An Integrated Clinical Documentation Improvement Program

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What efforts are being done to ensure the record can support the pt status and is coded correctly?

- CDI specialist
- Focus: concurrent interaction with providers to ensure co-morbidities and other complications are well documented.
- AND ICD 10 is coming

- UR/Case mgt
- Focus: work to ensure the patient status is correct and supported by the physician's order (and run reports & insurance work & criteria)

Do we have enough resources to do it all well and add charge capture ownership? Any? Or some?

With new challenges and demands on documentation – time to think new, creative (even scary thoughts)

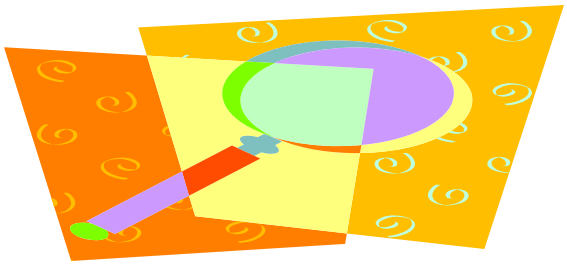
= AN INTEGRATED CDI PROGRAM

An Integrated CDI Program

LOOKS AT……

Three distinct documentation challenges (ICD 10, Pt Status and Charge Capture) and incorporates them all into 1 integrated CDI program with focused education for all 'at risk' patterns thru 1 coordinated CDI specialist/trainer.

Correct coding	Pt status	Charge Capture
• Coders back end clean up • CDI specialist – front end, more interactive • Tracking and trending patterns?	• UR/Case Mgr – both front end and back end • Auditors – denial /appeals • Tracking and trending patterns?	• Dedicated staff • Internal auditor – only upon request • Few individual depts doing • Tracking and trending patterns?



Let's look at how and why to implement an integrated approach

1) Limited resources and still need to do it 'all'
2) Providers confused, push back, lack of buy in, inconsistent message from multiple staff
3) No effective change in documentation – difficult to sustain – fragmented efforts.

Step 1: Clarify the current process for each component

1) **Current correct coding efforts (CDI current work)**
2) **UR daily efforts (Patient Status)**
3) **Charge capture efforts (any where? Or hot areas such as drug administration and OR)**

1) Current broken processes – Coding and ICD -10 Readiness

- Track and trend current coder queries
- What repeat patterns are present from the medical staff?
- What repeat patterns are being tracked by the concurrent coding/queries by the CDI specialists?
- Is there any joint tracking and trending?
- What education efforts are occurring to stop the repeat patterns? Ongoing audits?

Audit to determine current at risk patterns

1) Documentation to support ICD -10.

- Audit of existing documentation to identify ‘at risk’ patterns.
- 5 records per provider – begin with providers: ER, cardiology, ortho, surgery – inpt

2) Identify ‘place and chase’ with UR

- What are the daily hrs of coverage for UR?
- Is there UR in the ER and if so, hrs?
- Have patterns of poor admission orders and action plan to support both OBS and inpt status been tracked and trended? Discharge challenges included.
- What changes have been made to attack the new 2 midnight Medicare rule? Same for all payers?

Audit current inpt and obs:

2) Patient Status – Inpatient vs. Observation.

- Audit of existing documentation to determine current understanding of documentation requirements – for the physician as well as nursing. With the new definition of an inpt, this type of auditing and education is timely and critical.
  - 1 day stays, OBS, 3 day qualifying stay

3) Charge ownership

- Who owns completeness of the charges? Manual and/or electronic?
- Is a daily charge reconciliation process done – aligning orders with charges?
- Is there a dedicated charge capture analyst for certain 'nursing difficulty with accuracy' items – like drug adm in an outpt setting?
- Any known hot spots? (Surgery/Drugs, supplies, pharmacy)

Audit order to documentation to UB 04/billing document:

3) Charge capture

- Audit of existing 'hot spot' departments – surgery, ER, observation – with a focus on identifying under charges as well as over charges that includes 'challenges of orders matching what was done and billed.
  - Line item audit to match order to documentation to UB

Next – Share results from Audits, UR and Coder Feedback – Sr leaders buy in

- **Time to do education with impacted areas**
- **Physician, nursing, dept heads = all owners of an integrated CDI program**
- **No final decision yet on how to integrate – just learning the current processes**

Finally – brainstorm how to move to 1 consistent message of education

- Leadership facilitates the brainstorming session –sharing the goal:
  - To create a single, integrated system of CDI specialists within the organization.
  - To create a consistent message of how to fix what was broken from the audits- coding/ICD 10, pt status, charge audits.
  - To create a single, training message to providers with the 'pearls' from all the audits (as providers are the key in most audits)
  - To ensure no silos exist within the organization

EXCITING Kick Off Education with audit results – who of the UR , CDI, case mgt or others are the best trainers for the integrated team?

- Within a very short time frame, create a timeline for a 1 day kick off. (All CDI team = 1 trainer/mgs)
- Incorporate:
  - Kick off Physician education:
    - "What are documentation standards and why do I care" –with EASY to implement documentation tools
    - "Attacking the challenges of inpt vs obs- why is it so hard?" -with the tools for enhancing the patient story.
    - Determine if 'ensuring the order matches what was done' requires a formal class or individual physician education but share the 'big message' of the facility's commitment to CDI…

And additional clinical education

- **Nursing, nursing, nursing…. Has been left out of significant documentation training.**
- Ensure the audits include nursing's role in enhancing the pt story. (Obs, inpt)
- Ensure nursing understands how they can compliment the work of a dedicated CDI specialists – they are the eyes of the record 24/7 with immediate alerts.
- Other hot departments? Ensure they meet with the CDI team to determine –next steps.

Ongoing physician education looks like….

- Integrated CDI team (UR and Coders) and/or (UR, coders, charge capture) meet frequently to discuss – what is broken?
- Develop training outlines to address 'roll out' of pearls of training .
- EX) **ICD 10**- March/focus on ER; April/focus on Cardio; May/focus on Ortho with follow up by ALL the team on a daily basis
- EX) **Inpt status** – Dec/focus on Inpt certification form
- EX) **Chrg capture-** Jan/focus on protocols ordered specific to the pt.

Last step: Explore changing reporting relationships while consolidating into 1 **clinical-focused** educational voice

Coding
- ICD 10 audit and ongoing validation
- Coding specialists work with providers
- Option: report to Director of Revenue cycle

UR
- Daily review of pt status at the time of the original order
- UR documentation specialist work with providers
- Option: report to Director of Revenue cycle

Charge capture
- Daily review hot spots for lost charges
- Identify lost charges and documentation challenges-doc/dept head
- Option: report to Director of Revenue cycle

Doing nothing …is not an option. Be creative in attacking the challenges of documentation to support billable services.

It is darn fun! Move forward with a new, dynamic approach to a challenging environment.

PS Don't' forget those pesty EMR's too…they can help with creating 'coaching/ques/queries/forms" – all tools.

GO TEAM! THANKS A TON

Thanks for a fun training time!

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