart review and not provider education."

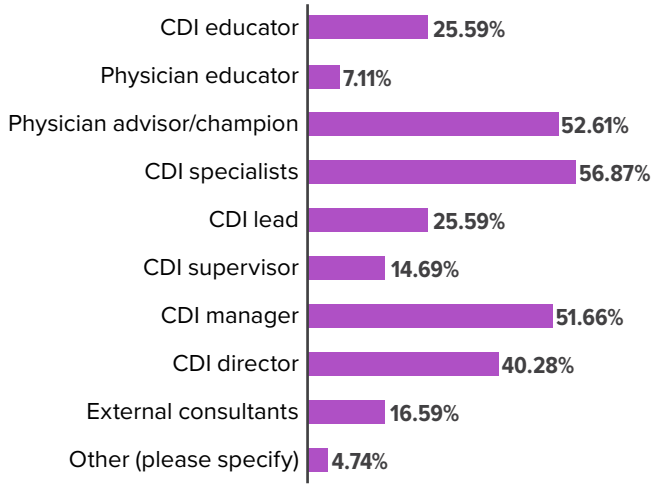
No matter who on the CDI team is responsible for physician education, joining ranks with a physician advisor or champion can further your efforts. Physicians often respond more favorably to a physician peer, and pairing up lets you provide all the relevant education in one go rather than in fits and spurts. Join up with a representative from your IT or EHR team as well and you'll be cooking with gas, according to **Tami McMasters-Gomez, CCS, CCDS, CDIP,** CDI director at UC Davis Health in Sacramento, California.

"We usually have one of our Epic trainers paired with one of our clinical documentation educators and our physician champion in the room with a group of providers. That seems to be the most favorable in terms of provider education because they get everything in one go," she says. "Typically, they like engaging with other physicians—their actual peers—and that's their preference. But when we do combine forces, it is well received by our clinicians."

If your organization is using a physician-facing AI solution, these joint educational efforts can also include information about how the tool supports physician and CDI efforts. Everything is connected, and integrating all pieces of the CDI picture into physician education—regardless of who's delivering the education—can be a big benefit.

"When providers are getting up to speed on their EHR, we want to point out, hey, you can use speech recognition to do these commands more quickly," adds **Kaitlyn Crowther, RHIA,** chief product owner at 3M Health Information Systems. "If we can build in CDI prompts and

Figure 1. Responsibility for conducting physician education



Selected other responses:

- CDI specialist level II
- We're developing an educator team
- CDI AVP
- Coding manager
- HIM director
- Vice president of HIM/CDI/DRG appeals
- We have a team of six FTE CDI specialists who do audits and education
- Coding educator
- We're not currently providing education

education alongside that, we really see the benefit of that holistic approach."

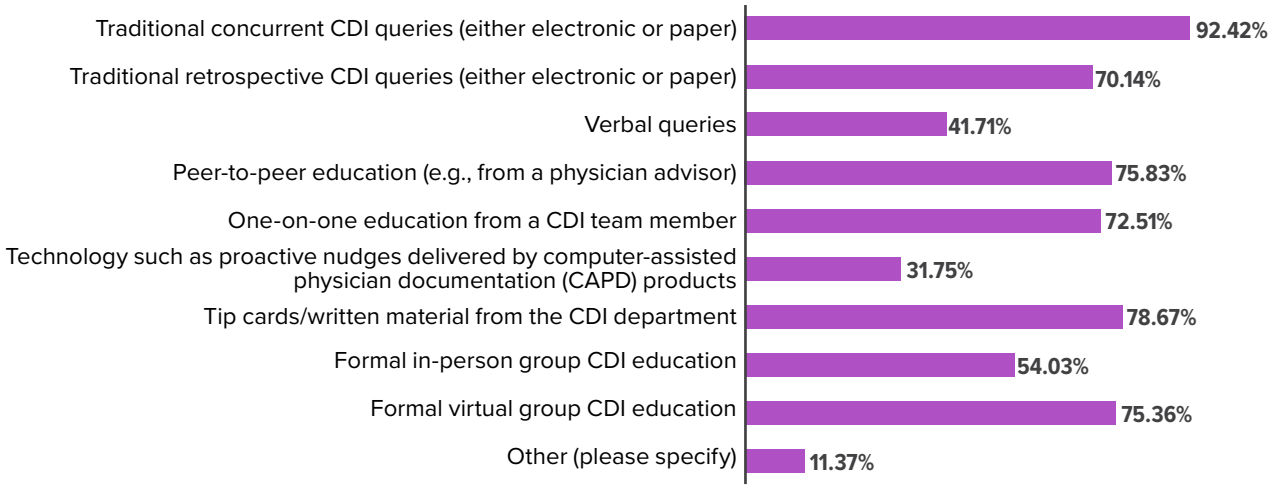
Physician education/engagement methods

CDI professionals often employ several education and engagement methods to reach their physicians effectively. While some methods are more popular than others, the survey results reveal the myriad of efforts CDI teams undertake. Most respondents (92.42%) said that they use concurrent CDI queries as part of the physician education and engagement strategy. Tip cards/written material (78.67%), peer-to-peer education (75.83%), virtual group education (75.36%), one-on-one education (72.51%), and retrospective queries (70.14%) also all rated highly. (See Figure 2.)

Though concurrent queries are undoubtedly *part* of the conversation, Risner warns that they are likely not the most effective educational tool. Instead, she recommends using your query data to direct your educational efforts, rather than using your queries *as* the educational effort. Otherwise, you're likely to be sending the same queries on the same topics indefinitely.

"The way that we use queries is as sort of a wayfinder. We'll evaluate what types of topics we're sending to physicians and then really tailor education based off of that," Risner says. "Having a stand-alone query in a chart, I don't know if that's necessarily an environment where a provider is going to learn by receiving that query. [...] But reviewing all the query topics, who you're sending them to, how frequently, and then tailoring education off that, I think is a wonderful way to gauge gaps."

Figure 2. Physician education/engagement methods



Selected other responses:

- Virtual drop-in office hours on Microsoft Teams that allow hospitalists to hop on and address any questions.
- We're implementing technology to provide proactive nudges.
- CDI orientation for all new providers, grand rounds with specific diagnosis topics, and releasing/marketing of diagnoses consensus statements.
- Learning platform with CDI and coding content.
- Follow-up emails on queries.
- On-demand video sessions.
- Service line focused education.
- Online education modules that give physicians CE credits.
- EHR enhancements.
- We're on the agenda at certain service line meetings.
- We're editing the new internal medicine resident handbook.
- Yearly learning modules on documentation.
- Podcasts recorded by our physician advisor that are available via medical education intranet site.
- Prospective queries (outpatient/ambulatory).

"Sometimes, you have to look at education as a customer service issue. When you have a particular group of providers in front of you, and it is very clear to them that you have taken the time to understand who they are and you're giving them real examples of their service line, it tends to sink in and you tend to get much better engagement."

—Jessica Risner, BSN, RN, CCDS, CDI director at Banner Health in Phoenix, Arizona

"The stand-alone queries are not really the best avenue for delivering education," agrees McMasters-Gomez. "Although we have noticed that some of the mundane queries over the years have naturally decreased as we've educated providers to be better documenters. [...] You have to look at the variety of tools you have available."

In addition to using queries as directional tools, knowing what is and isn't working with your query process and your repeat queried topics can help you determine which technological tools might work to supplement your efforts. According to Crowther, technology—particularly things like computer-assisted physician documentation (CAPD)—should never take the place of an effective query process that's engaging physicians. Instead, it should be used to further CDI's reach and impact.

"Traditional queries are really the gold standard when it comes to physician outreach for CDI topics. For every group I work with, I want to preserve what they're doing with the queries because the physicians have respect for them. There's a human thinking about these queries, presenting them in a logical way," she says. "However, I think it's very important too that [queries are] supplemented with technology like CAPD. The breadth to which we can apply the CAPD technology across the physician base is so much greater."

Physician response to CAPD

Though the CDI team may consider employing CAPD technology to address "low-hanging fruit" queries and reach previously unreached physician groups, the nature of the technology requires that physicians buy in and *use* it. Most respondents who have CAPD technology in place said that their physicians don't have a strong opinion about the technology or whether it's helped them document more efficiently/quickly (6.16% each). Among those who answered "other," many said that they are early in the CAPD implementation process, a few said that physicians turned off the CAPD feature because they felt it was intrusive, two responded that physicians liked it and it was helpful in reducing burnout and frustration, and one respondent commented that the problematic documenters are noncompliant even with CAPD in place. (See Figure 3.)

According to McMasters-Gomez, the first step to ensuring a smooth implementation process and long-term physician buy-in is to build a pilot program before rolling out the tool to all your physicians. During this period, you're giving physicians a platform for feedback and giving yourself the opportunity to adjust the tool to your needs and their concerns. Just make sure the physicians you engage in the pilot are ones who will give honest feedback, she adds.

"We were very, very deliberate in the beginning to look at our data, even the silent-mode data that was running in the background, and determine where we should focus in a pilot. So, we grabbed a pilot group of physicians that we

knew would be very candid and honest with their feedback," she says. "Some providers had some opinions and weren't happy with things, and we just kept working with them and educating them and asking what we can do to make this better. This tool is here to help [the physicians]. So, it really is an ongoing process even today. We continue to refine and work with our providers."

In conjunction with your pilot program, Risner suggests gathering all your stakeholders and deciding on the appropriate messaging to be conveyed to the rest of the physicians upon rollout of a technological solution or workflow. When some physicians inevitably push back, you'll be a united front.

"Getting your players, your stakeholders, and your champions in place for the change first, before anything is done, is absolutely key to really any project," says Risner. "You need to make sure you've got your team, then you go out with the same message and help the providers slowly get on board. [...] You just have to be ready for what your strategy or defense is going to be with those particular providers."

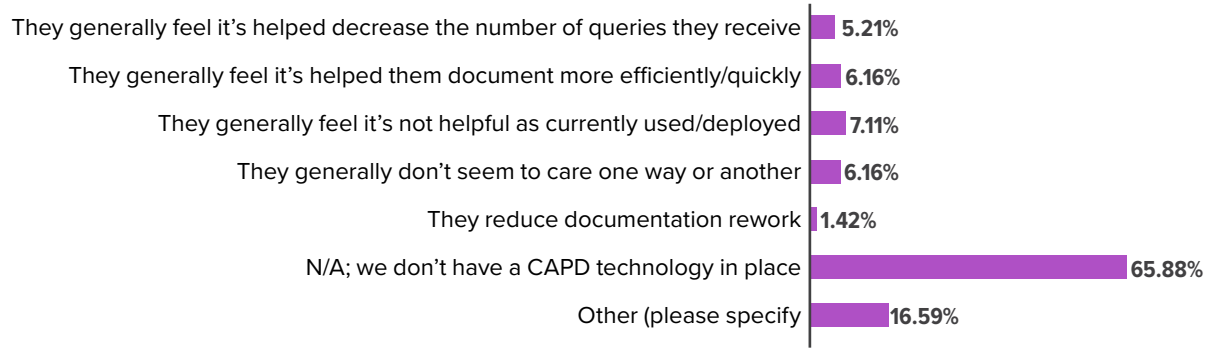
Consistency in messaging shouldn't be limited to the rollout, either; CDI leaders also need to be consistent between the education they provide directly to physicians and the information the technology uses. For example, during the implementation of CAPD technology, make sure that the clinical criteria used in the product's prompts match up with what you're telling physicians during educational sessions.

"The best thing I've seen [...] is when there's consistency between what CDI leaders are communicating with the physicians and what the CAPD is asking for," Crowther says. "It's extremely important that we have buy-in from the CDI leadership about which content we should be enabling for which groups of providers, and that we're using data as well from those CDI groups and choosing to enable the content for providers."

Rolling out new CDI education to physicians

In addition to ongoing education and engagement efforts,

Figure 3. Physician response to CAPD technology

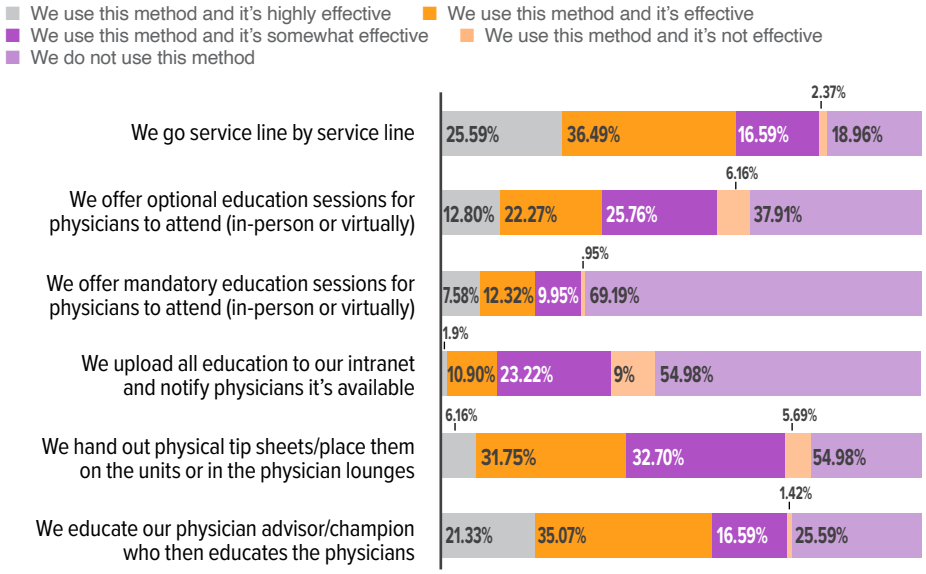


Selected other responses:

- We currently have a homegrown solution. The physicians are trying but can't seem to understand the concept of what is trying to be accomplished. We're looking into adopting a more formal CAPD solution.
- We're still in the early phases of implementation and haven't gotten a lot of participation yet.
- They're annoyed by it and turned the feature off.
- We looked at solutions but decided against it because it seemed like it would be an interruption to their work.
- Our CAPD only "fires" within their specific specialty or service line to prevent provider burnout or frustration.
- The physicians generally aren't participating with the CAPD because of COVID surges.
- We haven't implemented yet but are planning to do so soon.
- The problematic documenters are still noncompliant with the CAPD.

CDI leaders need to determine the most effective methods to roll out *new* CDI education to ensure quick adoption and limited pushback from physicians. According to survey respondents, the most effective method is to go service line by service line, with 25.59% saying this method is highly effective and 36.49% saying it's effective. On the flip side, the least adopted method is mandatory education, with 69.19% saying they do not use this method at all. (See Figure 4.)

Figure 4. Rolling out new CDI education to physicians



Selected other responses:

- We use more than one approach to try to meet physicians' needs.
- We record education and create CME modules accessible as an option.
- Our physician advisor program is still evolving.
- We engage an external expert CDI physician to conduct sessions twice annually.
- We use medical literature/guidelines to discuss current movement in medicine and while discussing the medical literature, we slip in documentation suggestions. I spend every Wednesday in the physician lounge. I schedule one-on-one education using their current patients and run each patient with their diagnoses through our software to show them if there were any documentation opportunities that would affect their length of stay, hierarchical condition category capture, etc. Our director also provides new physician orientation.
- We're currently developing strategies and shifting our methodology.
- We email monthly training topics.
- We send a letter to all new providers via email explaining who the CDI specialists are and the query process.
- Our physician advisors are responsible for peer-to-peer education.
- Prior to COVID, we went service line to service line and had ongoing education, which was highly effective. Patient volume and staffing no longer allow this.
- Our method depends on the facility and what works best there. We don't have a centralized program or method.
- We speak at practice group meetings.

While a service line-based approach may be an older method, it's stayed popular and effective because it puts the physicians' concerns at the forefront, according to Risner.

"Sometimes, you have to look at education as a customer service issue. When you have a particular group of providers in front of you, and it is very clear to them that you have taken the time to understand who they are and you're giving them real examples of their service line, it tends to sink in and you tend to get much better engagement," she says. "Whereas, if you have a larger group or a generalized education that doesn't really speak to the actual service line or particular provider group, you may lose some engagement there."

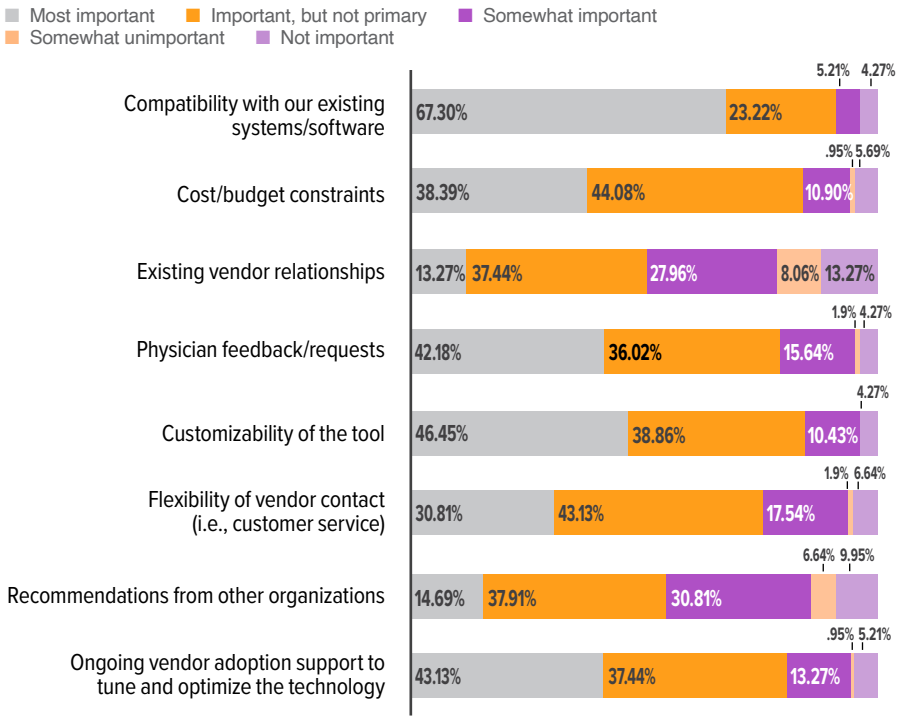
"You're able to kind of have that peer-to-peer interaction with the group [when you go service line by service line]. And they understand that this is important and how their group is performing," echoes Crowther. "I would say the things that can be outliers there are hospitalists and residents. Those have been some of the trickier ones to coordinate since they need a broader approach or the residents might be moving around a lot."

Though it may not work for all physicians, according to

McMasters-Gomez, leaning on existing mandatory education can help get the CDI word out to residents and new physicians. This will mean working with other groups in your organization to get on their agenda. You can also leverage communications that go out to all physicians, such as newsletters, to reach physicians in a low-key, non-required way, she says.

"I have a team of physician advocates [that does] all of the mandatory training and onboarding of new providers each spring as new residents rotate in. We bring in a presentation and we co-present with our CDI champion," she says. "Then we also have a newsletter. That goes out to all the physicians where we have a spotlight on CDI with links to videos and links to training, and things like that. We're not shoving it down anybody's throat, but we are trying to do what we can to get in front of things."

Figure 5. Factors for choosing, implementing a physician-facing AI technology



Selected other responses:

- Not applicable.
- We looked for a common platform for CDI and computer-assisted coding, strong reporting and analytic support with available dashboards for team members to drive their own productivity and results.
- The time required for staff to "tweak" the system.
- Compliancy is the most important.

Factors for choosing, implementing physician-facing AI

When it comes to choosing and implementing physician-facing AI, respondents reported that the most important factor is compatibility with existing systems and software (67.30%), followed by customizability (46.45%), ongoing vendor support (43.13%), and physician feedback/requests (42.18%). Just under 39% rated cost and budget constraints as an extremely important factor, and 44.08% rated it as important. Some of the "other" responses included the ability to build reports, the time required to customize the system, and accuracy and compliance. (See Figure 5.)

Regardless of what factors take priority, Risner suggests involving your IT colleagues as early in the implementation process as possible. They'll be able to provide context on what technology projects are already on the docket and what's possible given the systems in place at the organization.

"The IT folks absolutely need to be at the very beginning of the conversations, and having a well-nourished foundational relationship with your IT team at your facility is important," Risner says. "You really want to be sure that when you go into these conversations, you have a very

good understanding of your enterprise's road map for the next two or three years. What are the initiatives on an enterprise level, and how is this tool going to support those initiatives?"

Crowther says she isn't surprised to see customizability and compatibility concerns at the top of survey respondents' priority lists because that mirrors what she's seen in the field with her clients for some time. After those two concerns, she suggests weighing physician feedback and needs against the needs of the organization and the CDI program. Giving physicians a seat at the table along with IT will ensure everyone's needs are addressed.

"When it comes to balancing physician needs, it's really important to listen to them and understand what they're looking for in a tool because they may have clinical initiatives that we need to make sure are taken into account with the product," Crowther says. "I think making sure they have a seat in the selection is integral to the success of the project."

After all, the primary end goal of any physician-facing technology, according to McMasters-Gomez, is to streamline physician processes and free up their time to focus on patient care. Instead of burdening physicians in the name of improved documentation or a lighter CDI load, focus on reducing their administrative tasks. This will set you up for greater long-term buy-in.

"[Physicians] don't need to spend a bunch of time documenting things that, in their opinion, aren't focused on patient priorities," says McMasters-Gomez. "So, what we work to do is try to engage them at the point of patient care while they're documenting and not when they're going back to do other things like co-signing notes or something like that. We're really trying to focus on the compatibility with CAPD and how this can kind of help with the physician wellness component." ■

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