THE VALUE OF CLINICAL DOCUMENTATION IMPROVEMENT

By Annette Sullivan, Senior Manager

Healthcare is shifting its focus from volume to value, which essentially means placing emphasis on the quality of care. Quality health care should take precedence over anything else. Successful navigation of a value-based system will require all healthcare entities to become proficient in documentation and data analytics.

The Centers for Medicare and Medicaid Services (CMS) and other regulatory agencies utilize coded data to assess performance and outcomes. Coded data is derived from clinical documentation provided during the patient encounter. Healthcare entities that will fare the best under the new value-based system will have an integrated clinical documentation program in place that facilitates an accurate depiction of each patient's level of care, symptoms, diagnoses, treatment, and outcomes. Summarily, accurate clinical documentation supports correct coding, charge capture, billing, and reimbursement. The result is that hospital and physician profiles will reflect the appropriate quality of care provided and support resources utilized.

Clinical documentation improvement (CDI) initiatives are paramount to ensure the integrity of the data that will be used to assess performance and reimbursement. Consistent documentation improvement will require a CDI infrastructure that goes beyond the basic CDI concepts of documentation clarification and improved reimbursement. CDI programs that include all aspects of the patient continuum will be most effective.

Quality must be the underlying goal and objective of CDI and must be communicated as such to the providers and the leadership team. Once quality of care becomes the focus of the CDI program, it will be easier to garner support and engage providers. Following are the integral aspects of the initiative:

- Develop an integrated CDI program that involves all areas that affect performance, such as physicians and other providers, case management, nursing, pharmacy, PT/OT/ST, and quality. An integrated approach will support data integrity by ensuring that the clinical information is complete and interpreted uniformly.
- Establish mechanisms that engage physicians and provide non-intrusive documentation improvement support and education at the point of care. Physicians comply with CDI initiatives that occur while they are caring for the patient if the process does not directly interfere with patient care.
- Create metrics that conform to clinical documentation best practices, but incorporate metrics that are rooted in quality.
- Perform data analysis frequently, and regularly disseminate the information to the CDI team, leadership team, providers, and revenue cycle team.

- Document and communicate all outcomes or information that impede quality during the patient encounter to allow for interventions that promote performance improvement and better outcomes.
- Provide individual performance results to providers, patient care areas, clinical documentation specialists, and coders. These areas will be instrumental in improving documentation concerning malnutrition, complex pneumonia, and decubitus ulcers.
- Assess coding quality and provide education to coders as needed. Ensure that coders and clinical documentation specialists receive joint education regularly, especially about coding updates and documentation principles. Engage physicians, dieticians, respiratory therapists, wound care and other areas to assist with education as necessary. Provide peer-to-peer physician education for physicians or providers that are detrimental to the documentation improvement program.
- Lead the efforts to profile performance and quality of care by managing the quality and integrity of the data. Institute policies and procedures that govern the data that is used internally and externally. Data sources should be standardized, and the reporting and use of data should be identified and validated. Data integrity and reliability will solidify physician engagement and provide an accurate picture of the quality of care, resources used, and appropriate reimbursement.
- Establish documentation templates and standardized definitions of clinical indicators. Templates, especially for EHR, will make it easier for providers to deliver appropriate documentation. The documentation improvement team should be allowed to assist with the design of documentation templates and EHR implementations and updates. Examine documentation for gaps in documentation and quality, and implement standardized documentation protocols to circumvent deficiencies that are related to insufficient documentation.
- Celebrate successes and laud accomplishments! Own performance and quality of care. Don't rely on outside entities to define the quality of care for your organizations. Use CDI initiatives to build a foundation of quality patient care that is insurmountable and unprecedented.

The value of clinical documentation programs in a value-based system has been raised astronomically, and it is crucial to delineating quality of care.

Please share your thoughts about clinical documentation improvement and any questions you may have about how this affects your organization by contacting Annette Sullivan, Senior Manager at asullivan@cokergroup.com or by calling 678-832-2021.