Documentation 101: CDI

THE FIFTH NATIONAL PHYSICIAN ADVISOR AND UTILIZATION REVIEW BOOT CAMP

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Infirmary Health: About Us

Infirmary Health is the largest non-governmental healthcare system in Alabama, and the second largest not-for-profit healthcare system in the state. More than one million patient visits are made to Infirmary Health facilities each year.

Infirmary Health is the governing organization of 5 acute care hospitals, 2 post-acute care facilities, a physician clinic network with more than 30 locations, 3 diagnostic centers, 3 urgent care clinics, and other affiliates. The healthcare system serves an 11-county area of south Alabama and north Escambia County, Fla., with 700 active physicians and more than 5,000 employees.

Healthcare Industry

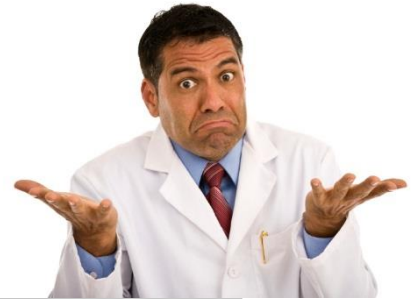
Change from ICD-9 to ICD-10

- Has had a big impact on coding and specificity needs in documentation

Rapidly changing environment from “volume based” to “outcome based”

- A shift from traditional fee-for-service to pay-for-performance
- Value-based care and quality reporting metrics
- Reimbursement models changing for hospitals and physicians
- MACRA…..

A day in the life of a physician at the hospital



I want to practice medicine. Period.

- Nursing—
  - You have to document for the restraints—6 pages later
  - I need pain med orders—the patient is screaming, so I now HAVE to call you
  - Sepsis BPA fired…they aren't septic, but I NEED orders.
  - I know you just saw the patient, but I need you to come back
  - Discharges need to be seen 1st and out by 11 am
  - You haven't seen my new admit yet and its 0900!
  - Critical Lab value called—orders?
  - ED calling for a new admission
  - I could go on for hours with this section
- Quality—
  - VTE prophylaxis
  - SEPSIS
- Infection Control—
  - Do they really need that foley? That culture?
  - You forgot to order a culture!!!!
  - Pull that Central Line
  - Was the perf bowel procedure a surgical site infection???
    - Well, inherently this is an infection, so would you rather me not operate and the patient get septic?

- Case Management—
  - We need to downgrade the patient to obs
  - This needs to be inpatient!!
  - Why are they still here???
  - I need orders to discharge the patient
  - You need to do a peer-to-peer because insurance is denying your patient here for a broken hip
  - I need daily rounds with you to plan discharge…SNF, I need PT, OT, and speech. NOW!
  - You had 2 patients last week readmitted—why??

Office—

- Clinic starts in 10 minutes why are you still at the hospital?
- Clinic started 30 minutes ago, where are you??
- Why haven't you finished your list of 20 patients, it's noon!

CDI—

- The H&P needs to be more specific—was that present on admission?
- I know you just saw the patient, and the consultants haven't seen the patient yet, but I need that CKD staged, I need that CHF specified.
- What are you treating?
- Why did you change the antibiotics?
- I need a diagnosis
- Are they really septic, or just had SIRS fire to rule out sepsis
- Was the foley present on admission?
- Can you re-state what the imaging report said into your note?

Reality for physicians

- Physicians do not learn “this stuff” in Medical School or during residency
  - I wish that a part of medical school touched on how vital documentation is to practicing medicine in the world of healthcare today.
- They are being squeezed in every direction, as are hospitals, so which person do you listen to? What ask is the most important one?
- Providers are being asked to do multiple things for 1 patient, and these groups can have competing goals, which makes it hard for physicians— “just tell me what you want.”
- Core measures, quality outcome measures, publically reported measures, and reimbursement penalties used to just hit the hospital, but now that it is creeping into the physician payment structure, there is more urgency in complete and accurate documentation
- And then there is the EMR….what seems so simple and a fix for issues, has created more issues

CDI Landscape

OLD CDI Model:

Reimbursement driven

DRG maximization

Medicare Only

Fee-for-service

NEW CDI Model:

Complete documentation integrity driven

Quality measures

Nursing documentation completeness

Medical necessity

Reimbursement and VBP driven

DRG maximization

All Payors

Pay-for-performance

Define Clinical Documentation Improvement (CDI)

Mission Statement:

Improve clinical documentation to accurately reflect the severity of illness, risk of mortality, length of stay, quality of care outcomes, and to protect the integrity of the care provided to our patients.

Why is Clinical Documentation so important?

Where do we start?

- The ED is a place where anywhere between 60-70% of admissions originate
  - I wish this was a part of medical school—what to expect when you start practicing
- ED provider documentation often differs from the attending provider's H&P
  - ED is fast paced shift work
  - The ED stabilizes and addresses acute issues, so by the time the attending sees the patient, the patient has already received some treatment for the symptoms they presented with and may not look the same as they did on presentation
- The difference in documentation and timing effects documentation, as well as a clear picture for medical necessity

ED example

- 84 year old female patient presents with UTI, AMS, and hypovolemic shock due to dehydration from GI E. coli infection. Patient had room air sats in 70's, placed on biPAP, respiratory distress resolved as fluids were given, transitioned to 2L NC. Patient given 5L IVF bolus in ED and decision made to admit for IV antibiotics and resolution of AMS, as patient is improving, but not back to baseline.
  - Attending documents in the H&P: Encephalopathy and hypotension, resolved. Does not carry forward shock or respiratory distress to the H&P…the ABGs and biPAP support acute respiratory failure, but none of that was put into H&P.
  - Opportunities and questions
    - Was the ED provider documentation complete and did it contain all of the events above?
    - Speak to the attending to ask why the shock and respiratory distress were not carried forward
    - CDI in the ED would be able to facilitate this conversation real time with the ED providers

ED CDI Strategy

- CDI to bridge the gap through the following:

- Collaboration
  - Case Management—correct status, correct level of care, provide the ED with appropriate options for care (OP, CHF Clinic, SNF)
  - Nursing—Education regarding documentation—help in the fast paced environment where everything is emergent, so documentation of all events can be difficult to capture
  - ER Providers—one on one education in real-time to understand what needs to be documented
  - Attending Providers—one on one education after the admission is made and they are examining the patient and starting the care plan

- CDI can facilitate the start of a care plan—circle the GMLOS and begin on day 1. This also helps to ensure the medical necessity of IP admission is clear from the beginning.

ED CDI Strategy

- Everything comes back to documentation, so having CDI that is familiar with the ED process is the 1st step in having a successful partnership
- Cross train to understand what the facility uses to determine the appropriate status, and apply this to documentation needs.
  - Severity of symptoms
  - Services received
  - ED physician rationale for admission (the presentation and why they want to admit, for what treatments or rule outs)
- Look at note templates or create templates that help the providers capture everything they need to document

Inpatient CDI

Follow the patients from admission thru discharge

- Initial Reviews
  - Establish a principal diagnosis and co-morbid conditions to establish a working DRG and GMLOS
    - Review of all pertinent records goes into this review (including ED notes)
- Re-reviews
  - Follow the plan of care and make adjustments/additions as tests result
  - Begin to look for quality indicators
  - Recognizing any potential patient safety questions or opportunities for clarifying questions
  - Make sure the clinical picture of the patient in the bed matches the picture of the patient on paper
- Focus reviews as needed
- All mortality reviews

Denials Management

Denials that come through for clinical validation

- Sent to CDI to review and make recommendations based on clinical review
  - CDI sends back the justification for our appeals/denials team to formally appeal
- Provides an avenue for physician education areas, as well as shared knowledge between the CDI, appeals, and coding departments.
- This gives CDI another opportunity to see how important it is to match clinical indications to the documentation, as well as learning opportunities on where to look for adequate documentation by the providers, as provide that education.

Readmissions

Readmission Reduction Committee

- Over 1 year into this structure
- Established a focus area for the hospital
- United the medical staff, nursing, case management, ED, pharmacy, PT, respiratory, and others to have one goal and work together to monitor and track opportunities
- We have changed the culture of a 500+ bed hospital
  - Concurrent readmission root cause analysis
  - Partnership with post-acute facilities for root cause
  - New Skilled Nursing Facility process with our ED when sending patients
- Communication and ownership

Readmissions

Documentation is one of the most important components when looking at readmissions and strategies to prevent avoidable readmissions

- One strategy we employ is to treat all co-morbid conditions during any hospitalization
  - You can only address and treat conditions, if they are known and documented by the providers
- Documentation to clearly outline the course of treatment and progression of care
- Follow ups post discharge and medication reconciliation
- Upon arrival to the ED—review the prior encounter's documentation to establish a baseline to evaluate the clinical presentation of the patient (i.e. chronic conditions)