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HEALTHCARE SOLUTIONS

OPPORTUN IT Y

CLINICAL DOCUMENTATION
IMPROVEMENT AND THE EHR:
SIMPLIFYING THE PROCESS

AGENDA

- Evolution of CDI
- Challenges
- Basics of a CDI Program
- Hierarchical Condition categories (HCCs)
- Provider Engagement & Education
- EHR Usability

Evolution of CDI

The good old days?
Reimbursement and documentation were not a focus.

Inpatient World
- DRGs (1983): Reimbursement methodology based on: Principal Diagnosis, Secondary Diagnosis (CCs) and Procedures.
- MS-DRGs (207): Secondary diagnoses were now considered for reimbursement.
- Hospital Value Based Purchasing (2011): Initiative to provide incentives to deliver healthcare more efficiently while maintaining/improving quality.

Current Trends:
Accountable Care Act, Meaningful Use, Pay-for-Performance and National Agency Reporting driving need for documentation to prove quality of care.

What the future holds:
CMS and other payers seeking to treat patients in the outpatient setting, reducing inpatient volume and reimbursement. This drive along with ICD-10 transition makes provider outpatient clinical documentation improvement programs a top priority.

CDI Challenges

- Lack of understanding about what constitutes outpatient CDI

- Unclear financial or other metric by which to measure progress

- Lack of qualified reviewers who understand outpatient CDI

- Not enough staff

- Lack of a clear model/workflow/timeframe for reviewing outpatient documentation

- Lack of physician buy-in

- Lack of clear physician query guidelines for outpatient CDI

- Lack of support from administration

Goals of CDI Program

- Identify and clarify missing, conflicting, or nonspecific physician documentation related to diagnoses and procedures

- Support accurate ICD-10 diagnostic and CPT procedural coding

- Promote health record completion during the patient's episode of care

- Improve communication between physicians and other members of the healthcare team

- Provide education

- Improve documentation to reflect quality and outcome scores

- Improve coders' clinical knowledge

Elements of CDI Program

Policies & Procedures
- Develop with input of other departments (compliance, case management, HIM)
- Include topics such as the education, experience, and credentials for hiring CDI staff; new employee training; ongoing education and training; compliant query practices; and a CDI quality assurance process

CDI Role Competencies
- Knowledge of coding concepts and guidelines and clinical terminology
- Ability to read and analyze all information in a client's health record
- Clinical knowledge (anatomy and physiology, pathophysiology, and pharmacology)
- Ability to establish and maintain strong verbal and written communication with providers and other clinicians
- Knowledge of healthcare regulations, including reimbursement and documentation requirements

Auditing
- Designated, experienced auditor should conduct health record audits, evaluating random samples and reviewing various record types
- Identify diagnosis, physicians, and services that require more documentation specificity
- Identify potential changes in principal diagnosis or procedural coding
- Additional findings that capture of comorbid conditions
- Query Compliance: verify questions are open-ended and non-leading
- Identify opportunities for further physician education

Elements of CDI Program (con't)

Queries

- Communication tool to obtain documentation clarification from providers
- Traditionally in paper form or performed verbally
- can be time-consuming due to insufficient initial queries
- Utilize EHR to create common template queries to ensure compliance and reduce the turnaround time

Continued Auditing & Monitoring

- Key to demonstrating that the goals of the program are being achieved
- Monthly general metric reviews (e.g. use of unspecified codes) not enough, must monitor individual physicians' documentation performance as well
- Sharing data directly with physicians enables them to make informed adjustments on an ongoing basis
- Ensure that you are proactively preventing poor documentation, not just retroactively correcting it

Hierarchical Condition Categories (HCC)

- The Medicare risk adjustment payment system uses clinical coding information to calculate risk premiums for Medicare Managed Care Organizations

- HCC payments are linked to the individual health risk profiles for each member in the plan

- HCC codes are captured through accurate physician documentation

Physician Engagement and Education

Communication is Key

- Consistently provide physicians with feedback about their documentation performance
- Host department and specialty group meetings
- Utilize the intranet to add common coding scenarios and tips, publish tips in newsletters
- Direct interaction can be powerful!

Tracking Performance

- Continue to audit provider records for improvement and to identify education opportunities
- providing scorecards. Leadership can better engage physicians by sharing individual performance compared with organizational and national peers

Elbow-to-Elbow Training

- Opportunity for real-time verbal queries and provide immediate feedback
- Helps develop rapport with providers

Let Provides Know How They Are Doing

- Appeal to physicians' competitive nature to incentivize better documentation.
- Physicians love metrics. Whatever concepts you teach them, should be what you are continuously auditing. The more you audit them and show them the results, the more they push themselves.

Barriers to Physician Engagement

The American Hospital Association, in conjunction with Executive Health Resources, launched a *Clinical Documentation Improvement (CDI) Trends Survey* in February 2015.

Based on your experience, what are the biggest barriers preventing physicians in your hospital from being effectively engaged in Clinical Documentation Improvement? (Select up to 3)

	qty	%
Lack of time	519	47.7%
Lack of interest	415	38.1%
Lack of understanding of importance of strong documentation	723	66.5%
Lack of commitment and championing from hospital leadership	368	33.8%
Lack of ongoing physician education	283	26.0%
Lack of effective collaboration between CDI and physicians	157	14.4%
Lack of a formal CDI program in place	55	5.1%
IT/technical difficulties	201	18.5%
None, our physicians are highly engaged	54	5.0%
Other	72	6.6%

EHR Usability

Moving to a Longitudinal Health Record
- Should be comprehensive clinical summary of a patient-based clinical experience, as opposed to encounter-based records of the past

Macros and Templates
- May be valuable in improving complete and efficient documentation, however capture of structured data should be kept to a minimum.
- EHR must support providers' cognitive processes during documentation process and preserve integrity of the patient narrative.

Does EHR facilitate easy review of previously documented clinical information?

Copy Forward
- Reviewing and copying forward information in EHR may result in efficiency, but these documentation methods can be misused to the detriment of accuracy, high-quality care and patient safety. Take caution!

Ongoing EHR training
- Initial training is not enough
- Additional training should be required with every system upgrade, as well as when record audits identify needs for documentation improvement.
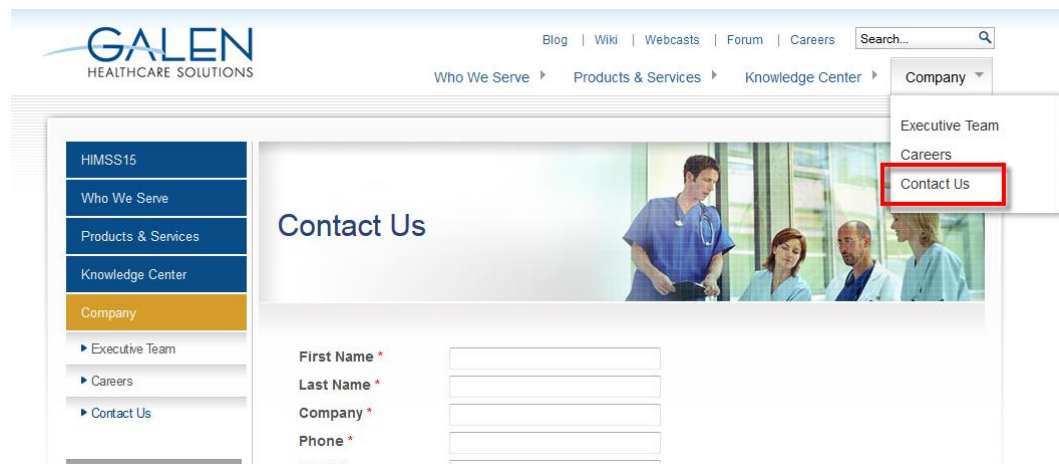
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