CDI Week

Provider engagement

As part of the twelfth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. **Hiral Patel, MHI, BSN, RN, CCDS,** is a CDI specialist at University of Texas Southwestern (UTSW) Medical Center in Dallas. She is a member of the Texas ACDIS chapter and the 2022 Furthering Education Committee. For questions about the committee or the Q&A, contact ACDIS Associate Editor Jess Fluegel (*jfluegel@acdis.org*).

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

A The engagement and collaboration of the medical staff at UTSW has been great so far, but there are challenges as with all CDI programs around the nation. The engagement goes down when there are new medical staff hired, higher than normal census of patients, or low staffing of medical staff. Overall, the medical staff at UTSW have embraced the CDI program and they are well engaged with the team members within the program.

Q The percentage of respondents with "highly engaged" medical staff decreased from 14.44% to 12.09% year-over-year, according to CDI Week Industry Survey data, continuing a downward trend from last year. What do you think are the reasons the high levels of physician engagement declined again this year?

A The high levels of physician engagement declined again this year due to COVID-19 at UTSW. This is because of physician burnout and having to take care of many patients and/or very sick patients at one time. Also, new physicians and residents joining UTSW has caused a downward trend in engagement as the new physicians become acclimated to the CDI program at UTSW, documentation trends, guidelines, and the complex patient population at UTSW.

Q While only around 12% of respondents said their medical staff is "highly engaged" with CDI staff, another 46.72% said their medical staff is "mostly engaged and motivated, with some exceptions." That's a lot of overall positive engagement, but 7.61% said their medical staff is "mostly disengaged and unmotivated." For those in that 7.61%, what advice do you have to help them increase engagement?

A I would first take time to go talk to them and find out why they are mostly disengaged and unmotivated. I would advise the leadership and CDI team to then find ways to help them feel engaged and motivated. I would provide education, data with trends, and probably have some rewards (e.g., kudos, candy, etc.) to help them feel engaged and motivated toward the program.

Q Each year, we hear that physician 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 physician engagement? What have you done to address and improve this?

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A I think CDI programs have such trouble in general engaging the medical staff because sometimes the medical staff feel that whatever CDI does is mostly only focused on increasing revenue for the medical facility and therefore, they tend to not take it seriously and get disengaged. The biggest challenges with gaining physician engagement have been to be able to set time aside from their busy schedules to provide education or to help with their concerns.

We have provided in-person lunch-and-learn sessions, education sessions virtually, tried to call, and use secure chat messages through our EHR to physicians to help them get engaged and inform them of the goal of CDI and why it is so important to the organization for accurate documentation.

Q According to the survey results, more than 17% of respondents do not have a physician advisor and do not plan to engage one. Does that surprise you? Why do you feel a physician advisor (or champion) is beneficial to CDI?

A Some organizations do not have a physician advisor and do not plan to engage one due to financial reasons as they must pay for this position, and many organizations do not have the funds for this role. This does not surprise me as I have heard this reason from organizations before. We do not have a physician advisor at UTSW, but we have physician champions for most of the service lines, and this has been beneficial. The champions are physicians, and sometimes physician-to-physician communication/education is taken well compared to CDI-to-physician communication/education. Sometimes the physician may explain in a way that is easier for the physician to understand in comparison to the CDI staff.

Q According to the 2022 CDI Week Industry Survey, 39.55% of respondents share their physician advisor with another department. Why do you think CDI departments share advisors?

A I think they try to utilize the physician advisor as much as they can in other departments to be cost efficient. From my experience, the physician advisor usually has other roles within the organization. I have not come across an organization where the physician advisor only does this role, but I am sure there are some organizations that have their physician advisor only focus on this full time. This can be true for larger organizations with many hospitals to manage, which would make the physician advisor responsible for all the sites in the organization.

Q Roughly 80% of respondents said they have an escalation policy in place for their physicians, but several free-text comments mentioned that their policy is ineffective. Do you have an escalation policy and if so, what does it entail? What's the benefit of having an escalation policy in place? What makes this type of policy effective?

A Yes, we do have an escalation policy in place for the physicians. The policy states that after two unsuccessful follow-up attempts for a query, we would escalate up to the CDI coordinator to then escalate to the physician champion. If the physician does not respond and it becomes a trend, the physician may be contacted by the higher level of physician leadership for education if needed. It is beneficial to have an escalation policy in place to help CDI staff escalate issues and help meet the organization's goals. This enables us to also know who has a trend of not answering queries and it can be addressed in a professional manner. In order for this type of policy to be effective, leadership must be willing to help solve any issues that arise and enforce the policy.

Q Do you provide formal education to your physicians (e.g., one-on-one meetings, group presentations by service line, informal coaching, tip sheets, newsletters, etc.)? How is education content decided (e.g., based on hospital standards, individual physician needs, etc.)? How have your physician engagement models changed over the last two-plus years in light of the pandemic?

A Yes, we do provide formal education to our physicians by using one-on-ones, group presentations by service lines, tip sheets, and informal coaching whenever an issue arises. The education content is based on reports that are generated to see the impact of the CDI program. Topics based on repeated query opportunities present a good opportunity to educate physicians and reduce the number of queries generated for the same things. In light of the pandemic, the provider engagement models have become more virtual compared to the on-site setting prior to the pandemic.

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NUANCE

Optimizing clinical documentation integrity with in-workflow AI

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With hospital margins under pressure and industrywide labor shortages, CDI teams are continuously asked to do more with less. Tasked with improving quality and financial outcomes, it is essential that CDI teams find innovative ways to not only increase physician engagement, but also optimize program effectiveness and drive efficiencies across the documentation life cycle. As CDI programs strive to adapt to these challenges and reach new heights, AI solutions will play a critical role in their success.

By injecting real-time, actionable intelligence into clinicians' workflow through computer-assisted physician documentation (CAPD) technology and simultaneously infusing the CDI workflow with intelligence on the back end, organizations can improve outcomes, ease challenges, and optimize clinical documentation integrity. Rather than replacing CDI teams, AI-driven CAPD solutions amplify the impact and effectiveness of CDI efforts. Here are three reasons why.

1. Ease physician engagement challenges and streamline workflows

Physician engagement is essential to any CDI program's success. And while research shows that the vast majority of physicians care about documentation accuracy, having to frequently revisit their documentation due to retrospective queries can contribute to cognitive overload and burnout, impacting their appetite to engage with CDI teams. When guidance is delivered in real time and at the point of care, documentation omissions and errors that a CDI specialist would traditionally need to follow up on via retrospective queries are less likely to slip through the cracks. As a result, CAPD technology not only improves the quality of documentation, but also reduces the amount of disruption physicians will face down the road. By achieving a greater balance between guidance delivered retrospectively and in-workflow, CAPD solutions can improve the relationship between CDI and care teams. CAPD solutions that integrate directly with CDI workflow solutions allow for even greater collaboration and communication across clinical, coding, and quality teams.

2. Enhance CDI team capacity and productivity

By proactively addressing and resolving certain documentation issues at the point of care, CAPD technology can increase the capacity for CDI teams to leverage their clinical expertise and focus on higher-priority, higher-value documentation integrity efforts. Meanwhile, AI infused into the CDI specialist's workflow can maximize the impact of CDI teams by enhancing productivity and influencing quality metrics. Efficiency tools, such as prioritization, identify cases with the most opportunity for quality and financial impact, taking the guesswork out of where to start.

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3. Mitigate physician burnout and alert fatigue

Frequent disruptions to the clinician workflow can lead to alert fatigue and exacerbate burnout. In fact, physicians who receive more than the average number of EHR-generated messages are *associated with a 40% higher probability of burnout*. However, when physicians are offered actionable advice at the point of care, the details of the patient's case can be recalled much more easily, reducing the cognitive burden and sidestepping the effort of reacclimating to a patient's chart when responding to a retrospective query. Over time, physicians become accustomed to documenting with greater precision, further supporting documentation integrity efforts. In turn, physicians are much more understanding of CDI assistive processes and willing to support their efforts.

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