BEST PRACTICES GUIDE

Creating the Next Generation CDI Department

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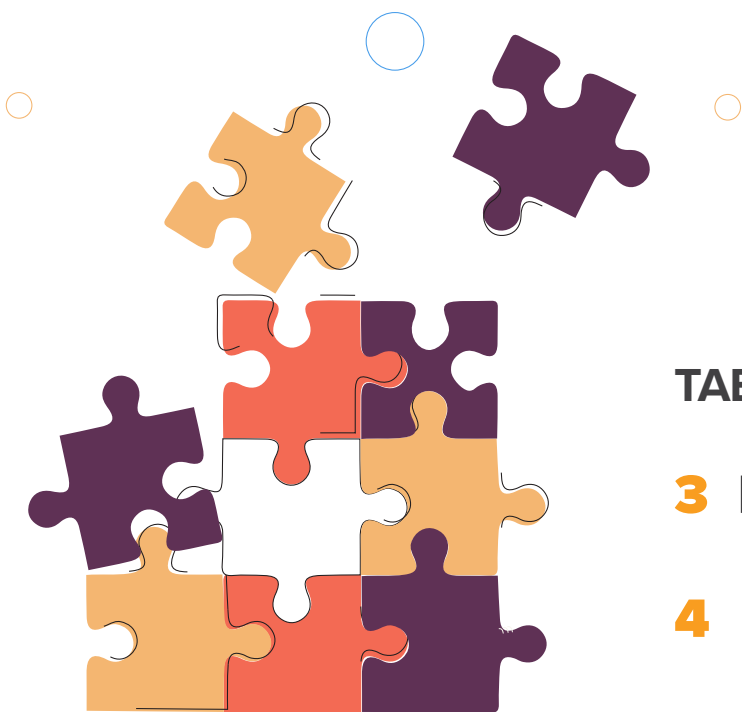**TABLE OF CONTENTS**

PERSPECTIVE LETTER

MIKE S. JONES

Vice President & General Manager, Clinical Quality and Revenue Integrity

Nuance Communications
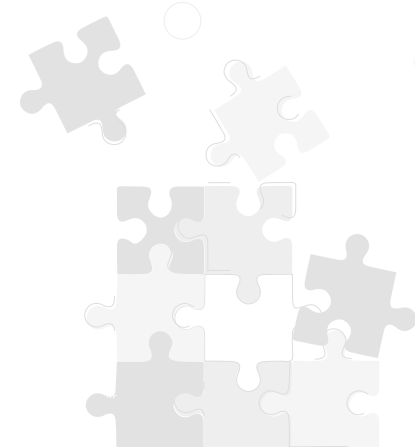
One silver lining that has come from the Covid-19 pandemic is that it has evolved attitudes toward innovation and helped many health systems understand just how quickly they can adapt when required. In one of the most challenging times in memory, health systems have realized just how resilient, agile, and adaptive they can be.

In order to rise to these challenges, we must consider what we can do—both on the front and back ends—to maintain the integrity, accuracy, and quality of charts and records while reducing friction and workloads for physicians. This mindset will ultimately lead to better outcomes for growing patient volumes and case complexities.

To achieve quality and financial objectives with fewer resources, we have found that a growing number of organizations are more willing and prepared to embrace disruptive innovation, and drive significant change in how services are delivered, workflows are optimized, and revenue is generated.

Given the role that CDI programs play in engaging physicians around patient documentation, it makes sense that you will be called upon to aide in developing buy-in for any computer assisted physician documentation (CAPD) technology being considered. As the healthcare landscape continues to shift and the future of healthcare is fluid, we ask you to consider "Where can I apply AI to help improve our workflows and clinical quality?"

ROI BEYOND REIMBURSEMENT: CDI QUALITY REVIEWS

BY: CAROLYN RIEL, EDITOR, ACDIS
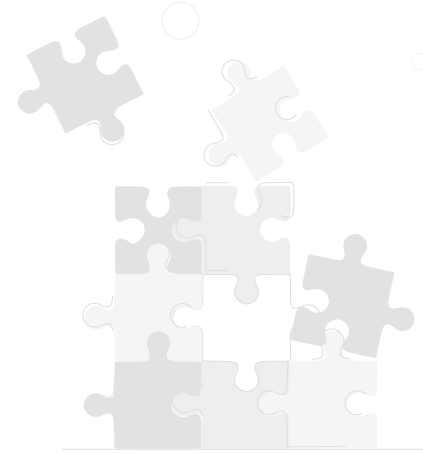
Most CDI programs came into being with the primary focus of financial improvement and reimbursement accuracy: capturing CCs/MCCs to shift the MS-DRG placement to one with a higher relative weight. The impacts of these efforts were straightforward to demonstrate, and highlighting a return on investment (ROI) was as simple as showing the DRG shifts associated with CDI activities.

As payment methodologies have begun to pivot away from strictly fee-for-service to pay-for-performance, CDI efforts have shifted focus too. Measuring the CDI impact and ROI related to quality concerns, however, is much more complex than strictly monitoring financial performance.

"You can't tie a dollar amount to it," says Deb Jones, MSN, RN, director of CDI at Brigham and Women's Hospital in Boston, Massachusetts. "There are so many benefits, [...] but you can't tie finances directly back to [our work]. It's not so clean as a financial metric or traditional CDI metrics."

Yet, if CDI is to keep up its vital contribution to an organization's health and continue receiving resources for expansion, CDI leaders need to show their returns concretely and decisively to organizational leadership.

Tracking length of stay metrics

The first step to showing an ROI for quality measures is knowing what information to track. There are a number of potential focal points when it comes to quality reviews—Patient Safety Indicators (PSI), mortality data, hospital-acquired conditions, readmissions, and more.

While CDI leaders may feel at a loss for where to start, Chinwe Anyika, PhD, RN-BC, CDIP, CCS, CCDS, CCDS-O, CPHIMS, manager of CDI and data operations at Memorial Sloan Kettering Cancer Center in New York City, suggests looking at your organization's unique focus areas and goals and selecting the most important measures of success from those focal points.

"Right now, we report out the LOS [length of stay] index (observed/expected ratio), a mortality index, ROM [risk of mortality], and SOI [severity of illness]," Anyika says. "We still track and use DRGs, but we focus more on our quality scores. We're a cancer center and have a critically ill patient population with multiple chronic conditions. Because of this, our patients generally stay longer, so our CDI reviews are more intensive because we need to ensure that anything which happens during admission is captured and accurately documented by the provider."

According to Anyika, when the mortality index (observed/expected mortality ratio) is less than 1, that's a success for Sloan Kettering.

"If a patient is scheduled for chemotherapy and they suddenly get admitted with pneumonia, for example, we may still need to administer the chemo when they're stable and during the same admission. The patient may have associated pancytopenia which may need transfusion. The patient may get transfused," Anyika says. "All these will invariably lead to a longer LOS for the patient. We always have to explain the medical necessity for this LOS, and this can only be optimally achieved when accurate and codable documentation is completed by the provider."

The sure way to obtain accurate expected LOS is to ensure that the patient's additional and applicable diagnoses/conditions are accurately documented in the record from the beginning of the stay through discharge. When this happens, the providers derive the optimal expected LOS available to care for their patients.

"If we can get this vital information documented as the events occur, then we can justify a longer LOS for the patients when this happens," she says. "It's so important that if there are any questions or ambiguity in documentation, the CDI specialists query for clarification."
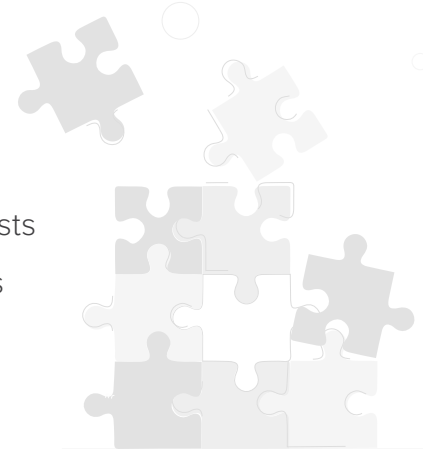
Tracking mortality metrics, public rankings

Often, the mortality index information offers a straightforward entry point for proving a quality-related ROI, agrees Jones. This is largely because the observed to expected (O/E) ratio can be trended over time to see the effect of your focused CDI mortality reviews.

Simply put, an O/E rate of greater than 1 means that more patients died than were expected. When the O/E rate is too high, it either indicates that the hospital didn't take care of their patients well, which led to their untimely deaths, or that the documentation didn't show how sick (and at risk of death) the patients really were.

"[CDI efforts] can't do anything really to change the observed, but you can make that denominator bigger for the expected," Jones says.

Brigham and Women's utilizes technology to help extrapolate the expected mortality rates and calculate the O/E ratio. Then, the CDI team can use that data to home in on particular diagnoses that are heavily weighted across different methodologies and used by payers for risk adjustment.

"Those particular diagnoses we've found are coagulopathy, weight loss, and fluid and electrolyte imbalance, so we have particular goals for capture rates for those," says Jones.

It's important, according to Jones, to look at your quality metrics (such as your O/E ratio) in relation to your peers for benchmarking purposes. This will help you understand where you may need to improve further to be competitive. At Brigham and Women's, Jones partnered with a quality analyst to do a focused review of their quality data.

"We took a look at the *U.S. News* top 20 hospital report, since we are included in that," says Jones. "That's where we figured out who our peers were and compared to see where there was the most opportunity for improvement."

Using the *U.S. News & World Report* list to show the quality success of their CDI program has won the support of organizational leadership, says Jones.
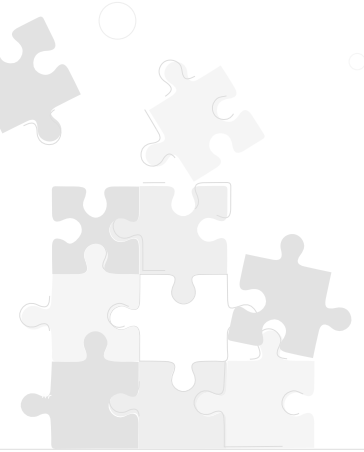
"Although it doesn't have direct [financial] ROI attached to it, we can say that the work we're doing improved the expected mortality and in turn will improve O/E that will then increase our ranking," she says.

In addition to outside quality ranking reports, Anyika suggests CDI leaders leverage their existing technology or employ the help of outside services to generate reports for the department showing its quality impact. At Memorial Sloan Kettering, the CDI team leverages their CDI technology for mortality tracking and the risk adjustment calculator offered through their external vendor, which also offers a level of predictive analysis for their future efforts.

"We use the tool to determine possible diagnoses that may improve the quality outcomes for the patients," she says.

Reporting, sharing data

While the aggregated CDI ROI data may be valuable for a CDI leader to see and pass along to organizational leadership, Jones suggests giving each CDI specialist access to their query impact data. This allows leaders to develop benchmark expectations, gives CDI specialists an idea where they stand, and shows staff members the impact they're making for the organization.

"At this point, it's only reported as an aggregate, although I do measure the number of individual queries that a CDI specialist sends that are quality or severity based," says Jones. "Each person has a goal of a 35% query rate for severity and quality–type queries."

Beyond the CDI staff, quality ROI data should be passed along to organizational leadership and decision-makers so that the true value of CDI efforts related to quality reviews can be recognized. Which leaders need the data, however, will depend on your organizational priorities and departmental reporting structure.

For example, though they review many of the same metrics, Anyika and Jones share their data with different organizational entities.
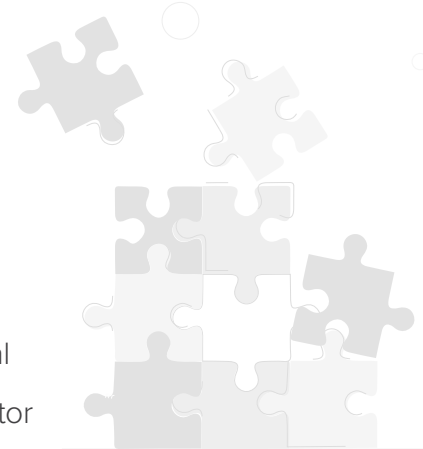
"In my facility, the quality ROI reports are looked at by the HIM director, the deputy physician in chief, and the finance department," says Anyika.

Jones adds that, depending on whom you're sharing the data with, you may need to customize the reports accordingly. Not every group or individual wants (or needs) to see every data point.

"A few people lay eyeballs on it, and so the information in the report will change depending on who is looking at it," she says. "We have a CDI steering committee that has representation from all leadership, and they're getting the highest level of overview of that information. Then, at that point, it gets tailored down a bit more depending on the audience. If I'm reporting it to just my leaders, it would contain the information that they're focusing on or the metrics they want to see."

Leveraging quality for physician engagement

While it may not have a concrete financial ROI attached to it, one of the hallmarks of quality review success is improved physician engagement, which will ultimately help all aspects of CDI work, Jones says.

"Every year for the past three years, we meet with each service line and show them their individual quality ranking and how we think they have improved their documentation, but also how they can improve their expected mortality and severity rankings," she says. "That has been a total game changer."

Now, when Jones approaches the department chairs and service line chiefs, they immediately want to know what they can do to improve their mortality rates. Their enthusiasm ultimately works its way down to the other physicians in the department.

"It's really been a top-down approach with engagement rather than going to them individually," she says. "The level of engagement has drastically improved."

Conversely, while improved physician engagement indicates that CDI efforts related to quality reviews may be working well, a dip in quality-associated metrics may indicate the CDI team needs to offer additional physician education, Anyika says. While some education opportunities are unique to the physician in question, leaders should monitor their metric performance for regular, predictable changes that could offer context around any decline.

"We are a teaching hospital, so we find that the metrics might drop when there is an influx of new residents, fellows, nurse practitioners, and physician assistants. As documentation improves, those metrics get better," she says.

Monitoring metrics by service line may also offer avenues for focused education, Anyika says. For example, when she noticed that a specific service line's physicians had longer LOS and mortality indexes, Anyika did a focused audit of their charts. Her audit revealed that some of the physicians were not documenting the patients' associated conditions, such as malnutrition and pancytopenia—these would have improved the LOS and mortality indexes. As a result of these findings, she was able to offer focused education to that service line and later reported better results.

"We've found that [quality reviews have] helped us open doors for provider engagement," says Jones. "When you're approaching them from the aspect of quality and how it will affect their quality scores, they respond much better to that than trying to get them engaged for reimbursement purposes."
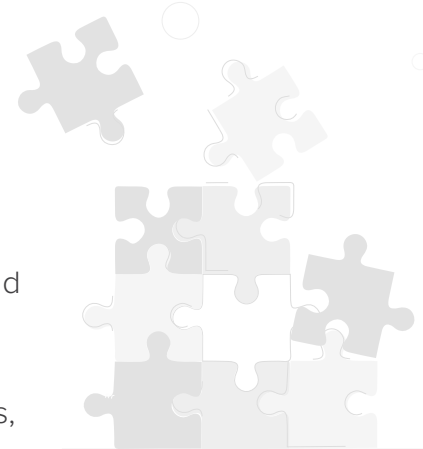
TECHNOLOGICAL IMPACT ON PHYSICIAN DOCUMENTATION, WORKFLOW

BY: CAROLYN RIEL, EDITOR, ACDIS
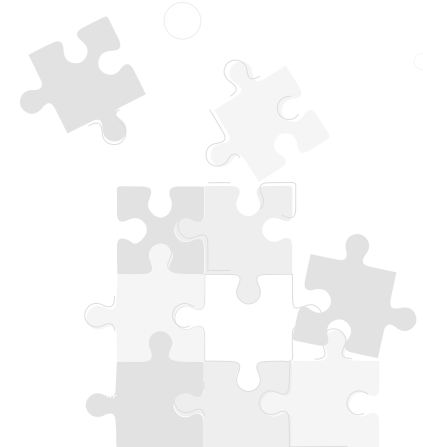
With most patient charts now housed in EHRs, technology has become a standard part of the healthcare industry. Growing technological adoption, however, means physicians spend an increasing amount of time on computers and using technology. Physicians sometimes meet this development with hesitation, as their main concern is providing patient care, not pressing a long series of buttons to input or acquire information. While physicians may be reluctant to use technology at first, there are many ways that its adoption can improve their workflow and patient care.

Education

As is often the case, physician engagement with new technological solutions hinges on proper education. When approaching physicians about a new system, make sure to bring the conversation back to the results expected from the new technology, how the system will help them, and how the resulting documentation will improve both metrics and patient care.

"They have to understand the critical importance of specific documentation and the tremendous benefits that CDI provides," says Christopher M. Petrilli, MD, SFHM, medical director of CDI and clinical lead of value-based management at NYU Langone Health in New York City. "Yes, their documentation is important for reimbursement and externally reported metrics, but most importantly, it's telling the full story of the patient and illustrating exactly what was happening."

According to Petrilli, that type of high-level overview gives physicians a sense of why they need to be more judicious about their documentation. "That education can be done individually or at rounds, as long as it's done. Then you can focus on training them on the specific use cases for technological solutions," he says.

Once physicians understand why their documentation is important, you can safely move on to the specifics of your new technology through a variety of avenues and methods.

"Whenever we add a new technology, we try to start months in advance and communicate to every physician forum—at medical staff meetings, department meetings, and medical executive meetings—so that we are being very comprehensive with that communication and informing them that a change will be made," says Vaughn Matacale, MD, CCDS, director of the CDI advisor program at Vidant Health in Greenville, North Carolina. "It's repetitive, so we know some providers are seeing the same presentation two to three times, but that's just making sure everyone is in the loop."

In addition to face-to-face time, Matacale says his organization has used numerous written formats to inform and begin training physicians on new technological solution implementations.

"We have developed tip sheets, shown screenshots, and have instructional sheets all circulated through multiple pathways," he says. "And whenever we're onboarding a new physician, we include any new technology as part of their onboarding."

In the past, Vidant Health has also asked physician leaders to partner with technology leaders to deliver the education. Leveraging peer-to-peer communication for workflows and information about new technologies ensures the trainee and trainer are speaking the same language, making the most out of education sessions.

"For brand-new technology, we have a number of physician leaders who will participate in the integration of the new technology," says Matacale. "They help from the start to design the educational information and then pass it along to all other physicians."
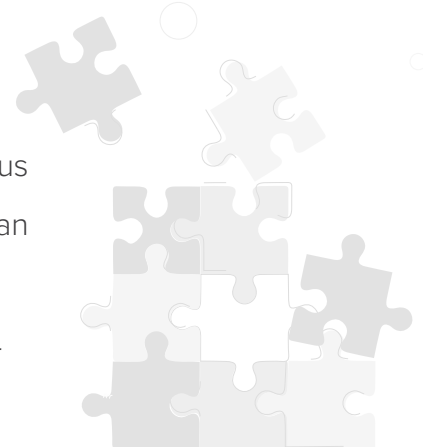
Matacale says that the director of medical informatics is always "in the know" with new technology, and he is often the bridge between the medical staff/providers and the IT area. Though your software vendor or internal IT department can offer a wealth of technological knowhow, leveraging your medical staff is helpful because they already know the workflow and likely have an existing rapport with colleagues.

"We have a lot of nurses in informatics, and they're used to the EHR and workflow already, so they will work with the physician champions in conjunction with the IT department to come up with the provider guides and tip sheets, working in collaboration to build those tech training materials," Matacale says. "If there's new technology that's hitting so many different areas and departments, it really needs to be a team-based approach between all the areas it will be impacting."

Provider struggles

No matter the level of training and preparation you put into implementing a new technology, you'll likely still encounter some struggles along the adoption journey. Inevitably, regardless of the project, there will always be a few troublesome providers, according to Matacale.

"There are three buy-in types for new technology," he says. "The early adopters are the people who hear there will be new technology, seek it out, and basically embrace and incorporate it into their workflow. Then there are the majority of us who are the normal adopters, where when new technology is implemented and information is given out, we adopt it then. And finally, there are the late adopters, [of which] some are non-adopters who reluctantly go along if there's no other choice."

Those falling into the late adopter category prefer to apply more thought before incorporating something new; they want to make sure the new technology is actually going to work for them, and are often reluctant to accept perceived

or actual changes to their existing workflow. With any new technological solution, make sure you know how the tool will affect physicians' daily work and long-term workflow before you fully implement it, Petrilli recommends.

"A lot of the issues I've seen have resulted from difficulty finding information that you need in the most efficient way possible," he says. "How do you find the most recent labs and vitals without having to dig around multiple tabs? Or if I do have to search, what's the most efficient process to navigate to the data I'm looking for? Any interruption to a provider's workflow can cause adoption hesitation."

When physicians do run into trouble or resist adopting the new solution, revisit your peer-to-peer education with a focus on the physicians who are having a problem. This education can be provided by another physician or even by a CDI staff member or informaticist.

"Sometimes people just struggle with new technology, and that's where other people from the team can do at-the-elbow support with struggling physicians and help integrate the new technology," Matacale says. "Leadership should also be aware that new technology will cause interruptions to normal physician workflow, and they need to be patient with that learning curve."

Even if all your physicians happily adopt a new technology, any interruption to physician workflow may lead to negative effects on documentation, even just for the short term. Matacale suggests reviewing your technology implementation and update schedule to try to limit these impacts.

"When you have established providers who are clinically very busy, adding [technology] on can sometimes be burdensome, so you have to look at timing and implement technological updates in batches so that you can have one update rather than multiple. That way physicians aren't constantly dealing with new technological updates," he says. "Make sure that the updates you're implementing are going to be improving documentation in the long run. Gauge what is important enough to merit causing that disruption to workflow."

When choosing a solution, in addition to keeping an eye on physician workflow impacts, make sure that the new solution will lead to outcomes that align with your organization goals and that the negative effects don't outweigh the positives, Petrilli says. If your chosen solution will cause undue disruptions instead of improvements, it may not be the best solution for your needs.

"You may think new technology is going to be beneficial but the burden to providers becomes excessive, which is not a good long-term strategy," he says. "For example, if you implement a technology that is going to catch any and every clinical abnormality on a patient record, there may be flags for clinically irrelevant conditions, and constant interruption may occur leading to significant alert fatigue and failure to advise on the specific unifying diagnosis, which the technology fails to capture when the human factor of CDI specialists would."

For necessary technology that still may interrupt physician workflow, Matacale says CDI professionals can do a few things to lessen such disturbances, including:

- Involve physicians throughout the implementation process.
- Communicate physician workflow impacts to leadership to ensure proper expectations.
- Bring clinical leadership to the table for feedback and adjust your solutions accordingly.

For smaller changes, the best way to ensure the most seamless integration without much interruption to physician workflow is to implement the solution a little bit at a time, so that when they are using the EHR they hardly notice the small differences, Matacale says.

For larger changes or implementation, you may need to slow down the timeline. When you move slowly, you also have a better chance at making sure you're doing things right the first time, which helps you avoid rework later.

"You want to make sure you've done the work to set yourself up for success," he says. "If you don't spend enough time on the front end to hit all the areas you need and involve everyone who will be using the new technology to gain their input, you'll be more likely to miss something and then have to do it all over."
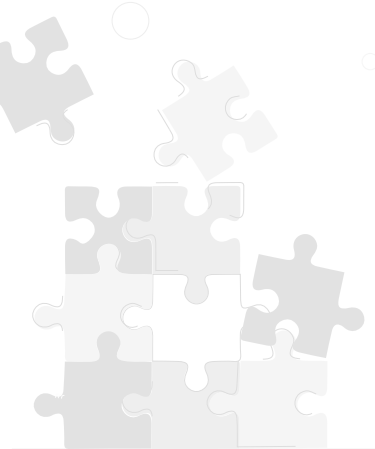
Documentation improvement

Of course, the goal of a new technology isn't to interrupt physician workflow and create more administrative work for them. Its purpose is to help improve their overall documentation, ensure all appropriate information is on a patient chart, and improve providers' workflow. While technology offers a myriad of potential documentation improvement opportunities, you'll need to assess where your greatest need lies and focus your efforts there to ensure a successful implementation.
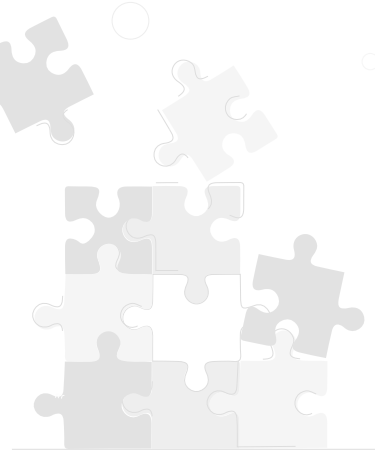
"When you're examining technology vendors, it's okay to cast a broad net and go slowly; have many people at the table to add thought and perspective," Matacale says. "Reach out to peers for their references. Do demos or site visits to see how this technology actually works firsthand."

Once you have chosen and are implementing a new solution, Matacale recommends doing a lot of work in "silent mode," running the technology for six to 12 months in the background. Then you can analyze what impact the new tool would have on providers, CDI staff, and coders before going live.

"It's always good to vet things before going live. If you don't, there may be unforeseen consequences that, if you did analysis before, you may have been able to discover and repair prior to going live," he says. "You really have one chance with big go-live events for technology, so you need it to be right."

You want any new technology to make meaningful improvements, Matacale says. "The goal of technology is to make sure that it's layering on added value. That value could be compliance for physician billing, ensuring medical necessity; it could be financial such as quality-based initiatives. There are many ways that technology can layer onto documentation for improvements, so you want to hit as many of those goals as you can," he says.

For example, Vidant Health uses templates in the EHR to make sure that the patient's chart includes all the necessary documentation and the provider isn't missing anything. A brief operative note, for example, is required on the chart before the patient leaves the post-anesthesia care unit (PACU), but a full operative note is necessary after. For these

cases, Vidant leverages voice-to-text capabilities and an auto-populated template so that physicians can easily create their full operative note in the PACU.

"No one wants to duplicate work, so we have it set so the physicians can use that voice-to-text technology with a template before the patient even leaves, then all of their documentation is completed with one note, rather than two," Matacale says. "If you find the features that physicians realize make their lives easier, it makes adoption of that technology very palatable. It reduces their documentation time, reduces redundancy, and they're more willing to be on board with solutions like that."

According to Petrilli, the "holy grail" for EHR technology would be to make sure that the provider addresses every relevant patient diagnosis. Once the entire suite of diagnoses is addressed with physician orders or evidence of monitoring, the overall documentation process will be improved.

"That's where I think the real synergy with CDI and these technological solutions lies. The tech can help identify critical conditions that providers may not have already noticed," he says. "Or even if the provider would have noticed, it notifies them in real-time at the point of care, which is also a wonderful opportunity for continued education."

While technology can aid dramatically in improving physician documentation, it is not a catch-all solution, so CDI's role will always be necessary in the documentation process.

"Even if in my documentation I occasionally may write the patient has abnormal renal function, which is clearly not precise enough to fully capture the clinical picture. You need to document at the highest level of specificity. This is where CDI adds tremendous value because they have that clinical eye that technology won't have for the foreseeable future," says Petrilli. "Technology has been very successful in various areas, but the reason why it falls short of expectations is because you still need someone with the clinical training experience reviewing these charts to optimize documentation. Computers will only take us so far. [...] No current technological solution comes anywhere close to replacing what a CDI specialist offers."

A HUMAN WORKPLACE: STAFF APPRECIATION AND RETENTION

BY: CAROLYN RIEL, EDITOR, ACDIS
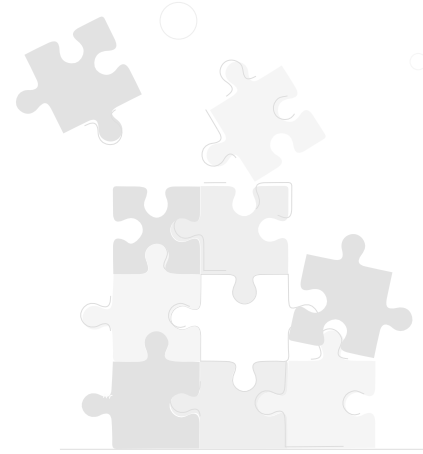
Employers often put significant thought, time, and energy into hiring new team members and ensuring they will be a good fit. All this effort, however, can go to waste if you have employees leaving the organization after only a few years. You may have hired the best staff in the world and found people who excel at their jobs, but if you don't make sure they feel appreciated, the odds of them staying with the company long term are low.

"One of the biggest risks of staff not feeling appreciated is they will seek placement elsewhere. When you have staff feeling underappreciated, it can turn into a staff who will also be underperforming," says Jessica Burrell, CPC, CRC, director of coding with Curation Health, headquartered in Annapolis, Maryland. "Then that's not only bad for the person, but bad for the company as a whole. Underappreciated people generally won't stay in that position."

When you're feeling underappreciated in a role, it's easy to spiral into negative thought patterns as well, says Elizabeth Morgenroth, RHIA, CPC, director of ambulatory CDI with Curation Health. "As coders and CDI reviewers, we are taught to look or perform work with a critical eye. It's easy for us to be critical of ourselves, documentation, and others, so if you add on the negative feeling of your work not being appreciated, it's very easy to pass on those negative emotions to others."

While coders and CDI specialists aren't involved with direct patient care, they work to support those who are, and their negative attitudes can have a long-reaching impact.

"We're part of a partnership, and we don't want to contribute to provider burnout. We want to be the solution," says Morgenroth. "If your staff are feeling underappreciated, that can impact their interactions with physicians, which can

impact the care a patient gets. In this profession, appreciation isn't just about the singular employee, but about the whole working mechanism of patient care and where you fit into that mechanism."

Spotting, remedying underappreciated staff

To remedy staff members who feel underappreciated, you must first recognize how to spot them. The ways employees show their feelings will vary depending on their personality, but leaders can look for general trends that may indicate a problem is afoot.

"Something I look for is the quality and productivity in their work," says Burrell. "Staff who aren't necessarily in it for the long haul anymore stop putting the same effort into their work. That's generally something you can notice easily."

Morgenroth adds that other employees might display their dissatisfaction not through their work, but through their demeanor.

"Their work might remain the same, but they may become quiet and unengaged," she says. "They're going to act in a way that's uncharacteristic of their true north, who they are and what they are."

Employees showing emotion in different ways is one of the many important reasons that leaders should get to know their employees not just as workers, but as people. Knowing how they act in a day-to-day setting and how they appear when they're happy makes it much easier to spot when something is wrong.

"Hopefully we as leaders have done a good job in first listening to our direct reports and building a culture of trust and understanding," says Morgenroth. "If we don't take time to care about and listen to them, how do we know they're acting uncharacteristically? We have to be engaged with them intentionally and on a regular basis."

It can be easy for leaders to get caught up in their own daily tasks, but it's imperative to keep people front and center—not just in terms of patient care, but also the people you're leading.
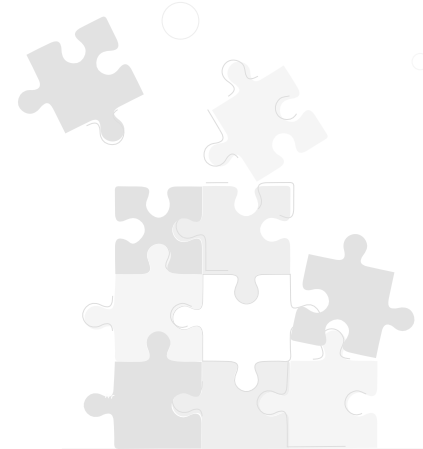
"You want to know them well enough that you almost know what is important to them," says Morgenroth. "At the end of the day, maybe that person is not necessarily burned out or disgruntled. Maybe they're just looking for something more, and maybe there is an opportunity for us to provide personal growth and professional development for them."

The first and most important step in ensuring your employees feel appreciated is having a conversation to make sure they know you care about them.

"Provide education for them, give them feedback, let them know you care about their professional development as well as them personally," says Burrell. "As a leader, you have to be flexible and understanding of people; everyone is different and has a different family life. You don't want people burned out or feeling like they're always fighting fires. We're all working as a team, so if they need days off or have questions, we're there to support them. They need to feel supported and educated."

As humans, we need to feel cared about in all facets of our lives, and we need to know we have the support of our managers.

"We work in a human workplace; we work with other human beings," says Morgenroth. "I care about you as a person. You can't forget the human aspect of life just because you're in a workplace."

When it becomes apparent that an employee might leave due to feeling underappreciated, Burrell says she might reach out and provide some one-on-one attention, ask how the employee is feeling, and see what she can do to volunteer support.

"Even if they do end up leaving, it's a good learning experience for me to see what I may have overlooked as a leader," she says. "Many times, they just need to be heard or have a break. So, it's my job to ensure they have the tools to do so and feel supported."

"If suddenly you find with your staff that you're no longer aligned, maybe it's time to part ways in an amicable way," Morgenroth adds. "Don't burn bridges with them. Again, we are all human; don't take it personally."
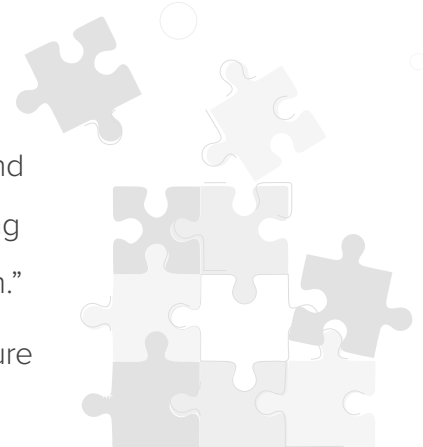
Gaining physician appreciation

In addition to leadership showing staff they're appreciated, it's important that physicians extend that same appreciation too. CDI specialists work with physicians constantly, and sometimes physicians act in a way that comes off as unappreciative or annoyed because they're not sure about the role of CDI and its importance.

"Part of our role is having to prove our value to providers," says Burrell. "We have to communicate how we are helping them."

Providers can be intimidating and aren't always open to communication with the CDI or coding team, but developing a rapport with them and proving CDI's value is the first step toward gaining their appreciation, Burrell adds. "Help them see that we have their interest at heart and the patients' interest at heart. We're all on the same team."

"When you're personally engaging with physicians, a great way to start is to ask how you can help them," suggests Morgenroth. "Maybe there isn't anything for you to directly help with, but you've still taken the time to ask them and let them know that you're there to support them."

First and foremost, remember that you can all agree that patient care comes first. "Be prepared to listen. Keep your mouth shut and your ears open. Even your body language should be open and inviting," Morgenroth says. "Really, be open always. Sometimes a burned-out physician may feel attacked by our queries or defensive, so be willing to take all of that and listen with a sense of passion without getting defensive yourself."

Go into the conversation with an attitude of humility and appreciation. This creates a better environment for the physicians to really hear you. Also, remember to speak their language. Physicians will find it much more difficult to be invested in the conversation if you're using coding terminology they don't know or appreciate.
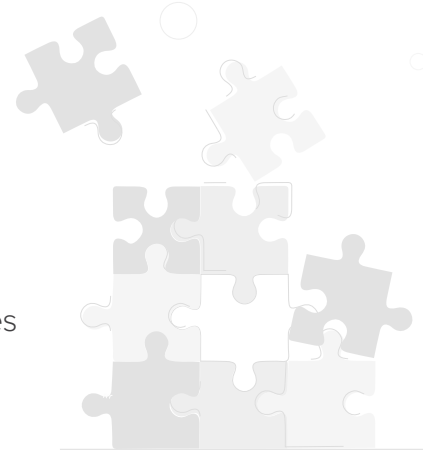
Therefore, keep in mind what is important to the physicians and communicate it in a way that makes sense to them. If you don't have the means to do this yourself, talk with a physician advisor or champion who might. Depending on the scenario, that advisor or champion may have more success speaking with physicians in a peer-to-peer discussion.

When it comes to appreciation and burnout, physicians aren't the only ones who experience fatigue and overwork—anyone can experience these feelings.

"Our leadership does a great job of reaching out to us individually and making sure we feel mentally and physically well," says Burrell. "They really want to prevent burnout, not just for providers but for us all as well. Maybe it's an extra day off or to lighten the workload by having a team member help out. Just easing that burnout makes anyone feel much more seen, heard, and appreciated."
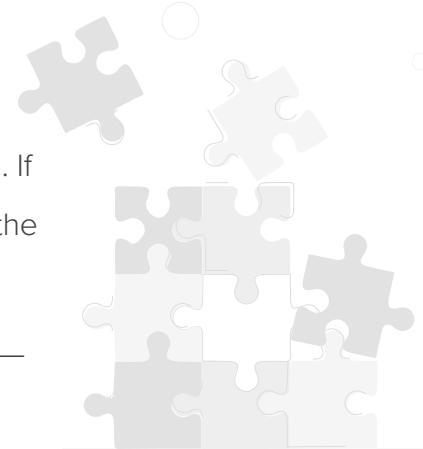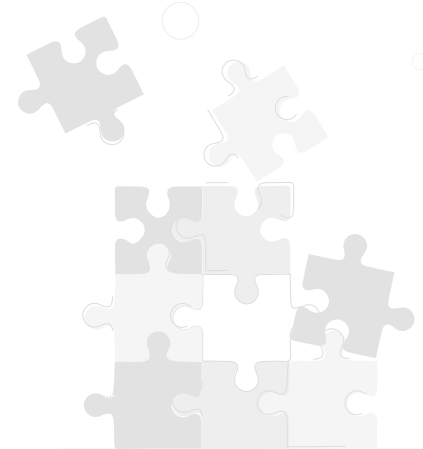
About Nuance

Nuance healthcare solutions capture patient stories, helping clinicians drive clinical and financial outcomes. Nuance CDI is a comprehensive portfolio of cloud-based technologies designed to help increase the productivity and effectiveness of CDI teams to drive clinical documentation excellence. Our clinically focused program and services deliver documentation guidance, AI-powered encounter prioritization, workflow management, denials support and analytics to drive better documentation across the care continuum.

Nuance Inpatient Guidance for Dragon Medical Advisor is an in-workflow guidance solution that helps improve overall documentation accuracy, ensures higher quality and promotes more appropriate reimbursement. It provides CDI teams with the ability to properly sequence diagnoses that can impact DRG assignment and search for clinical clarification opportunities based on evidence.

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