PHYSICIAN ENGAGEMENT AND CREATING TIME TO CARE

Leadership research survey illuminates CDI efforts to reduce documentation burdens and improve physician engagement.

The Participants

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Physician engagement in the clinical documentation integrity (CDI) process is imperative, but the rate of physician burnout and overwhelming documentation burdens force CDI professionals to constantly balance the priorities of the CDI program against the ever-pressing time constraints placed on providers. Ultimately, CDI leaders are seeking to reduce documentation challenges for physicians and thereby create time to care for patients and keep them engaged in CDI efforts.

"CDI program outcomes depend on provider engagement with CDI initiatives, and there are a lot of concerns and challenges to provider engagement in today's fast-paced landscape," says **Alba Kuqi, MD, CICA, CCS, CDIP, CCDS, CRCR, CSMC,** CDI supervisor at Prime Healthcare in Philadelphia.

In partnership with 3M, the Association of Clinical Documentation Integrity Specialists (ACDIS) CDI Leadership Council asked four of its members to evaluate the results of a nationwide survey on physician engagement and CDI efforts to create time for care. Following is a review of the survey results and summary of that discussion.

Engagement with the CDI process

CDI programs often employ different tactics to engage their physicians. They also monitor a number of outcomes to determine how engaged physician staff are in the CDI process. One of the clearest indicators of physician engagement is their willingness to answer queries, and fortunately, nearly three-quarters of survey respondents said that their physicians are very strongly or strongly engaged in their willingness to answer.

Another 60% of respondents said that their physicians are very strongly or strongly engaged with the involvement of a physician champion or advisor—which validates the strength of a peer-to-peer approach. (See Figure 1.)

"In general, folks who are communicating with a peer are more likely to be open to listening and hearing what's going on," says **L. Gordon Moore, MD**, senior medical director, clinical strategy and value-based care, at 3M Health Information Systems in Washington, D.C.
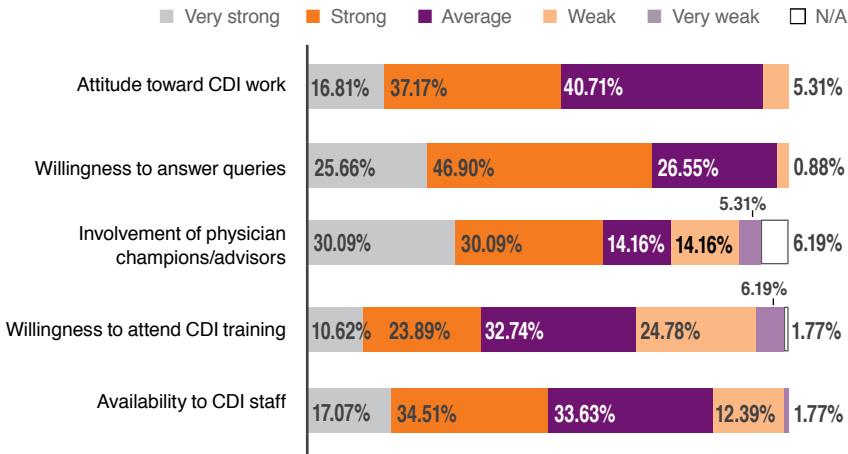
This increased engagement, according to Moore, is partly due to the fact that an advisor or champion knows firsthand what will resonate with physicians most.

"When I talk to physician champions and leaders who are doing CDI work, they're often shifting the focus to that of documentation integrity and quality. That resonates pretty deeply with clinicians," he says.

Figure 1. Physician's level of engagement with the following indicators

Legend: Very strong | Strong | Average | Weak | Very weak | N/A

Indicator	Very strong	Strong	Average	Weak	Very weak	N/A
Attitude toward CDI work	16.81%	37.17%	40.71%	5.31%		
Willingness to answer queries	25.66%	46.90%	26.55%	0.88%		
Involvement of physician champions/advisors	30.09%	30.09%	14.16%	14.16%	5.31%	6.19%
Willingness to attend CDI training	10.62%	23.89%	32.74%	24.78%	6.19%	1.77%
Availability to CDI staff	17.07%	34.51%	33.63%	12.39%	1.77%	

A CDI physician advisor program, however, doesn't need to start as a full-fledged, salaried position with a business plan, according to **Leif Laframboise, BSN, RN, CCS, CCDS,** manager of CDI at Yale New Haven (Connecticut) Health System. Instead, look to the physician leaders who are *already* supporting the CDI program and enlist their help in a more organized way. Look for physicians from different areas of expertise to speak to different physician concerns.

"We've been using a form of physician advisor for a number of years," says Laframboise. They started with the program's medical director and offered to give that person the additional title of physician advisor. When providers wouldn't respond to queries, the physician advisor provided a verbal prompt asking for a response and support for the CDI program.

"Over the past few years, we've expanded that role and included some people outside of our [immediate CDI] area. We've enlisted the help of the director of medical relations and some quality leaders," Laframboise says. "Partnering with quality has been a big advantage for us because the ask to the physician doesn't always seem like it's related to reimbursement; it's a little more multipronged than that."

Those managing systemwide CDI efforts may need to tailor their physician advisor program to suit the needs of each facility, especially if resources are limited, says **Angie Comfort, MBA, RHIA, CDIP, CCS, CCS-P, CICA,** senior director of CDI and coding operations at LifePoint Health in Brentwood, Tennessee. Having some form of peer-to-peer support is better than none at all.

"Not every facility has an official physician advisor and most have no additional physician support. Some facilities use the head of their resident programs in this capacity or their chief of staff," Comfort says. Facilities with a physician advisor in place, however, have shown notable improvement in CDI engagement. For example, "There are less instances of using the escalation policy which involves the C-suite at those facilities."

While survey respondents reported strong engagement with query responses and with physician advisor involvement, there's still room for improvement in other physician engagement efforts. Respondents reported that physicians are *least* engaged when it comes to attending CDI training, with more than 40% saying their engagement is weak or very weak; this gives credence to the concern that CDI may be seen as an additional demand on physicians' time.

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> —Leif Laframboise, BSN, RN, CCS, CCDS, manager of CDI at Yale New Haven (Connecticut) Health System

"I think the difficulty with having providers engage with the training for CDI is that they don't understand the value of CDI up front. It's very common for our sessions to run over because of questions from providers, but the important thing to me is that we make sure they understand that we are adding value. If they only see it as dollars, they lose interest very quickly," Laframboise says. "When it's all said and done, I think the most important thing is that they walk away understanding that the program has purpose. […] If they believe that, we have great impact."

Beyond getting a meaningful message across during educational sessions, CDI leaders need to be aware that the format and style of the education has a big effect as well. Organizations often require physicians to sit through various trainings on compliance and the like that may not be interesting for them, so try to set your CDI sessions apart from those preconceived notions, Laframboise says.

"We need to make sure that when we speak to providers, we add value, that it's not just a monotone lecture; we make sure to make the sessions interactive," he says.

If physicians are truly opposed to attending CDI training, try to find other ways to provide the education. According to Moore, one of the most successful approaches is to integrate the education into the physicians' existing workflows using technology, limiting the additional time commitments placed on them.

"When I think about what's useful in terms of creating education programs that engage people, you always have to have an array of different approaches. You can have online asynchronous stuff as well as, if possible, embedded learning as a physician's looking at a chart. That lines up nicely with adult learning theory," Moore says. "You know, I'm looking at the patient's chart right now and I see a query and I can look at the context and understand what's going on with them and why that fits."
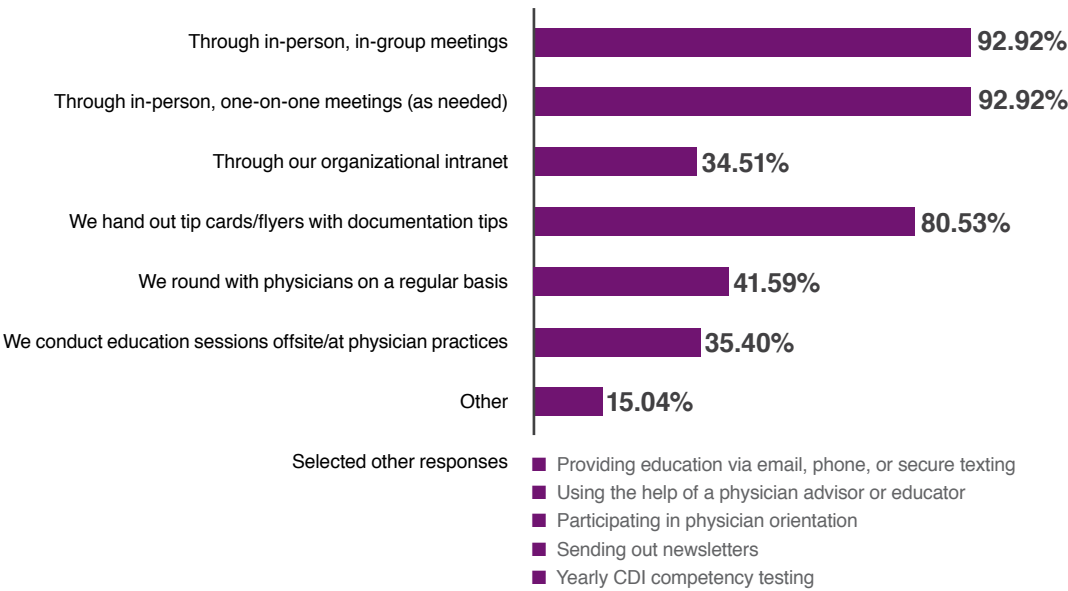
Educational tactics

When it comes to engaging physicians, there are a host of educational tactics CDI professionals can employ. Not all approaches, however, are created equally, so CDI leaders often employ a variety of methods to reach their audience.

The most popular education tactics involve face-to-face interaction, with nearly 93% of respondents saying they use group and one-on-one educational sessions to connect with providers. (See Figure 2.)

"I think the in-person works because I'm going to have a chance to interact with my peers and ask questions and dig into stuff, or if I'm feeling cranky and thinking that this is tangential, I can put that issue out there and maybe actually understand why it's not," Moore says.

Figure 2. Physician education tactics employed

Tactic	Percentage
Through in-person, in-group meetings	92.92%
Through in-person, one-on-one meetings (as needed)	92.92%
Through our organizational intranet	34.51%
We hand out tip cards/flyers with documentation tips	80.53%
We round with physicians on a regular basis	41.59%
We conduct education sessions offsite/at physician practices	35.40%
Other	15.04%

Selected other responses
- Providing education via email, phone, or secure texting
- Using the help of a physician advisor or educator
- Participating in physician orientation
- Sending out newsletters
- Yearly CDI competency testing

Whether a program chooses to favor one-on-one or group education largely depends on the physicians involved—their preferences for one over the other, etc.—and on the subject matter at hand. If you're trying to educate the physicians on a topic that applies to everyone, it's best to present in a group setting, Laframboise says, because it gets you in front of everyone at once and gives the physicians a sense of community involvement in the process.

"Primarily, we focus on in-person group meetings, and I think the reason it works well is because it's hard to maintain preconceived biases with the person in the room," he says. "There's a small subset that are sort of dedicated to not answering queries and not being engaged, but that's actually a rare phenomenon. […] I think the best bang for our buck is in the group meetings. It lets them feel like they're part of a group that is buying into this."

If, however, you need to provide feedback on a documentation concern perpetrated by a particular physician, opt for a one-on-one approach. According to Kuqi, these person-to-person interactions also give the physician an opportunity to express thoughts and concerns in a private setting, making that physician feel heard and valued.
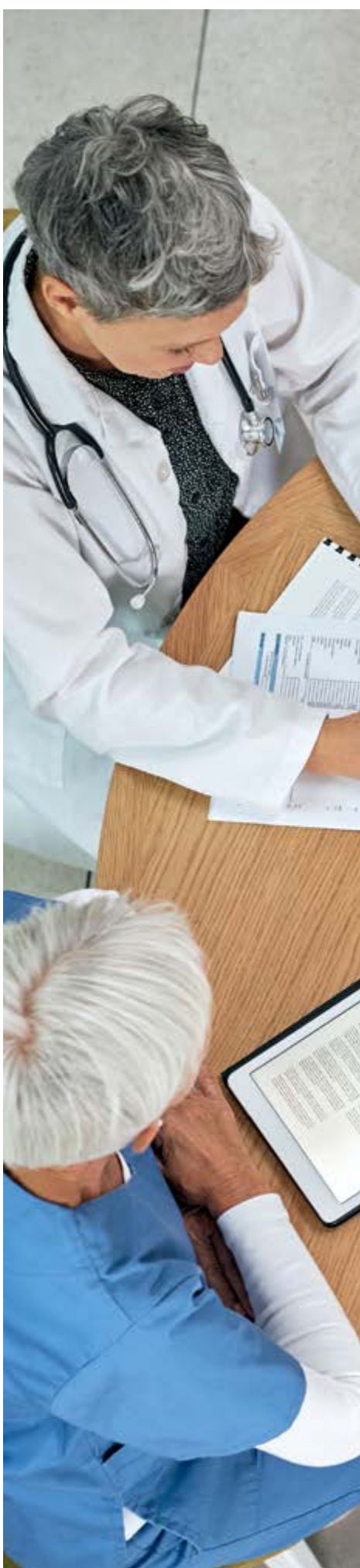
"For us, having one-on-one meetings is really beneficial because you can get to understand the other party," she says. "The physician is our customer in a sense, and we can try to respond to their needs better. If we take the time and meet with them—even if it's only for 10 minutes or five minutes—it's really beneficial."

Coming in just behind in-person education, 80.53% of respondents said they hand out documentation tip cards. (See Figure 2.) Yet tip cards, according to Moore, can be a double-edged sword.

"Handing out documentation tip cards and things like that are helpful in a sense. I would have an easy acceptance of that because I could then choose to just tuck it in my pocket or leave it on my desk and forget about it or engage. It's a low threshold for me," he says.

Not only can a physician smile, take the card, and never look at it again, but the tip cards may also be redundant if you're providing explanations with your query process, says Laframboise. Even still, having a stack of tip cards if someone asks for a reference never hurts.

"We do [tip cards] because every once in a while somebody asks for them, but in truth, if we can put enough detail into the query in a concise way to make it meaningful, they answer them," Laframboise says.

> **If I'm in the context of the patient's chart and I'm thinking about that person and I see there's a notification about them, I can quickly review and see what the necessary elements are for me to call it one way or another, then you've served everything right up to me. You've made it really easy for me.**
> —L. Gordon Moore, MD, Senior medical director, clinical strategy and value-based care, 3M Health Information Systems, Washington, D.C.

Despite the overall prevalence of technological solutions available to CDI professionals, especially those at larger healthcare systems, only 34.51% of respondents said they leverage their organizational intranet for education.

Part of the difficulty, according to Moore, is that physicians may associate education provided through the intranet with compliance courses and administrative burden, as mentioned earlier. That association, however, can be overcome.

"Technology has the potential of really shining. What I would want to avoid is all those compliance courses that I have to take online where I'm just clicking through and thinking, 'Gosh, I'd really like to be doing something else right now,' " he says. "On the other end of the spectrum, if I'm in the context of the patient's chart and I'm thinking about that person and I see there's a notification about them, I can quickly review and see what the necessary elements are for me to call it one way or another, then you've served everything right up to me. You've made it really easy for me."

CDI leaders need to dig into the available technology and get a firm understanding of how to use it without overdoing it.

"We don't want to exhaust clinicians with alerts either," Moore says.

Only a relatively small percentage of survey respondents (35.40%) reported providing off-site educational sessions at physician practices. This perhaps speaks to the slow spread of CDI programs into the outpatient or ambulatory space. It may also be because off-site education can be perceived as another time constraint on busy outpatient/primary care physicians.

"Most physicians feel this cuts into their patient care time. As CDI leaders, if we cut down these offerings to less than 10 minutes, more physicians would be receptive," Comfort says.

However, every CDI program is different, and physician groups vary in their response to educational efforts.

Adult learning theory says that "being taught in the context of the workflow is ideal," Moore explains again. "However, I think it's probably best to have a number of different approaches. We each have different ways that we learn—some are visual, some read things, some want to hear it on the fly. If you have a bunch of different opportunities, you can probably capture more and engage more physicians in the learning."

Of the more than 15% of respondents who wrote in "other" tactics, some of the most popular options were:

- Education via email, phone calls, and secure texting
- Physician educator and advisor education
- Rounding with physicians
- Participation in orientation
- Sending out newsletters
- Yearly CDI competency online education

"There is not a one-size-fits-all mentality for physician education on CDI. While one physician may like the interaction of a short online documentation course, there are others that prefer face-to-face, one-on-one interaction," Comfort says.

CDI managers, along with their staff, need to get to know their physicians to identify and leverage those preferred methods.

Delivering education

When a CDI program first launches, the educational efforts might fall principally on the CDI leaders disseminating information about the new program throughout the organization. As a program matures, however, CDI leaders may decide on a different distribution of the education work.
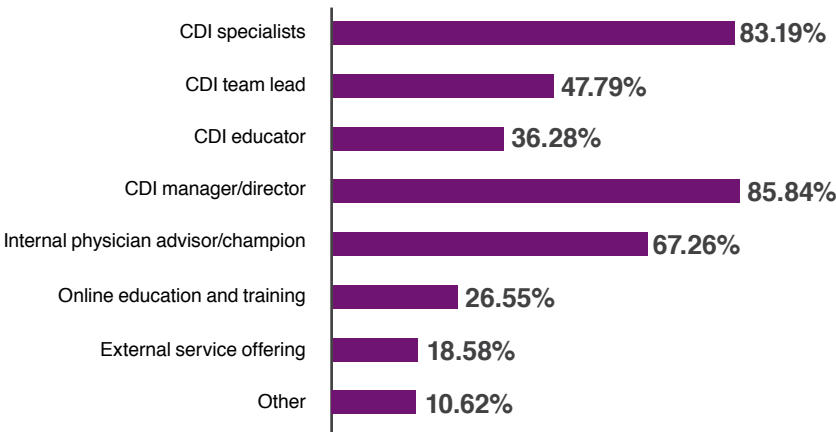
According to the survey results, nearly 86% employ their managers or directors for physician education, but another 83% use their CDI specialists. (See Figure 3.)

"I feel that the CDI specialist does need to be a partner at the table with the physicians. Not to be there to practice medicine, but to be a partner to help [the physicians] ensure that the full clinical picture of how ill our patients are is well defined," says Kuqi. "We try to help them as much as we can."

Leaders who ask their CDI specialists to provide the physician education can reap the benefit of added physician engagement because physicians are familiar with the CDI staff's expertise. It can, however, be a balancing act to avoid taking staff members' time away from record reviews. Because of this concern, some programs leverage other positions within the CDI department to provide education.

Figure 3. Groups and individuals who provide education

Group	Percentage
CDI specialists	83.19%
CDI team lead	47.79%
CDI educator	36.28%
CDI manager/director	85.84%
Internal physician advisor/champion	67.26%
Online education and training	26.55%
External service offering	18.58%
Other	10.62%

According to the survey, more than 67% of respondents said they use a physician advisor or champion, nearly 48% use a CDI team lead, and more than 36% use a CDI educator.

This division of labor can help ensure the educational message presented to the physicians remains consistent across an organization and allows CDI professionals to move into specialized roles or to provide education targeted to their skill sets.

"We use a combination of the manager and three team leads/educators that cover our system. The reason is really just efficiency and consistency. I think it's hard to deliver a message that's consistent across the system through 57 people," Laframboise says. "When your system grows large enough, the 5% of the time each specialist might use for education can be pulled together and turned into a full-time employee and you have an educator."

Organizations with the means to do so may also choose to employ an outside consulting company to provide physician education. Often, CDI leaders may employ this sort of approach at the beginning of their program's existence or to help with education relating to industrywide updates. Only a small portion of survey respondents (less than 19%), however, reported using an external service offering in this way.

"I've seen some of the external agencies coming in when health systems need a surge and it's just beyond [the CDI staff's] capacity," Moore says.

Limiting burdens

Providers are busy, and more and more studies show that they're burned out, with documentation burdens partly to blame. CDI professionals are uniquely positioned to ease those burdens and combat the burnout.

The most popular way CDI professionals do so, according to the survey, is to limit the number of queries on any given chart, with 40.71% of respondents favoring this tactic. (See Figure 4.)

One way leaders can limit the number of queries landing in physicians' inboxes is to set up parameters for when a CDI specialist should send a query, according to Laframboise.

"[We're] trying to limit how much we reduce their time to care," he says. "We have a table of when you can send a query that every CDI has at the ready to help them understand the value that that query is going to add. […] We try to minimize the unnecessary—that's first and foremost."
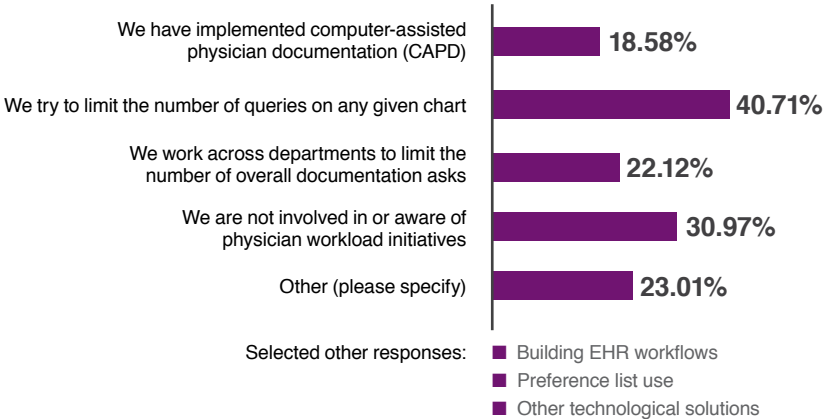
At her organization, Comfort says "there are always rumblings from physicians about why we query them for things that are blatantly in the record. So, we provide education to them on why we can't just pick up things from nonphysician documentation."

In addition to limiting the query numbers, nearly a quarter of respondents wrote in other methods for reducing the burden. Some of the most popular included:

- Building EHR workflows
- Providing feedback on documentation issues to reduce overall query rates
- Allowing physicians to use preference lists in the EHR
- Using computer-assisted physician documentation software

Though many of the write-in responses referenced technological solutions to reduce documentation burdens and time commitments, only slightly more than half of survey respondents said they've worked with their IT

Figure 4. Helping with provider workload and creating opportunities to spend time with patients

Category	Percent
We have implemented computer-assisted physician documentation (CAPD)	18.58%
We try to limit the number of queries on any given chart	40.71%
We work across departments to limit the number of overall documentation asks	22.12%
We are not involved in or aware of physician workload initiatives	30.97%
Other (please specify)	23.01%

Selected other responses:
- Building EHR workflows
- Preference list use
- Other technological solutions

department or software vendor to reduce documentation burdens. (See Figure 5.) An additional 30% said they weren't aware of any efforts to reduce burdens at all. (See Figure 4.)

The respondents who had worked with their internal IT department or external vendor said they've developed templates, removed duplicative documentation requests by making queries part of the permanent record, used artificial intelligence notifications to prompt further documentation, and implemented smart phrase use.
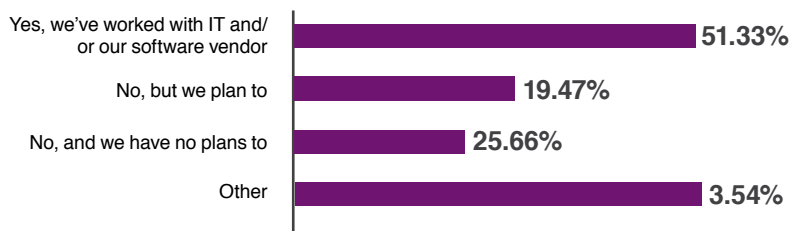
Those looking to work with their software vendor or IT department have various promising opportunities to choose from. Due to the centrality of their query process, Laframboise and his team focused on that part of the EHR to limit duplicative documentation requirements and streamline their processes.

"I know there are programs that don't make their queries part of the medical record. We do […] so the provider is able to answer directly on the query," he says. "We also have about 75 templates for queries. We've actually worked with the providers to help rewrite some of those."

Part of the problem with ignoring the technology side of the CDI process and the burdens it puts on physicians is that not all technological solutions are created equal, according to Moore. Even the most advanced, flashy program needs a human touch to ensure it makes things better rather than worse.

"Some early iterations have been awkward and not ideal. When you turn on automated queries and throw them at the docs without being careful, some providers may come back feeling like you're spamming them. If the queries are inappropriate, then their trust plummets," he says. "The whole point of using technology is to enable an easier workflow and collaboration across this diverse team. We're all working towards the same end. When [the solution] is working and you have the conversations with vendors around that, then you can hit the sweet spot and you can actually hit a pretty good ROI [return on investment]."

Figure 5. Working with IT/software vendor to reduce documentation burdens

Category	Percentage
Yes, we've worked with IT and/or our software vendor	51.33%
No, but we plan to	19.47%
No, and we have no plans to	25.66%
Other	3.54%

Knowing where to start the conversation with your vendor or IT department can be a challenge since expensive solutions are often multifaceted. According to Kuqi, the best place to start is with self-directed education on the products and programs at your disposal.

"In my experience, working with the IT department and software vendor is really, really important," she says. "I recently obtained a certificate by my software vendor, Epic, in hospital coding. It helped me help the physicians to assess their notes and to better deal with the EHR workflow. […] At the end of the day, though, even if we have the best EHR vendor and the best leadership team, physician engagement is really important, and nothing can replace that."

When introducing a new process or changing providers' workflow with queries or education, remember that patient care is the true priority for everyone involved. While a query response may be important and proper documentation offers a host of benefits, the process should not detract from that one central purpose, Laframboise says.

"You need to be respectful of the providers' time. I think that's where the business side of hospitals have gotten in trouble in the past—not respecting that the number one priority of the hospital is taking care of the patients," he says. "We really try to build on the partnership because without that, it's a fight you're going to lose."

Adjusting to a global pandemic
At the time of the survey's completion, the COVID-19 pandemic had yet to hit the United States. Its arrival, of course, shifted the entire healthcare landscape and forced CDI professionals to adapt accordingly.

In these times of crisis, physician engagement looks a bit different. Rather than focusing on education and query responses, CDI leaders have re-evaluated what it looks like to support physicians. For some, that's meant stepping back from their traditional CDI efforts.

"In mid-March, I instructed our CDI teams across the company to halt all physician education so that our physicians would be able to fully participate in the urgent needs that could arise with our patients. Additionally, I paused our escalation policy for getting queries answered," says Comfort. "The patient's care is of the utmost importance."

This time in history is far from business as usual, says Kuqi, whose team has shifted to remote work during the pandemic. While they're continuing to educate over video conference and phone, they've shifted their focus away from straight education in favor of answering questions and offering their help wherever needed.
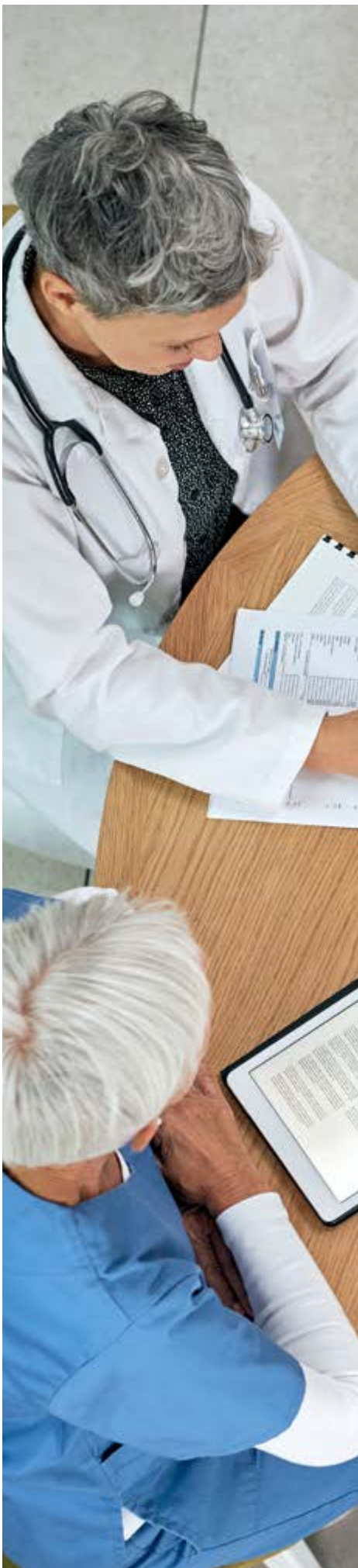
"We're trying to help them to the best of our abilities," says Kuqi. "We are here for *them*, and they know that they can get ahold of us if they have any questions. Especially during this time, we are there to help them because we know how difficult it is."

For CDI departments in areas where the pandemic hit hardest, helping physicians involves taking on roles outside of the "regular" CDI job description. According to a recent ACDIS survey, more than 35% of CDI professionals have taken on additional nontraditional roles during the pandemic. Laframboise's team falls into that percentage.

"We sent a number of staff up to the call center, and that was the unfortunate start of all this for us," he says. "We've probably sent 10 of our staff back to the bedside. Mostly, we employ former ICU nurses, so they've been very busy."

Moore reminds CDI leaders, however, that now may be the perfect time to start working with your IT department or vendor to integrate some of that education into the provider workflow. That way, the CDI team is still reaching the physicians with valuable education but not taking chunks of time away from patient care.

"The experience of pressure is just immense," says Moore. "As much as possible, whenever you've got a crisis going on, you put nonessential things to the side. You may do less of the 'show up in the class,' less of the 'I'm going to come in and take you away from patient care.' Maybe emphasize, for instance, a technological approach that could embed those questions in the context of the chart."

CDI leaders should keep an eye toward the processes that are within their purview and seek to limit the burden on providers to give them more time for all-important patient care.

"Ultimately, CDI isn't going to add time for the physician to provide care for the patient," Laframboise says. "All we can do is hope to reduce the amount we impact their care of the patient."

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