



PACE *Healthcare*
CONSULTING

This is Not Your Parents' CDI

CDI 2.0 Beyond Coding

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Learning Objectives

- To learn ways to structure the CDI program to maximize impact.
- To understand how the CDI program enhances hospital-physician relationships to improve documentation and quality.

Evolution of Clinical Documentation Improvement Programs

- DRGs - Coding and Relative Weight
- MS-DRG - Added secondary codes with three levels of complications
- Value Based Purchasing - Captured services provided
- ICD-10 – Provided more specificity to coding along with severity and co-morbidities
- Billing Audits – To maintain regulatory compliance
- CDI as a resource to and educator of healthcare providers
- Expanded demand for expanded clinical knowledge
- Move from revenue capture to compliance and accuracy

American Health Information Management Association (AHIMA)

- “Successful Clinical Documentation Improvement (CDI) programs **facilitate the accurate representation of a patient’s clinical status that translates into coded data.**”
- “Coded data is then **translated into quality report cards, physician report cards, reimbursement, public health data, and disease tracking and trending.**”
- “Health Information Management (HIM) professionals provide two key roles within a CDI program as **clinical documentation improvement specialists and coding professionals.**”

Source: AHIMA CDI webpage. <http://www.ahima.org/topics/cdi>. Accessed June 15, 2016.

Association of Clinical Documentation Improvement Specialists (ACDIS)

- “Clinical documentation specialists understand a wide range of specialized disciplines, including **education in anatomy and physiology, pathophysiology, and pharmacology;**
- Knowledge of **official medical coding guidelines, CMS, and private payer regulations related to the Inpatient Prospective Payment System;**
- An ability **to analyze and interpret medical record documentation and formulate appropriate physician queries; and**
- An ability to **benchmark and analyze clinical documentation program performance.”**

Source: HCPro webpage regarding acdis CCDS certification. <http://hcmarketplace.com/ccds-certification>. Accessed June 15, 2016.

CDI Gaining Recognition

- CDI “is the recognized process of improving healthcare records to ensure improved patient outcomes, data quality and accurate reimbursement”
- “CDI professionals act **as intermediaries between inpatient coders who translate diagnoses into data and healthcare providers and nurses.**”
- “As many clinical coders don't have patient care backgrounds, and healthcare providers might not realize the importance of accurate documentation, the CDI professional serves to make the connection between these two groups.”
- “Healthcare documentation serves as a legal document, validates the patient care provided, facilitates claims processing, coding, billing and reimbursement, and facilitates quality reviews.”

Source: Wikipedia CDI webpage. https://en.wikipedia.org/wiki/Clinical_documentation_improvement. Accessed June 15, 2016.

Core Of Clinical Documentation Improvement Specialists

- While not explicitly stated in any of the descriptions above, Clinical Documentation Improvement Specialists (CDIS) are very skilled auditors
- They are part of the new world of healthcare compliance
- PAC
 - Pro-actively
 - Audit and Inspect
 - Correct

What We are Up Against



Medical Director

Makes up
Extrapolation
Numbers

12 year old
Earning Extra
Money

Previous Hospital Audit Department



An internal auditor
takes time to enjoy a
hearty joke.

THERE IS MUCH INFORMATION ON WHAT CDI DOES

But A Lot of Variation in How CDI
Programs are Structured

The New Audit Challenge



Next Generation: “CDI 2.0”

- Move from Just Health Information to Mainstream of Utilization Management and Revenue Cycle
- Pro-active Instead of Reactive
- Interactive Through Rounding & Queries (Point of Service Education)
- Serve as Guide for Physicians to the Electronic Health Record Saving Physician Time
- Assess Risk to Hospital and Physicians
- Serve as Resource to all Clinicians for Appropriate Documentation
- Part of Committees and Reporting
- Clinical Knowledge, Coding, Regulatory

So Where Does CDI Reside?

We Recommend the Care Management Department; however, this depends on your organization . . .

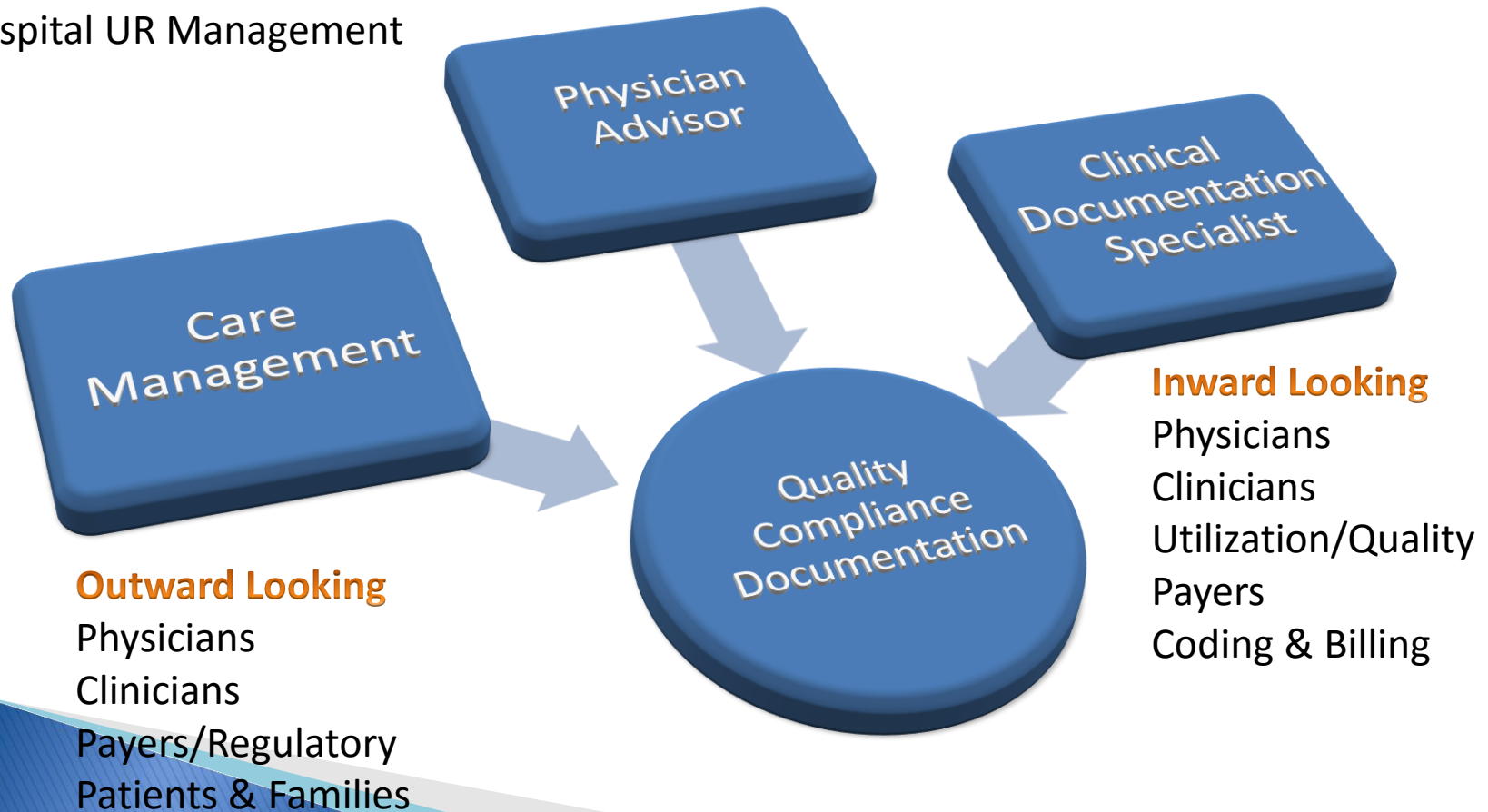
It is More Important that:

- The organization elevates the importance of the CDI program
- That the program resides in the Committee Structure as the Information Highway to ensure CDI is at the table and goals are balanced between all silos
- The CDI scorecard be a part of the Utilization, Quality, Medical Staff, Compliance and Revenue Cycle reporting

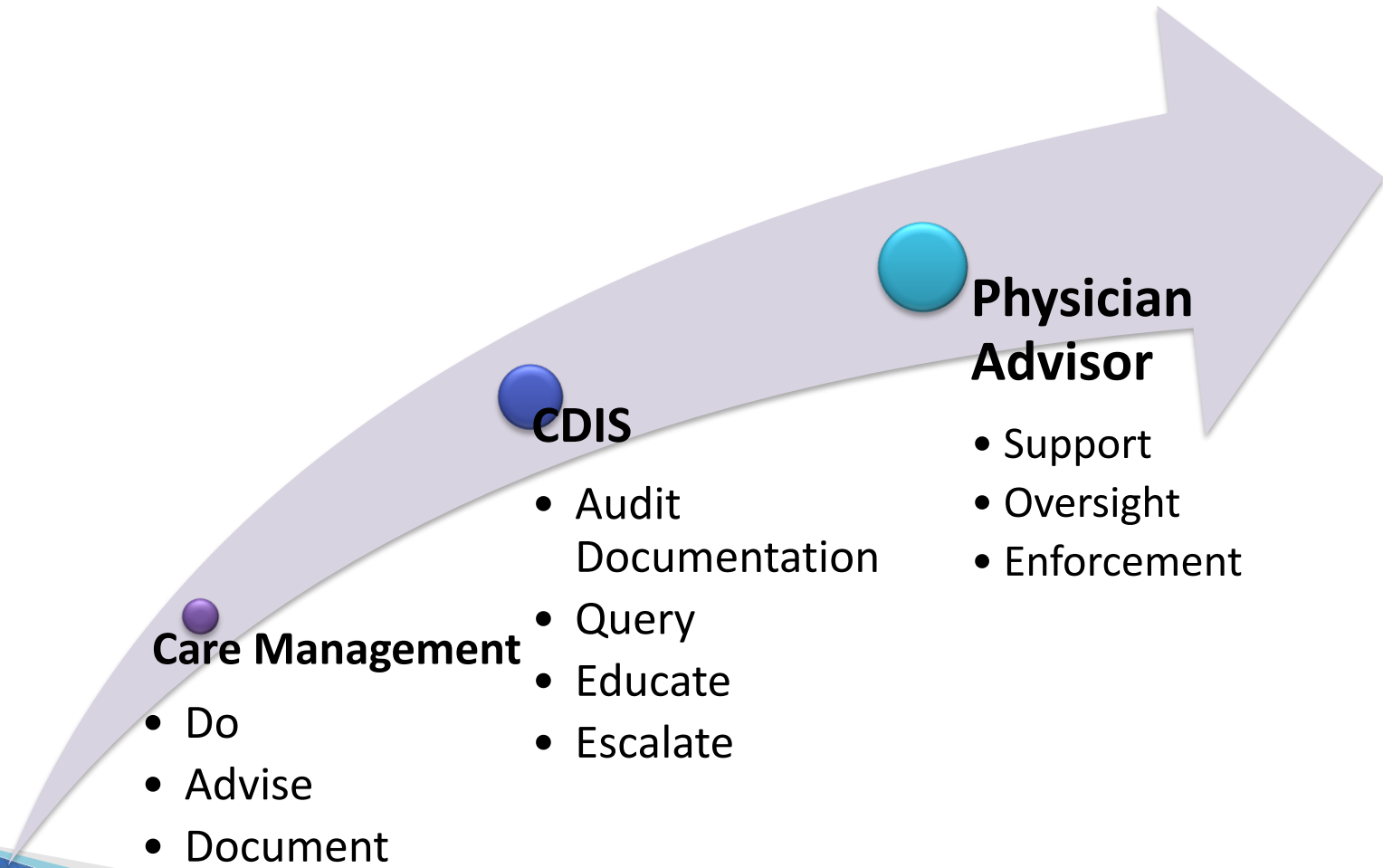
No Matter Where CDI Resides Form the Dream Team

Inward and Outward Looking - Plus

Medical Staff UR Management
Hospital UR Management



Team Act



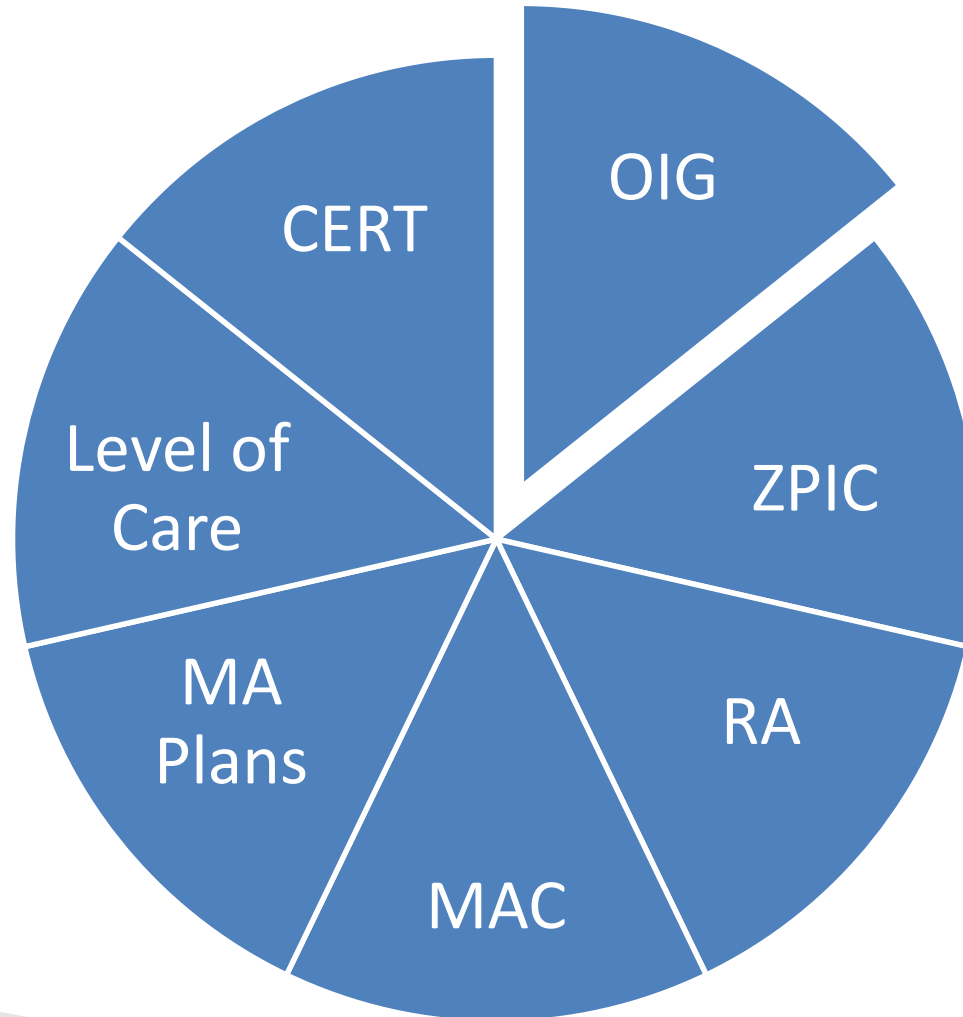
What Does CDI Audit in Your Setting

- Utilization
 - Admission Medical Necessity
 - Physician Admission Orders
 - Admission Criteria for Level of Care (No just IP/OP but units such as intensive care)
- Communication Amongst Caregivers
 - Did Physician React to PT Note
 - Was Something Missed-An Order
- ICD-10 Coding
- Quality
 - Core Measures

Remember

Pearson's Law: "That which is measured improves. That which is measured and reported improves exponentially." - Karl Pearson

There is a Lot to Choose From Regulatory Enforcement of Hospitals



No Matter Where CDI Resides Cross Over Department Silos

- Use the Quality department as “air traffic controller” to track and provide audits tools and report tools to all types of audits including CDI
- Coordinate and organize all related audits to reduce duplication
- Look for cross over and efficiencies between chart auditors
- Engage Compliance Department for training
- Invest in software to assist CDI to audit, communicate, aggregate and report audit results

Link CDI Work to Outcomes

- Bill Holds
- Days in Dropped Not Billed
- Coding Accuracy
- Denials (Government and Commercial)
- Bed Status Changes
- Physician Engagement/Compliance
- Coding Accuracy Percent
- Compliance Indicators
- Reduce Queries Required from HIMS Coders
- Fewer Audits Performed in QAPI Due to Reduced Core Measure Audits
- Readmission Reduction (Audit for Discharge Plans)
- Patient Rights
- **Customize for Your Organization**

PHYSICIAN ENGAGEMENT

Will Enhance Quality and
Documentation

Next Generation CDI 2.0

Physician Engagement

- The average physician does not interact with C-suite on a regular basis
- Daily interactions with hospital staff occur around patient care units and in documentation
- CDI schedules must be compatible with physician schedules
 - Be available to physicians to encourage communication
- Trust is built through team work with physicians
- Link CDI to the Physician Advisor as a team and for PA support

Next Generation CDI 2.0

Physician Engagement

- Relieve physician frustration with the Electronic Medical Record (EMR)
 - Be an EMR navigator and time saver for physicians
- Be a resource to physicians on proper documentation at the point of service
- Reduce the number of times the physician has to respond from the office or after a shift
- Arm CDI with knowledge of physician risk even in the physician office to enhance role as a resource
- Relate better documentation to quality patient care for their patients
- Make physician engagement part of CDI training

Next Generation CDI 2.0

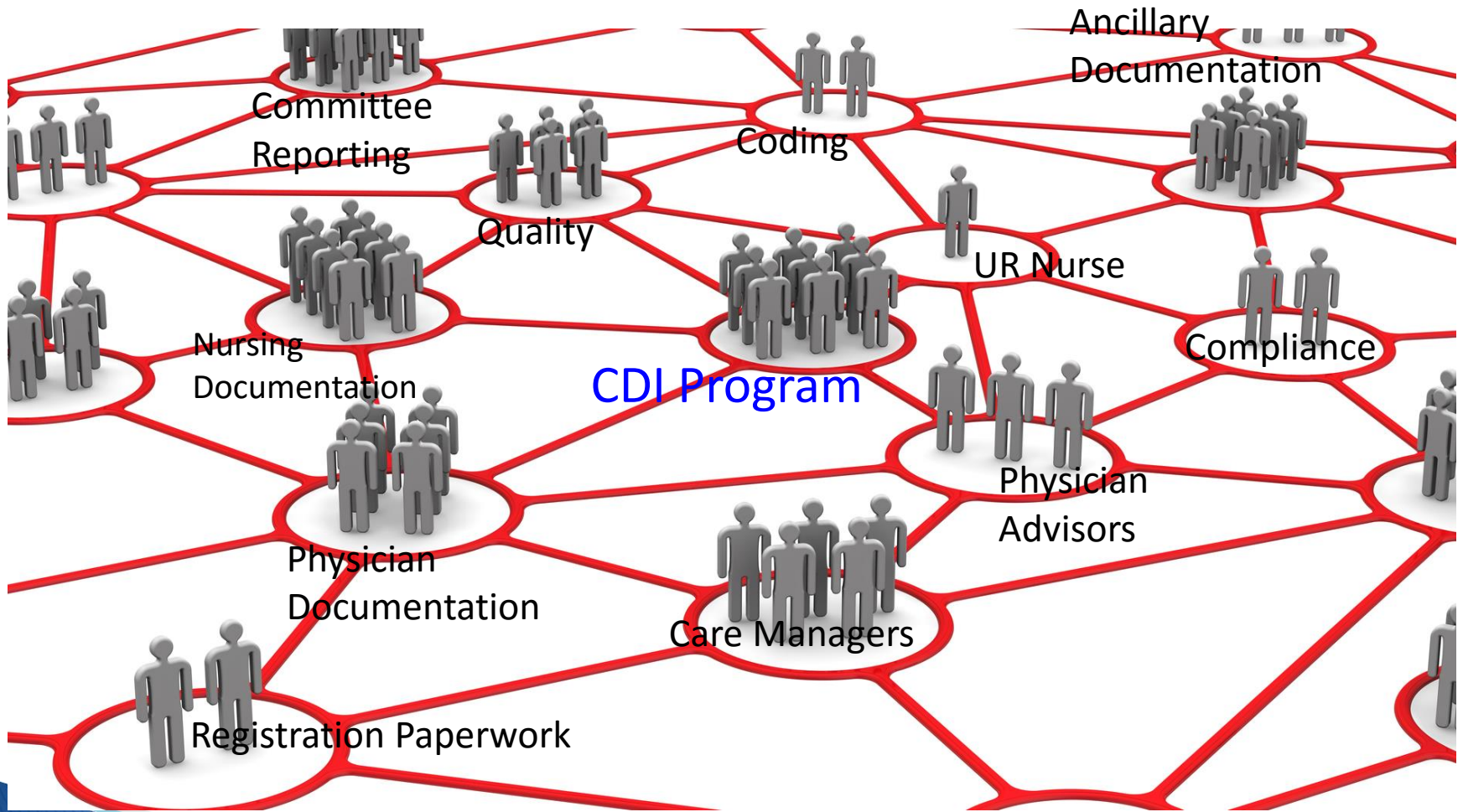
Measure Physician Engagement

- Conduct annual physician engagement surveys
- Track Physician HCAHPS Scores
- Report on physician documentation accuracy
- Track denials based on documentation
- Develop specific indicators for your organization
- Report quality and UR improvements through Medical Staff Committees

Think Strategically

- Where will the next CDI auditors come from?
 - RNs are limited
 - Can other clinical specialties fill the gap
 - Train new auditors
 - Cross train CDI and other auditors
- Integrate CDI into the strategy for utilization audit and improvement activities (Dream Team)
- Use CDI to meet CMS compliance monitoring

CDI as Safety Net



THANK YOU